



FORMULARY LIST OF COVERED DRUGS

Johns Hopkins Advantage MD D-SNP (HMO)

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

HPMS Approved Formulary File Submission ID 00024151, Version 11

This formulary was updated on 04/01/2024 For more recent information or other questions, please contact Johns Hopkins Advantage MD D-SNP (HMO) Customer Service at 1-877-293-4998 (TTY users should call 711), 24 hours a day, 7 days a week, or visit www.hopkinsmedicare.com.

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 Johns Hopkins Advantage MD. When it refers to “plan” or “our plan,” it means Johns Hopkins Advantage MD D-SNP (HMO).

This document includes the list of the drugs (formulary) for our plan which is current as of 04/01/2024. For updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What is the Johns Hopkins Advantage MD D-SNP (HMO) Formulary?

A formulary is a list of covered drugs selected by our plan 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. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan 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 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 Johns Hopkins Advantage MD D-SNP (HMO) Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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 04/01/2024. To get updated information about the drugs covered by our plan please contact us. Our contact information appears on the front and back cover pages. In the event of any mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 9. 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 - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS”. If you know what your drug is used for, look for the category name in the list that begins page 10. 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 74. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Johns Hopkins Advantage MD D-SNP (HMO) Formulary?" on page 5 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service 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 Customer Service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Johns Hopkins Advantage MD D-SNP (HMO) Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to 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 or utilization restriction exception. **When you request a formulary 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 experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary (or if your ability to get your drugs is limited), we will cover a onetime temporary supply for up to 30-days (or 31-days if you are a long-term care resident) from a network pharmacy. During this period you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For more information

For more detailed information about your Johns Hopkins Advantage MD D-SNP (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

Johns Hopkins Advantage MD D-SNP (HMO) Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 74.

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

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

- PA – Prior Authorization. Our plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- QL – Drug has Quantity limit. For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets per 30 days per prescription for rosuvastatin.
- ST – Step Therapy. In some cases, our plan requires you to first try certain drugs to treat your medical condition, before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
- NM – Not available at mail-order pharmacies
- LA – Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-877-293-4998, 24 hours a day, 7 days a week. TTY users should call 711.
- B/D – This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Some additional drugs that are not covered by Medicare may be covered through your Maryland Department of Health (Medicaid) benefits. Members can learn about the Maryland drug program at: <https://mmcp.health.maryland.gov/pap/pages/preferred-drug-list.aspx>.

Johns Hopkins Advantage MD D-SNP (HMO)		
Cost Sharing Tier	Standard Retail Cost-Sharing (in-network)	Standard Mail Order Cost-Sharing (in-network)
All Formulary Drugs	<p>25% or \$0 / \$1.55 / \$4.50 for generics (including drugs treated as generics) \$0 / \$4.60 / \$11.20 for all other drugs *</p>	<p>25% or \$0 / \$1.55 / \$4.50 for generics (including drugs treated as generics) \$0 / \$4.60 / \$11.20 for all other drugs *</p>

NOTE:

- Drugs are provided in a Long-Term Care Facility up to a 31-day supply
- Mail order is available to conveniently order up to a 90-day supply of medications. Contact us by calling the phone number listed on the front and back page.
- You can find complete cost-sharing information in your Evidence of Coverage

*Cost sharing is based on your level of Extra Help.

Johns Hopkins Advantage MD D-SNP (HMO)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION		
GOUT - DRUGS TO TREAT GOUT		
<i>allopurinol</i> TABS 100mg, 300mg	1	
<i>colchicine</i> TABS .6mg QL (120 tabs / 30 days)	1	QL
<i>colchicine w/ probenecid tab</i> 0.5-500 mg	1	
<i>MITIGARE</i> CAPS .6mg QL (60 caps / 30 days)	1	QL
<i>probenecid</i> TABS 500mg	1	
NSAIDS - DRUGS TO TREAT PAIN AND INFLAMMATION		
<i>celecoxib</i> (generic of CELEBREX) CAPS 50mg, 100mg, 200mg QL (60 caps / 30 days)	1	QL
<i>celecoxib</i> (generic of CELEBREX) CAPS 400mg QL (30 caps / 30 days)	1	QL
<i>diclofenac potassium</i> TABS 50mg QL (120 tabs / 30 days)	1	QL
<i>diclofenac sodium</i> TB24 100mg; TBEC 25mg, 50mg, 75mg	1	
<i>diflunisal</i> TABS 500mg	1	
<i>ec-naproxen</i> (generic of EC- NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	1	QL
<i>ec-naproxen</i> (generic of EC- NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	1	QL
<i>etodolac</i> CAPS 200mg, 300mg; TABS 500mg; TB24 400mg, 500mg, 600mg	1	
<i>etodolac</i> (generic of LODINE) TABS 400mg	1	
<i>flurbiprofen</i> TABS 100mg	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>ibu</i> TABS 400mg, 600mg, 800mg	1	
<i>ibuprofen</i> SUSP 100mg/5ml; TABS 400mg, 600mg, 800mg	1	
<i>meloxicam</i> TABS 7.5mg, 15mg	1	
<i>nabumetone</i> TABS 500mg, 750mg	1	
<i>naproxen</i> TABS 250mg, 375mg	1	
<i>naproxen</i> (generic of NAPROSYN) TABS 500mg	1	
<i>naproxen</i> (generic of EC- NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	1	QL
<i>naproxen</i> (generic of EC- NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	1	QL
<i>naproxen sodium</i> TABS 275mg	1	
<i>naproxen sodium</i> (generic of ANAPROX DS) TABS 550mg	1	
<i>piroxicam</i> (generic of FELDENE) CAPS 10mg, 20mg	1	
<i>sulindac</i> TABS 150mg, 200mg	1	
OPIOID ANALGESICS, LONG-ACTING		
<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr QL (10 patches / 30 days)	1	QL PA
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	1	QL PA
<i>HYSINGLA ER</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	1	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml QL (450 mL / 30 days)	1	QL PA
<i>methadone hcl</i> TABS 5mg, 10mg QL (90 tabs / 30 days)	1	QL PA
<i>methadone hydrochloride i</i> (generic of METHADOSE) CONC 10mg/ml QL (90 mL / 30 days)	1	QL PA
<i>morphine sulfate</i> (generic of MS CONTIN) TBCR 15mg, 30mg, 60mg, 100mg, 200mg QL (90 tabs / 30 days)	1	QL PA
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen w/ codeine</i> <i>soln</i> 120-12 mg/5ml QL (2700 mL / 30 days)	1	QL
<i>acetaminophen w/ codeine</i> <i>tab</i> 300-15 mg QL (400 tabs / 30 days)	1	QL
<i>acetaminophen w/ codeine</i> <i>tab</i> 300-30 mg QL (360 tabs / 30 days)	1	QL
<i>acetaminophen w/ codeine</i> <i>tab</i> 300-60 mg QL (180 tabs / 30 days)	1	QL
<i>butorphanol tartrate</i> SOLN 1mg/ml, 2mg/ml	1	
<i>endocet</i> tab 2.5-325mg (generic of PERCOSET) QL (360 tabs / 30 days)	1	QL
<i>endocet</i> tab 5-325mg (generic of PERCOSET) QL (360 tabs / 30 days)	1	QL
<i>endocet</i> tab 7.5-325mg (generic of PERCOSET) QL (240 tabs / 30 days)	1	QL
<i>endocet</i> tab 10-325mg (generic of PERCOSET) QL (180 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>fentanyl citrate</i> LPOP 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg QL (120 lozenges / 30 days)	1	QL PA
<i>hydrocodone-acetaminophen</i> <i>soln</i> 7.5-325 mg/15ml QL (2700 mL / 30 days)	1	QL
<i>hydrocodone-acetaminophen</i> <i>tab</i> 5-325 mg QL (240 tabs / 30 days)	1	QL
<i>hydrocodone-acetaminophen</i> <i>tab</i> 7.5-325 mg QL (180 tabs / 30 days)	1	QL
<i>hydrocodone-acetaminophen</i> <i>tab</i> 10-325 mg QL (180 tabs / 30 days)	1	QL
<i>hydrocodone-ibuprofen</i> tab 7.5-200 mg QL (150 tabs / 30 days)	1	QL
<i>hydromorphone hcl</i> (generic of DILAUDID) LIQD 1mg/ml QL (600 mL / 30 days)	1	QL
<i>hydromorphone hcl</i> (generic of DILAUDID) TABS 2mg, 4mg, 8mg QL (180 tabs / 30 days)	1	QL
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 50mg/ml	1	B/D
<i>morphine sulfate</i> SOLN 4mg/ml, 8mg/ml, 10mg/ml	1	B/D
<i>morphine sulfate</i> SOLN 10mg/5ml, 20mg/5ml QL (900 mL / 30 days)	1	QL
<i>morphine sulfate</i> SOLN 20mg/ml QL (180 mL / 30 days)	1	QL
<i>morphine sulfate</i> TABS 15mg, 30mg QL (180 tabs / 30 days)	1	QL
MORPHINE SULFATE/SODIUM C SOLN 1mg/ml	1	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>nalbuphine hcl</i> SOLN 10mg/ml, 20mg/ml	1	
<i>oxycodone hcl</i> CAPS 5mg QL (180 caps / 30 days)	1	QL
<i>oxycodone hcl</i> CONC 100mg/5ml QL (180 mL / 30 days)	1	QL
<i>oxycodone hcl</i> SOLN 5mg/5ml QL (900 mL / 30 days)	1	QL
<i>oxycodone hcl</i> TABS 5mg, 10mg, 20mg QL (180 tabs / 30 days)	1	QL
<i>oxycodone hcl</i> (generic of ROXICODONE) TABS 15mg, 30mg QL (180 tabs / 30 days)	1	QL
<i>oxycodone w/ acetaminophen</i> 1 tab 2.5-325 mg (generic of PERCO CET) QL (360 tabs / 30 days)	1	QL
<i>oxycodone w/ acetaminophen</i> 1 tab 5-325 mg (generic of PERCO CET) QL (360 tabs / 30 days)	1	QL
<i>oxycodone w/ acetaminophen</i> 1 tab 7.5-325 mg (generic of PERCO CET) QL (240 tabs / 30 days)	1	QL
<i>oxycodone w/ acetaminophen</i> 1 tab 10-325 mg (generic of PERCO CET) QL (180 tabs / 30 days)	1	QL
<i>tramadol hcl</i> TABS 50mg QL (240 tabs / 30 days)	1	QL
<i>tramadol-acetaminophen tab</i> 1 37.5-325 mg QL (240 tabs / 30 days)	1	QL
ANESTHETICS - DRUGS FOR NUMBING		
LOCAL ANESTHETICS		
<i>lidocaine hcl</i> (local anesth.) (generic of XYLOCAINE-MPF) SOLN .5%, 1%, 1.5%	1	B/D

Drug Name	Drug Requirements/ Tier	Limits
<i>lidocaine hcl</i> (local anesth.) (generic of XYLOCAINE) SOLN .5%, 1%, 2%	1	B/D
ANTI-INFECTIVES - DRUGS TO TREAT		
INFECTIONS		
ANTI-INFECTIVES - MISCELLANEOUS		
<i>albendazole</i> TABS 200mg QL (672 tabs / year)	1	QL PA
<i>amikacin sulfate</i> SOLN 1gm/4ml, 500mg/2ml	1	
<i>atovaquone</i> (generic of MEPRON) SUSP 750mg/5ml	1	
<i>aztreonam</i> (generic of AZACTAM) SOLR 1gm, 2gm	1	
<i>CAYSTON</i> SOLR 75mg	1	NM LA PA
<i>clindamycin hcl</i> (generic of CLEOCIN) CAPS 75mg, 150mg, 300mg	1	
<i>clindamycin palmitate</i> hydrochloride (generic of CLEOCIN PEDIATRIC GRANULE) SOLR 75mg/5ml	1	
<i>clindamycin phosphate</i> (generic of CLEOCIN PHOSPHATE) SOLN 600mg/4ml, 900mg/6ml, 9000mg/60ml	1	
<i>clindamycin phosphate</i> in d5w iv soln 300 mg/50ml	1	
<i>clindamycin phosphate</i> in d5w iv soln 600 mg/50ml	1	
<i>clindamycin phosphate</i> in d5w iv soln 900 mg/50ml	1	
CLINDMYC/NAC INJ 300/50ML	1	
CLINDMYC/NAC INJ 600/50ML	1	
CLINDMYC/NAC INJ 900/50ML	1	
<i>colistimethate sodium</i> (generic of COLY-MYCIN M) SOLR 150mg	1	
<i>dapsone</i> TABS 25mg, 100mg	1	
DAPTO MYCIN SOLR 350mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
daptomycin (generic of DAPTOMYCIN) SOLR 350mg	1		metronidazole (generic of METRONIDAZOLE) SOLN 500mg/100ml	1	
daptomycin SOLR 500mg	1		metronidazole TABS 250mg, 500mg	1	
EMVERM CHEW 100mg QL (12 tabs / year)	1	QL	neomycin sulfate TABS 500mg	1	
ertapenem sodium SOLR 1gm	1		nitazoxanide (generic of ALINIA) TABS 500mg QL (6 tabs / 30 days)	1	QL
gentamicin in saline inj 0.8 mg/ml	1		nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 50mg, 100mg	1	
gentamicin in saline inj 1 mg/ml	1		nitrofurantoin monohyd macro (generic of MACROBID) CAPS 100mg	1	
gentamicin in saline inj 1.2 mg/ml	1		pentamidine isethionate inh (generic of NEBUPENT) SOLR 300mg	1	B/D
gentamicin in saline inj 1.6 mg/ml	1		pentamidine isethionate inj (generic of PENTAM 300) SOLR 300mg	1	
gentamicin in saline inj 2 mg/ml	1		praziquantel (generic of BILTRICIDE) TABS 600mg	1	
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	1		SIVEXTRO SOLR 200mg; TABS 200mg	1	
imipenem-cilastatin intravenous for soln 250 mg	1		streptomycin sulfate SOLR 1gm	1	
imipenem-cilastatin intravenous for soln 500 mg (generic of PRIMAXIN IV)	1		sulfadiazine TABS 500mg	1	
ivermectin (generic of STROMECTOL) TABS 3mg QL (12 tabs / 90 days)	1	QL PA	sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml	1	
linezolid (generic of ZYVOX) SOLN 600mg/300ml	1		sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
linezolid (generic of ZYVOX) SUSR 100mg/5ml QL (1800 mL / 30 days)	1	QL	sulfamethoxazole-trimethoprim tab 400-80 mg (generic of BACTRIM)	1	
linezolid (generic of ZYVOX) TABS 600mg QL (60 tabs / 30 days)	1	QL	sulfamethoxazole-trimethoprim tab 800-160 mg (generic of BACTRIM DS)	1	
LINEZOLID INJ 2MG/ML	1		tinidazole TABS 250mg, 500mg	1	
meropenem SOLR 1gm, 500mg	1				
methenamine hippurate (generic of HIPREX) TABS 1gm	1				

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

12

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
tobramycin (generic of KITABIS PAK) NEBU 300mg/5ml	1	NM PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	1	
trimethoprim TABS 100mg	1	
vancomycin hcl (generic of VANCOCIN) CAPS 125mg QL (80 caps / 180 days)	1	QL
vancomycin hcl (generic of VANCOCIN) CAPS 250mg QL (160 caps / 180 days)	1	QL
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	1	
VANCOMYCIN INJ 1 GM	1	
VANCOMYCIN INJ 500MG	1	
VANCOMYCIN INJ 750MG	1	
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ABELCET SUSP 5mg/ml	1	B/D
amphotericin b SOLR 50mg	1	B/D
amphotericin b liposome (generic of AMBISOME) SUSR 50mg	1	B/D
caspofungin acetate (generic of CANCIDAS) SOLR 50mg, 70mg	1	
fluconazole (generic of DIFLUCAN) SUSR 10mg/ml, 40mg/ml; TABS 100mg, 150mg, 200mg	1	
fluconazole TABS 50mg	1	
fluconazole in nacl 0.9% inj 200 mg/100ml	1	
fluconazole in nacl 0.9% inj 400 mg/200ml	1	
flucytosine (generic of ANCOPON) CAPS 250mg, 500mg	1	PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
griseofulvin ultramicrosize TABS 125mg, 250mg	1	
itraconazole (generic of SPORANOX) CAPS 100mg	1	PA
ketoconazole TABS 200mg	1	PA
micafungin sodium (generic of MYCAMINE) SOLR 50mg, 100mg	1	
nystatin TABS 500000unit	1	
posaconazole (generic of NOXAFL) SUSP 40mg/ml QL (630 mL / 30 days)	1	QL PA
posaconazole (generic of NOXAFL) TBEC 100mg QL (93 tabs / 30 days)	1	QL PA
terbinafine hcl TABS 250mg QL (90 tabs / year)	1	QL
voriconazole (generic of VFEND IV) SOLR 200mg	1	PA
voriconazole (generic of VFEND) SUSR 40mg/ml	1	PA
voriconazole (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	1	QL PA
voriconazole (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	1	QL PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl tab 62.5-25 mg (generic of MALARONE)	1	
atovaquone-proguanil hcl tab 250-100 mg (generic of MALARONE)	1	
chloroquine phosphate TABS 250mg, 500mg	1	
COARTEM TAB 20-120MG	1	
mefloquine hcl TABS 250mg	1	
PRIMAQUINE PHOSPHATE TABS 26.3mg	1	
primaquine phosphate (generic of PRIMAQUINE PHOSPHATE) TABS 26.3mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
quinine sulfate (generic of QUALAQUIN) CAPS 324mg	1	PA
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate (generic of ZIAGEN) SOLN 20mg/ml	1	NM
abacavir sulfate TABS 300mg	1	NM
APTVUS CAPS 250mg	1	NM
atazanavir sulfate CAPS 150mg	1	NM
atazanavir sulfate (generic of REYATAZ) CAPS 200mg, 300mg	1	NM
darunavir (generic of PREZISTA) TABS 600mg QL (60 tabs / 30 days)	1	QL NM
darunavir (generic of PREZISTA) TABS 800mg QL (30 tabs / 30 days)	1	QL NM
EDURANT TABS 25mg	1	NM
efavirenz CAPS 50mg, 200mg	1	NM
efavirenz (generic of SUSTIVA) TABS 600mg	1	NM
emtricitabine (generic of EMTRIVA) CAPS 200mg	1	NM
EMTRIVA SOLN 10mg/ml	1	NM
etravirine (generic of INTELENCE) TABS 100mg, 200mg	1	NM
fosamprenavir calcium (generic of LEXIVA) TABS 700mg	1	NM
FUZEON SOLR 90mg	1	NM LA
INTELENCE TABS 25mg	1	NM
ISENTRESS CHEW 25mg, 100mg; PACK 100mg; TABS 400mg	1	NM
ISENTRESS HD TABS 600mg	1	NM
lamivudine (generic of EPIVIR) SOLN 10mg/ml; TABS 150mg, 300mg	1	NM
LEXIVA SUSP 50mg/ml	1	NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
maraviroc (generic of SELZENTRY) TABS 150mg, 300mg	1	NM
nevirapine SUSP 50mg/5ml; TABS 200mg; TB24 400mg	1	NM
NORVIR PACK 100mg	1	NM
PIFELTRO TABS 100mg	1	NM
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	1	QL NM
PREZISTA TABS 75mg QL (480 tabs / 30 days)	1	QL NM
PREZISTA TABS 150mg QL (240 tabs / 30 days)	1	QL NM
REYATAZ PACK 50mg	1	NM
ritonavir (generic of NORVIR) TABS 100mg	1	NM
RUKOBIA TB12 600mg	1	NM
SELZENTRY SOLN 20mg/ml; TABS 25mg, 75mg	1	NM
SUNLENCA TBPK 300mg	1	NM LA
tenofovir disoproxil fumarate (generic of VIREAD) TABS 300mg	1	NM
TIVICAY TABS 10mg, 25mg, 50mg	1	NM
TIVICAY PD TBSO 5mg	1	NM
TROGARZO SOLN 200mg/1.33ml	1	NM LA
TYBOST TABS 150mg	1	NM
VIRACEPT TABS 250mg, 625mg	1	NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	1	NM
zidovudine (generic of RETROVIR) CAPS 100mg; SYRP 50mg/5ml	1	NM
zidovudine TABS 300mg	1	NM
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	1	NM

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
BIKTARVY TAB 30-120-15 MG	1	NM
BIKTARVY TAB 50-200-25 MG	1	NM
CIMDUO TAB 300-300	1	NM
COMPLERA TAB	1	NM
DELSTRIGO TAB	1	NM
DESCOVY TAB 120-15MG QL (30 tabs / 30 days)	1	QL NM
DESCOVY TAB 200/25MG QL (30 tabs / 30 days)	1	QL NM
DOVATO TAB 50-300MG	1	NM
efavirenz-emtricitabine- tenofovir df tab 600-200-300 mg (generic of ATRIPLA)	1	NM
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (generic of SYMFI LO)	1	NM
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (generic of SYMFI)	1	NM
emtricitabine-tenofovir disoproxil fumarate tab 100- 150 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 133- 200 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 200- 300 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
EVOTAZ TAB 300-150	1	NM
GENVOYA TAB	1	NM
JULUCA TAB 50-25MG	1	NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
lamivudine-zidovudine tab 150-300 mg	1	NM
lopinavir-ritonavir soln 400- 100 mg/5ml (80-20 mg/ml) (generic of KALETRA)	1	NM
lopinavir-ritonavir tab 100-25 mg (generic of KALETRA)	1	NM
lopinavir-ritonavir tab 200-50 mg (generic of KALETRA)	1	NM
ODEFSEY TAB	1	NM
PREZCOBIX TAB 800-150	1	NM
STRIBILD TAB	1	NM
SYMTUZA TAB	1	NM
TRIUMEQ PD TAB	1	NM
TRIUMEQ TAB	1	NM
TRIZIVIR TAB	1	NM
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine CAPS 250mg	1	
ethambutol hcl TABS 100mg	1	
ethambutol hcl (generic of MYAMBUTOL) TABS 400mg	1	
isoniazid SYRP 50mg/5ml; TABS 100mg, 300mg	1	
PRIFTIN TABS 150mg	1	
pyrazinamide TABS 500mg	1	
rifabutin (generic of MYCOBUTIN) CAPS 150mg	1	
rifampin CAPS 150mg, 300mg	1	
rifampin (generic of RIFADIN) SOLR 600mg	1	
SIRTURO TABS 20mg, 100mg	1	NM LA PA
TRECATOR TABS 250mg	1	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir CAPS 200mg; SUSP 200mg/5ml; TABS 400mg, 800mg	1	
acyclovir sodium SOLN 50mg/ml	1	B/D
adefovir dipivoxil TABS 10mg	1	NM

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

LA - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
BARACLUDE SOLN .05mg/ml	1	NM
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	1	NM
EPCLUSUSA PAK 150-37.5	1	NM PA
EPCLUSUSA PAK 200-50MG	1	NM PA
EPCLUSUSA TAB 200-50MG	1	NM PA
EPCLUSUSA TAB 400-100	1	NM PA
famciclovir TABS 125mg, 250mg, 500mg	1	
ganciclovir sodium SOLR 500mg	1	B/D
HARVONI PAK 33.75-150MG	1	NM PA
HARVONI PAK 45-200MG	1	NM PA
HARVONI TAB 45-200MG	1	NM PA
HARVONI TAB 90-400MG	1	NM PA
lamivudine (hbv) TABS 100mg	1	NM
MAVYRET PAK 50-20MG	1	NM PA
MAVYRET TAB 100-40MG	1	NM PA
oseltamivir phosphate (generic of TAMIFLU) CAPS 30mg	1	QL QL (168 caps / year)
oseltamivir phosphate (generic of TAMIFLU) CAPS 45mg, 75mg	1	QL QL (84 caps / year)
oseltamivir phosphate (generic of TAMIFLU) SUSR 6mg/ml	1	QL QL (1080 mL / year)
PAXLOVID TAB 150-100	1	QL QL (40 tabs / 30 days) \$0 Cost Share
PAXLOVID TAB 300-100	1	QL QL (60 tabs / 30 days) \$0 Cost Share
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	1	NM PA
PREVYMIS TABS 240mg, 480mg	1	QL PA QL (28 tabs / 28 days)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
RELENZA DISKHALER AEPB 5mg/blister	1	QL QL (6 inhalers / year)
ribavirin (hepatitis c) CAPS 200mg; TABS 200mg	1	NM
rimantadine hydrochloride TABS 100mg	1	
valacyclovir hcl (generic of VALTREX) TABS 1gm, 500mg	1	
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml; TABS 450mg	1	
VEMLIDY TABS 25mg	1	NM
VOSEVI TAB	1	NM PA
XOFLUZA TBPK 40mg, 80mg	1	QL QL (1 tab / 180 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor CAPS 250mg, 500mg; SUSR 250mg/5ml	1	
CEFACLOR ER TB12 500mg	1	
cefadroxil CAPS 500mg; SUSR 250mg/5ml, 500mg/5ml	1	
CEFAZOLIN SOLR 2gm, 3gm	1	
CEFAZOLIN INJ 1GM/50ML	1	
cefaezolin sodium SOLR 1gm, 2gm, 10gm, 500mg	1	
CEFAZOLIN SOLN 2GM/100ML-4%	1	
cefdinir CAPS 300mg; SUSR 125mg/5ml, 250mg/5ml	1	
cefpeme hcl SOLR 1gm, 2gm	1	
cefixime CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	1	
cefoxitin sodium SOLR 1gm, 2gm, 10gm	1	
cefpodoxime proxetil SUSR 50mg/5ml, 100mg/5ml; TABS 100mg, 200mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	1	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	1	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	1	
<i>cephalexin</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml	1	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	1	
<i>TEFLARO</i> SOLR 400mg, 600mg	1	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
<i>azithromycin</i> PACK 1gm; TABS 600mg	1	
<i>azithromycin</i> (generic of ZITHROMAX) SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml; TABS 250mg, 500mg	1	
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>clarithromycin</i> (generic of BIAXIN XL) TB24 500mg	1	
<i>DIFICID</i> SUSR 40mg/ml; TABS 200mg	1	
e.e.s. 400 TABS 400mg	1	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	1	
<i>ERYTHROCIN LACTOBIONATE</i> SOLR 500mg	1	
<i>erythrocin stearate</i> TABS 250mg	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	1	
<i>erythromycin ethylsuccinate</i> TABS 400mg	1	
<i>erythromycin lactobionate</i> (generic of ERYTHROCIN LACTOBIONATE) SOLR 500mg	1	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
<i>CIPRO</i> SUSR 500mg/5ml	1	
<i>ciprofloxacin</i> 200 mg/100ml in d5w	1	
<i>ciprofloxacin</i> 400 mg/200ml in d5w	1	
<i>ciprofloxacin hcl</i> (generic of CIPRO) TABS 250mg, 500mg	1	
<i>ciprofloxacin hcl</i> TABS 750mg	1	
<i>levofloxacin</i> SOLN 25mg/ml; TABS 250mg, 500mg, 750mg	1	
<i>levofloxacin</i> in d5w iv soln 250 mg/50ml	1	
<i>levofloxacin</i> in d5w iv soln 500 mg/100ml	1	
<i>levofloxacin</i> in d5w iv soln 750 mg/150ml	1	
<i>moxifloxacin hcl</i> TABS 400mg	1	
<i>moxifloxacin hcl</i> 400 mg/250ml in sodium chloride 0.8% inj	1	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
<i>amoxicillin</i> CAPS 250mg, 500mg; CHEW 125mg, 250mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	
<i>amoxicillin & k clavulanate</i> chew tab 200-28.5 mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

17

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
amoxicillin & k clavulanate chew tab 400-57 mg	1		dicloxacillin sodium CAPS 250mg, 500mg	1	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	1		nafcillin sodium SOLR 1gm, 2gm, 10gm	1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	1		oxacillin sodium SOLR 1gm, 2gm, 10gm	1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	1		PEN GK/DEXTR INJ 40000/ML	1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml (generic of AUGMENTIN ES-600)	1		PEN GK/DEXTR INJ 60000/ML	1	
amoxicillin & k clavulanate tab 250-125 mg	1		penicillin g potassium SOLR 5000000unit, 20000000unit	1	
amoxicillin & k clavulanate tab 500-125 mg (generic of AUGMENTIN)	1		penicillin g sodium SOLR 5000000unit	1	
amoxicillin & k clavulanate tab 875-125 mg	1		penicillin v potassium SOLR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	1		pfizerpen SOLR 5000000unit, 1 20000000unit	1	
ampicillin CAPS 500mg	1		piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	1	
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm (generic of UNASYN)	1		piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	1	
ampicillin & sulbactam sodium for inj 3 (2-1) gm (generic of UNASYN)	1		piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)	1	
ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm	1		piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)	1	
ampicillin & sulbactam sodium for iv soln 3 (2-1) gm	1		piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	1	
ampicillin & sulbactam sodium for iv soln 15 (10-5) gm (generic of UNASYN BULK PACK)	1		TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
ampicillin sodium SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	1		doxy 100 SOLR 100mg	1	
BICILLIN L-A SUSY 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml	1		doxycycline (monohydrate) CAPS 50mg, 100mg; TABS 50mg, 75mg, 100mg	1	
			doxycycline (monohydrate) (generic of VIBRAMYCIN) SUSR 25mg/5ml	1	
			doxycycline hyclate CAPS 50mg; SOLR 100mg; TABS 20mg, 100mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

18

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>doxycycline hyclate</i> (generic of VIBRAMYCIN) CAPS 100mg	1	
<i>minocycline hcl</i> CAPS 50mg, 75mg, 100mg	1	
NUZYRA SOLR 100mg; TABS 150mg	1	NM LA
<i>tetracycline hcl</i> CAPS 250mg, 500mg	1	PA
<i>tigecycline</i> (generic of TYGACIL) SOLR 50mg	1	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml	1	B/D NM LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	1	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	1	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg; SOLR 1gm, 2gm, 500mg	1	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml, 500mg/ml; TABS 25mg, 50mg	1	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	1	B/D
GLEOSTINE CAPS 10mg, 40mg, 100mg	1	NM
LEUKERAN TABS 2mg	1	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg, 100mg	1	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	1	B/D
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	1	B/D
<i>doxorubicin hcl liposomal</i> (generic of DOXIL) INJ 2mg/ml	1	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	1	B/D

Drug Name	Drug Requirements/ Tier	Limits
ANTIMETABOLITES		
<i>azacitidine</i> (generic of VIDAZA) SUSR 100mg	1	B/D NM
<i>cytarabine</i> SOLN 20mg/ml	1	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	1	B/D
<i>gemcitabine hcl</i> (generic of GEMCITABINE HYDROCHLORIDE) SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml	1	B/D
<i>gemcitabine hcl</i> SOLR 1gm, 2gm, 200mg	1	B/D
INQOVI TAB 35-100MG QL (5 tabs / 28 days)	1	QL NM LA PA
LONSURF TAB 15-6.14 QL (100 tabs / 28 days)	1	QL NM LA PA
LONSURF TAB 20-8.19 QL (80 tabs / 28 days)	1	QL NM LA PA
<i>mercaptopurine</i> TABS 50mg	1	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	1	B/D
ONUREG TABS 200mg, 300mg	1	QL NM LA PA
	QL (14 tabs / 28 days)	
<i>pemetrexed disodium</i> (generic of ALIMTA) SOLR 100mg, 500mg	1	B/D
<i>pemetrexed disodium</i> SOLR 750mg, 1000mg	1	B/D
PURIXAN SUSP 2000mg/100ml	1	NM LA
TABLOID TABS 40mg	1	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i> (generic of ZYTIGA) TABS 250mg	1	QL NM PA
	QL (120 tabs / 30 days)	
<i>abiraterone acetate</i> (generic of ZYTIGA) TABS 500mg	1	QL NM PA
	QL (60 tabs / 30 days)	
AKEEGA TAB 50/500MG	1	QL NM LA PA
	QL (60 tabs / 30 days)	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

19

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
AKEEGA TAB 100/500 QL (60 tabs / 30 days)	1	QL NM LA PA
anastrozole (generic of ARIMIDEX) TABS 1mg	1	
bicalutamide (generic of CASODEX) TABS 50mg	1	
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	1	NM PA
EMCYT CAPS 140mg	1	
ERLEADA TABS 60mg QL (120 tabs / 30 days)	1	QL NM LA PA
ERLEADA TABS 240mg QL (30 tabs / 30 days)	1	QL NM LA PA
EULEXIN CAPS 125mg	1	
exemestane (generic of AROMASIN) TABS 25mg	1	
FIRMAGON SOLR 80mg, 120mg/vial	1	NM PA
fulvestrant (generic of FASLODEX) SOSY 250mg/5ml	1	B/D
letrozole (generic of FEMARA) TABS 2.5mg	1	
leuprolide acetate KIT 1mg/0.2ml	1	NM PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	1	NM PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	1	NM PA
LYSODREN TABS 500mg	1	NM LA
megestrol acetate TABS 20mg, 40mg	1	
nilutamide (generic of NILANDRON) TABS 150mg	1	
NUBEQA TABS 300mg QL (120 tabs / 30 days)	1	QL NM LA PA
ORGOVYX TABS 120mg	1	NM LA PA
ORSERDU TABS 86mg QL (90 tabs / 30 days)	1	QL NM LA PA
ORSERDU TABS 345mg QL (30 tabs / 30 days)	1	QL NM LA PA
SOLTAMOX SOLN 10mg/5ml	1	
tamoxifen citrate TABS 10mg, 20mg	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>toremifene citrate</i> (generic of FARESTON) TABS 60mg	1	
XTANDI CAPS 40mg QL (120 caps / 30 days)	1	QL NM LA PA
XTANDI TABS 40mg QL (120 tabs / 30 days)	1	QL NM LA PA
XTANDI TABS 80mg QL (60 tabs / 30 days)	1	QL NM LA PA
IMMUNOMODULATORS		
<i>lenalidomide</i> CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	1	QL NM LA PA
<i>lenalidomide</i> CAPS 20mg, 25mg QL (21 caps / 28 days)	1	QL NM LA PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg QL (21 caps / 28 days)	1	QL NM LA PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	1	QL NM LA PA
REVLIMID CAPS 20mg, 25mg QL (21 caps / 28 days)	1	QL NM LA PA
THALOMID CAPS 50mg, 100mg QL (28 caps / 28 days)	1	QL NM LA PA
THALOMID CAPS 150mg, 200mg QL (56 caps / 28 days)	1	QL NM LA PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml QL (2 syringes / 28 days)	1	QL NM LA PA
<i>bexarotene</i> (generic of TARGRETIN) CAPS 75mg QL (300 caps / 30 days)	1	QL NM PA
<i>hydroxyurea</i> (generic of HYDREA) CAPS 500mg	1	
<i>irinotecan hcl</i> (generic of CAMPTOSAR) SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml	1	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

20

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
irinotecan hcl SOLN 500mg/25ml	1	B/D
IWLFIN TABS 192mg QL (240 tabs / 30 days)	1	QL NM LA PA
KISQALI 200 PAK FEMARA QL (49 tabs / 28 days)	1	QL NM PA
KISQALI 400 PAK FEMARA QL (70 tabs / 28 days)	1	QL NM PA
KISQALI 600 PAK FEMARA QL (91 tabs / 28 days)	1	QL NM PA
MATULANE CAPS 50mg tretinoin (chemotherapy) CAPS 10mg	1	NM LA
WELIREG TABS 40mg QL (90 tabs / 30 days)	1	QL NM LA PA
MITOTIC INHIBITORS		
docetaxel (generic of DOCETAXEL) CONC 20mg/ml, 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
etoposide SOLN 1gm/50ml, 100mg/5ml, 500mg/25ml	1	B/D
paclitaxel CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	1	B/D
paclitaxel protein-bound particles for iv susp 100 mg	1	B/D NM
vincristine sulfate SOLN 1mg/ml	1	B/D
vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml	1	B/D
MOLECULAR TARGET AGENTS		
ALECensa CAPS 150mg QL (240 caps / 30 days)	1	QL NM LA PA
ALUNBRIG TABS 30mg QL (120 tabs / 30 days)	1	QL NM LA PA
ALUNBRIG TABS 90mg, 180mg QL (30 tabs / 30 days)	1	QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ALUNBRIG PAK QL (30 tabs / 30 days)	1	QL NM LA PA
AUGTYRO CAPS 40mg QL (240 caps / 30 days)	1	QL NM LA PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg QL (30 tabs / 30 days)	1	QL NM LA PA
BALVERSA TABS 3mg QL (84 tabs / 28 days)	1	QL NM LA PA
BALVERSA TABS 4mg QL (56 tabs / 28 days)	1	QL NM LA PA
BALVERSA TABS 5mg QL (28 tabs / 28 days)	1	QL NM LA PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	1	NM PA
bortezomib (generic of VELCADE) SOLR 3.5mg	1	NM PA
BOSULIF CAPS 50mg QL (360 caps / 30 days)	1	QL NM PA
BOSULIF CAPS 100mg QL (150 caps / 25 days)	1	QL NM PA
BOSULIF TABS 100mg QL (180 tabs / 30 days)	1	QL NM PA
BOSULIF TABS 400mg, 500mg QL (30 tabs / 30 days)	1	QL NM PA
BRAFTOVI CAPS 75mg QL (180 caps / 30 days)	1	QL NM LA PA
BRUKINSA CAPS 80mg QL (120 caps / 30 days)	1	QL NM LA PA
CABOMETYX TABS 20mg, 40mg, 60mg QL (30 tabs / 30 days)	1	QL NM LA PA
CALQUENCE CAPS 100mg QL (60 caps / 30 days)	1	QL NM LA PA
CALQUENCE TABS 100mg QL (60 tabs / 30 days)	1	QL NM LA PA
CAPRELSA TABS 100mg QL (60 tabs / 30 days)	1	QL NM LA PA
CAPRELSA TABS 300mg QL (30 tabs / 30 days)	1	QL NM LA PA
COMETRIQ (60MG DOSE) KIT 20mg QL (84 caps / 28 days)	1	QL NM LA PA

PA - Prior Authorization **QL** - Quantity Limits

ST - Step Therapy **NM** - Not available at mail-

order **B/D** - Covered under Medicare B or D

LA - Limited Access

V/I - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier Limits
COMETRIQ KIT 100MG QL (56 caps / 28 days)	1 QL NM LA PA
COMETRIQ KIT 140MG QL (112 caps / 28 days)	1 QL NM LA PA
COPIKTRA CAPS 15mg, 25mg QL (56 caps / 28 days)	1 QL NM LA PA
COTELLIC TABS 20mg QL (63 tabs / 28 days)	1 QL NM LA PA
DAURISMO TABS 25mg QL (60 tabs / 30 days)	1 QL NM LA PA
DAURISMO TABS 100mg QL (30 tabs / 30 days)	1 QL NM LA PA
ERIVEDGE CAPS 150mg QL (30 caps / 30 days)	1 QL NM LA PA
<i>erlotinib hcl</i> (generic of TARCEVA) TABS 25mg QL (90 tabs / 30 days)	1 QL NM PA
<i>erlotinib hcl</i> (generic of TARCEVA) TABS 100mg, 150mg QL (30 tabs / 30 days)	1 QL NM PA
everolimus (generic of AFINITOR) TABS 2.5mg, 5mg, 7.5mg, 10mg QL (30 tabs / 30 days)	1 QL NM PA
everolimus (generic of AFINITOR DISPERZ) TBSO 2mg QL (150 tabs / 30 days)	1 QL NM PA
everolimus (generic of AFINITOR DISPERZ) TBSO 3mg QL (90 tabs / 30 days)	1 QL NM PA
everolimus (generic of AFINITOR DISPERZ) TBSO 5mg QL (60 tabs / 30 days)	1 QL NM PA
EXKIVITY CAPS 40mg QL (120 caps / 30 days)	1 QL NM LA PA
FOTIVDA CAPS .89mg, 1.34mg QL (21 caps / 28 days)	1 QL NM LA PA

Drug Name	Drug Requirements/ Tier Limits
FRUZAQLA CAPS 1mg QL (84 caps / 28 days)	1 QL NM LA PA
FRUZAQLA CAPS 5mg QL (21 caps / 28 days)	1 QL NM LA PA
GAVRETO CAPS 100mg QL (120 caps / 30 days)	1 QL NM LA PA
<i>gefitinib</i> (generic of IRESSA) TABS 250mg QL (30 tabs / 30 days)	1 QL NM PA
GILOTrif TABS 20mg, 30mg, 40mg QL (30 tabs / 30 days)	1 QL NM LA PA
HERCEP HYLEC SOL 60- 10000	1 NM LA PA
HERCEPTIN SOLR 150mg	1 NM LA PA
HERZUMA SOLR 150mg, 420mg	1 NM PA
IBRANCE CAPS 75mg, 100mg, 125mg QL (21 caps / 28 days)	1 QL NM LA PA
IBRANCE TABS 75mg, 100mg, 125mg QL (21 tabs / 28 days)	1 QL NM LA PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1 QL NM LA PA
IDHIFA TABS 50mg, 100mg QL (30 tabs / 30 days)	1 QL NM LA PA
<i>imatinib mesylate</i> (generic of GLEEVEC) TABS 100mg QL (90 tabs / 30 days)	1 QL NM PA
<i>imatinib mesylate</i> (generic of GLEEVEC) TABS 400mg QL (60 tabs / 30 days)	1 QL NM PA
IMBRUVICA CAPS 70mg QL (30 caps / 30 days)	1 QL NM LA PA
IMBRUVICA CAPS 140mg QL (120 caps / 30 days)	1 QL NM LA PA
IMBRUVICA SUSP 70mg/ml QL (216 mL / 27 days)	1 QL NM LA PA
IMBRUVICA TABS 140mg, 280mg, 420mg QL (30 tabs / 30 days)	1 QL NM LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

22

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier Limits
INLYTA TABS 1mg QL (180 tabs / 30 days)	1 QL NM LA PA
INLYTA TABS 5mg QL (120 tabs / 30 days)	1 QL NM LA PA
INREBIC CAPS 100mg QL (120 caps / 30 days)	1 QL NM LA PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg QL (60 tabs / 30 days)	1 QL NM LA PA
JAYPIRCA TABS 50mg QL (30 tabs / 30 days)	1 QL NM LA PA
JAYPIRCA TABS 100mg QL (60 tabs / 30 days)	1 QL NM LA PA
KADCYLA SOLR 100mg, 160mg	1 B/D NM LA
KANJINTI SOLR 150mg, 420mg	1 NM LA PA
KEYTRUDA SOLN 100mg/4ml	1 NM LA PA
KISQALI 200 DOSE TBPK 200mg QL (21 tabs / 28 days)	1 QL NM PA
KISQALI 400 DOSE TBPK 200mg QL (42 tabs / 28 days)	1 QL NM PA
KISQALI 600 DOSE TBPK 200mg QL (63 tabs / 28 days)	1 QL NM PA
KOSELUGO CAPS 10mg QL (240 caps / 30 days)	1 QL NM LA PA
KOSELUGO CAPS 25mg QL (120 caps / 30 days)	1 QL NM LA PA
KRAZATI TABS 200mg QL (180 tabs / 30 days)	1 QL NM LA PA
<i>lapatinib ditosylate</i> (generic of TYKERB) TABS 250mg QL (180 tabs / 30 days)	1 QL NM PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg QL (30 caps / 30 days)	1 QL NM LA PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg QL (60 caps / 30 days)	1 QL NM LA PA

Drug Name	Drug Requirements/ Tier Limits
LENVIMA 10 MG DAILY DOSE CPPK 10mg QL (30 caps / 30 days)	1 QL NM LA PA
LENVIMA 12MG DAILY DOSE CPPK 4mg QL (90 caps / 30 days)	1 QL NM LA PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg QL (60 caps / 30 days)	1 QL NM LA PA
LENVIMA CAP 14 MG QL (60 caps / 30 days)	1 QL NM LA PA
LENVIMA CAP 18 MG QL (90 caps / 30 days)	1 QL NM LA PA
LENVIMA CAP 24 MG QL (90 caps / 30 days)	1 QL NM LA PA
LORBRENA TABS 25mg QL (90 tabs / 30 days)	1 QL NM LA PA
LORBRENA TABS 100mg QL (30 tabs / 30 days)	1 QL NM LA PA
LUMAKRAS TABS 120mg QL (240 tabs / 30 days)	1 QL NM LA PA
LUMAKRAS TABS 320mg QL (90 tabs / 30 days)	1 QL NM LA PA
LYNPARZA TABS 100mg, 150mg QL (120 tabs / 30 days)	1 QL NM LA PA
LYTGOBI (12 MG DAILY DOSE) TBPK 4mg QL (84 tabs / 28 days)	1 QL NM LA PA
LYTGOBI (16 MG DAILY DOSE) TBPK 4mg QL (112 tabs / 28 days)	1 QL NM LA PA
LYTGOBI (20 MG DAILY DOSE) TBPK 4mg QL (140 tabs / 28 days)	1 QL NM LA PA
MEKINIST SOLR .05mg/ml QL (1260 mL / 30 days)	1 QL NM LA PA
MEKINIST TABS 2mg QL (30 tabs / 30 days)	1 QL NM LA PA
MEKINIST TABS .5mg QL (90 tabs / 30 days)	1 QL NM LA PA
MEKTOVI TABS 15mg QL (180 tabs / 30 days)	1 QL NM LA PA
MONJUVI SOLR 200mg	1 NM LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

23

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
NERLYNX TABS 40mg QL (180 tabs / 30 days)	1 QL NM LA PA	ROZLYTREK CAPS 200mg QL (90 caps / 30 days)	1 QL NM LA PA
NEXAVAR TABS 200mg QL (120 tabs / 30 days)	1 QL NM LA PA	ROZLYTREK PACK 50mg QL (336 packets / 28 days)	1 QL NM LA PA
NINLARO CAPS 2.3mg, 3mg, 4mg QL (3 caps / 28 days)	1 QL NM PA	RUBRACA TABS 200mg, 250mg, 300mg QL (120 tabs / 30 days)	1 QL NM LA PA
ODOMZO CAPS 200mg QL (30 caps / 30 days)	1 QL NM LA PA	RYDAPT CAPS 25mg QL (224 caps / 28 days)	1 QL NM PA
OGIVRI SOLR 150mg	1 NM LA PA	SCEMBLIX TABS 20mg QL (60 tabs / 30 days)	1 QL NM PA
OGIVRI INJ 420MG	1 NM LA PA	SCEMBLIX TABS 40mg QL (300 tabs / 30 days)	1 QL NM PA
OGSIVEO TABS 50mg QL (180 tabs / 30 days)	1 QL NM LA PA	<i>sorafenib tosylate</i> (generic of NEXAVAR) TABS 200mg QL (120 tabs / 30 days)	1 QL NM PA
OJJAARA TABS 100mg, 150mg, 200mg QL (30 tabs / 30 days)	1 QL NM LA PA	SPRYCEL TABS 20mg QL (90 tabs / 30 days)	1 QL NM PA
ONTRUZANT SOLR 150mg, 420mg	1 NM LA PA	SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg QL (30 tabs / 30 days)	1 QL NM PA
<i>pazopanib hcl</i> (generic of VOTRIENT) TABS 200mg QL (120 tabs / 30 days)	1 QL NM PA	STIVARGA TABS 40mg QL (84 tabs / 28 days)	1 QL NM LA PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg QL (28 tabs / 28 days)	1 QL NM LA PA	<i>sunitinib malate</i> (generic of SUTENT) CAPS 12.5mg, 25mg, 37.5mg, 50mg QL (30 caps / 30 days)	1 QL NM PA
PHESGO SOL	1 NM LA PA	TABRECTA TABS 150mg, 200mg QL (112 tabs / 28 days)	1 QL NM PA
PIQRAY 200MG DAILY DOSE TBPK 200mg QL (28 tabs / 28 days)	1 QL NM PA	TAFINLAR CAPS 50mg, 75mg QL (120 caps / 30 days)	1 QL NM LA PA
PIQRAY 250MG TAB DOSE QL (56 tabs / 28 days)	1 QL NM PA	TAFINLAR TBSO 10mg QL (900 tabs / 30 days)	1 QL NM LA PA
PIQRAY 300MG DAILY DOSE TBPK 150mg QL (56 tabs / 28 days)	1 QL NM PA	TAGRISSO TABS 40mg, 80mg QL (30 tabs / 30 days)	1 QL NM LA PA
QINLOCK TABS 50mg QL (90 tabs / 30 days)	1 QL NM LA PA	TALZENNA CAPS .1mg, .35mg, .5mg, .75mg, 1mg QL (30 caps / 30 days)	1 QL NM LA PA
RETEVMO CAPS 40mg QL (180 caps / 30 days)	1 QL NM LA PA	TALZENNA CAPS .25mg QL (90 caps / 30 days)	1 QL NM LA PA
RETEVMO CAPS 80mg QL (120 caps / 30 days)	1 QL NM LA PA		
REZLIDHIA CAPS 150mg QL (60 caps / 30 days)	1 QL NM LA PA		
ROZLYTREK CAPS 100mg QL (150 caps / 30 days)	1 QL NM LA PA		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
TASIGNA CAPS 50mg QL (120 caps / 30 days)	1	QL NM PA
TASIGNA CAPS 150mg, 200mg QL (112 caps / 28 days)	1	QL NM PA
TAZVERIK TABS 200mg QL (240 tabs / 30 days)	1	QL NM LA PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	1	NM LA PA
TEPMETKO TABS 225mg QL (60 tabs / 30 days)	1	QL NM LA PA
TIBSOVO TABS 250mg QL (60 tabs / 30 days)	1	QL NM LA PA
TRAZIMERA SOLR 150mg, 420mg	1	NM PA
TRUQAP TABS 160mg, 200mg QL (64 tabs / 28 days)	1	QL NM LA PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	1	NM PA
TUKYSA TABS 50mg, 150mg QL (120 tabs / 30 days)	1	QL NM LA PA
TURALIO CAPS 125mg QL (120 caps / 30 days)	1	QL NM LA PA
VANFLYTA TABS 17.7mg, 26.5mg QL (56 tabs / 28 days)	1	QL NM LA PA
VENCLEXTA TABS 10mg, 50mg QL (112 tabs / 28 days)	1	QL NM LA PA
VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	1	QL NM LA PA
VENCLEXTA TAB START PK QL (42 tabs / 28 days)	1	QL NM LA PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	1	QL NM LA PA
VITRAKVI CAPS 25mg QL (180 caps / 30 days)	1	QL NM LA PA
VITRAKVI CAPS 100mg QL (60 caps / 30 days)	1	QL NM LA PA
VITRAKVI SOLN 20mg/ml QL (300 mL / 30 days)	1	QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
VIZIMPRO TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1	QL NM LA PA
VONJO CAPS 100mg QL (120 caps / 30 days)	1	QL NM LA PA
VOTRIENT TABS 200mg QL (120 tabs / 30 days)	1	QL NM LA PA
XALKORI CAPS 200mg, 250mg; CPSP 50mg QL (120 caps / 30 days)	1	QL NM LA PA
XALKORI CPSP 20mg QL (240 caps / 30 days)	1	QL NM LA PA
XALKORI CPSP 150mg QL (180 caps / 30 days)	1	QL NM LA PA
XOSPATA TABS 40mg QL (90 tabs / 30 days)	1	QL NM LA PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg QL (4 tabs / 28 days)	1	QL NM LA PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	1	QL NM LA PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg QL (4 tabs / 28 days)	1	QL NM LA PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg QL (24 tabs / 28 days)	1	QL NM LA PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	1	QL NM LA PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg QL (32 tabs / 28 days)	1	QL NM LA PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg QL (8 tabs / 28 days)	1	QL NM LA PA
ZEJULA CAPS 100mg QL (90 caps / 30 days)	1	QL NM LA PA
ZEJULA TABS 100mg, 200mg, 300mg QL (30 tabs / 30 days)	1	QL NM LA PA
ZELBORAF TABS 240mg QL (240 tabs / 30 days)	1	QL NM LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	1	NM LA PA
ZOLINZA CAPS 100mg QL (120 caps / 30 days)	1	QL NM PA
ZYDELIG TABS 100mg, 150mg QL (60 tabs / 30 days)	1	QL NM LA PA
ZYKADIA TABS 150mg QL (84 tabs / 28 days)	1	QL NM LA PA
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	1	B/D
leucovorin calcium TABS 5mg, 10mg, 15mg, 25mg	1	
MESNEX TABS 400mg	1	
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate-	1	QL
benazepril hcl cap 2.5-10 mg QL (30 caps / 30 days)		
amlodipine besylate-	1	QL
benazepril hcl cap 5-10 mg (generic of LOTREL) QL (30 caps / 30 days)		
amlodipine besylate-	1	QL
benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days)		
amlodipine besylate-	1	QL
benazepril hcl cap 5-40 mg QL (30 caps / 30 days)		
amlodipine besylate-	1	QL
benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days)		
amlodipine besylate-	1	QL
benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days)		

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
benazepril & hydrochlorothiazide tab 5- 6.25mg	1	
benazepril & hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT)	1	
benazepril & hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT)	1	
benazepril & hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT)	1	
captopril & hydrochlorothiazide tab 25-15 mg	1	
captopril & hydrochlorothiazide tab 25-25 mg	1	
captopril & hydrochlorothiazide tab 50-15 mg	1	
captopril & hydrochlorothiazide tab 50-25 mg	1	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)	1	
fosinopril sodium & hydrochlorothiazide tab 10- 12.5 mg	1	
fosinopril sodium & hydrochlorothiazide tab 20- 12.5 mg	1	
lisinopril & hydrochlorothiazide 1 tab 10-12.5 mg (generic of ZESTORETIC)	1	
lisinopril & hydrochlorothiazide 1 tab 20-12.5 mg (generic of ZESTORETIC)	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

26

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>lisinopril & hydrochlorothiazide</i> 1 tab 20-25 mg (generic of ZESTORETIC)		
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>benazepril hcl</i> TABS 5mg	1	
<i>benazepril hcl</i> (generic of LOTENSIN) TABS 10mg, 20mg, 40mg	1	
<i>captopril</i> TABS 12.5mg, 25mg, 50mg, 100mg	1	
<i>enalapril maleate</i> (generic of VASOTEC) TABS 2.5mg, 5mg, 10mg, 20mg	1	
<i>fosinopril sodium</i> TABS 10mg, 20mg, 40mg	1	
<i>lisinopril</i> (generic of ZESTRIL) TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	
<i>quinapril hcl</i> (generic of ACCUPRIL) TABS 5mg, 10mg, 20mg, 40mg	1	
<i>ramipril</i> (generic of ALTACE) CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>eplerenone</i> (generic of INSPRA) TABS 25mg, 50mg	1	
KERENDIA TABS 10mg, 20mg	1	QL
QL (30 tabs / 30 days)		
<i>spironolactone</i> (generic of ALDACTONE) TABS 25mg, 50mg, 100mg	1	

Drug Name	Drug Requirements/ Tier	Limits
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>doxazosin mesylate</i> (generic of CARDURA) TABS 1mg, 2mg, 4mg, 8mg	1	
<i>prazosin hcl</i> (generic of MINIPRESS) CAPS 1mg, 2mg, 5mg	1	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 5-20 mg (generic of AZOR)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 5-40 mg (generic of AZOR)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 10-20 mg (generic of AZOR)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> tab 10-40 mg (generic of AZOR)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 5-160 mg (generic of EXFORGE)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 5-320 mg (generic of EXFORGE)	1	QL
QL (30 tabs / 30 days)		
<i>amlodipine besylate-valsartan</i> tab 10-160 mg (generic of EXFORGE)	1	QL
QL (30 tabs / 30 days)		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
amlodipine besylate-valsartan tab 10-320 mg (generic of EXFORGE) QL (30 tabs / 30 days)	1	QL
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg (generic of ATACAND HCT) QL (60 tabs / 30 days)	1	QL
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg (generic of ATACAND HCT) QL (30 tabs / 30 days)	1	QL
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg (generic of ATACAND HCT) QL (30 tabs / 30 days)	1	QL
ENTRESTO TAB 24-26MG QL (60 tabs / 30 days)	1	QL
ENTRESTO TAB 49-51MG QL (60 tabs / 30 days)	1	QL
ENTRESTO TAB 97-103MG QL (60 tabs / 30 days)	1	QL
irbesartan-hydrochlorothiazide tab 150-12.5 mg (generic of AVALIDE) QL (60 tabs / 30 days)	1	QL
irbesartan-hydrochlorothiazide tab 300-12.5 mg (generic of AVALIDE) QL (30 tabs / 30 days)	1	QL
losartan potassium & hydrochlorothiazide tab 50-12.5 mg (generic of HYZAAR)	1	
losartan potassium & hydrochlorothiazide tab 100-12.5 mg (generic of HYZAAR)	1	
losartan potassium & hydrochlorothiazide tab 100-25 mg (generic of HYZAAR)	1	
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	QL
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	QL
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	QL
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	QL
telmisartan-amlodipine tab 40- 5 mg QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

28

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
telmisartan-amlodipine tab 40- 10 mg QL (30 tabs / 30 days)		QL
telmisartan-amlodipine tab 80- 5 mg QL (30 tabs / 30 days)		QL
telmisartan-amlodipine tab 80- 10 mg QL (30 tabs / 30 days)		QL
telmisartan-hydrochlorothiazide tab 40- 12.5 mg (generic of MICARDIS HCT) QL (30 tabs / 30 days)	1	QL
telmisartan-hydrochlorothiazide tab 80- 12.5 mg (generic of MICARDIS HCT) QL (60 tabs / 30 days)	1	QL
telmisartan-hydrochlorothiazide tab 80-25 mg (generic of MICARDIS HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 80-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 160-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 160-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil (generic of ATACAND) TABS 4mg, 8mg, 16mg QL (60 tabs / 30 days)	1	QL
candesartan cilexetil (generic of ATACAND) TABS 32mg QL (30 tabs / 30 days)	1	QL
irbesartan (generic of AVAPRO) TABS 75mg, 150mg, 300mg QL (30 tabs / 30 days)	1	QL
losartan potassium (generic of COZAAR) TABS 25mg, 50mg, 100mg QL (60 tabs / 30 days)	1	QL
olmesartan medoxomil (generic of BENICAR) TABS 5mg QL (60 tabs / 30 days)	1	QL
olmesartan medoxomil (generic of BENICAR) TABS 20mg, 40mg QL (30 tabs / 30 days)	1	QL
telmisartan (generic of MICARDIS) TABS 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	QL
valsartan (generic of DIOVAN) TABS 40mg, 80mg, 160mg QL (60 tabs / 30 days)	1	QL
valsartan (generic of DIOVAN) TABS 320mg QL (30 tabs / 30 days)	1	QL
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 200mg, 400mg 1		
disopyramide phosphate (generic of NORPACE) CAPS 100mg, 150mg 1		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
dofetilide (generic of TIKOSYN) CAPS 125mcg, 250mcg, 500mcg	1	NM
flecainide acetate TABS 50mg, 100mg, 150mg	1	
MULTAQ TABS 400mg	1	
NORPACE CR CP12 100mg, 150mg	1	
pacerone TABS 100mg, 200mg, 400mg	1	
propafenone hcl CP12 225mg, 325mg, 425mg; TABS 150mg, 225mg, 300mg	1	
quinidine sulfate TABS 200mg, 300mg	1	
sorine (generic of BETAPACE) TABS 80mg, 120mg, 160mg	1	
sorine TABS 240mg	1	
sotalol hcl (generic of BETAPACE) TABS 80mg, 120mg, 160mg	1	
sotalol hcl TABS 240mg	1	
sotalol hcl (afib/afl) (generic of BETAPACE AF) TABS 80mg, 120mg, 160mg	1	
ANTILIPEMICS, FIBRATES		
fenofibrate (generic of TRICOR) TABS 48mg, 145mg	1	
fenofibrate TABS 54mg, 160mg	1	
fenofibrate micronized CAPS 67mg, 134mg, 200mg	1	
gemfibrozil (generic of LOPID) TABS 600mg	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
atorvastatin calcium (generic of LIPITOR) TABS 10mg, 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
lovastatin TABS 10mg, 20mg, 40mg	1	QL QL (60 tabs / 30 days)
pravastatin sodium TABS 10mg, 20mg, 40mg, 80mg	1	QL QL (30 tabs / 30 days)
rosuvastatin calcium (generic of CRESTOR) TABS 5mg, 10mg, 20mg, 40mg	1	QL QL (30 tabs / 30 days)
simvastatin TABS 5mg, 80mg	1	QL QL (30 tabs / 30 days)
simvastatin (generic of ZOCOR) TABS 10mg, 20mg, 40mg	1	QL QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
cholestyramine (generic of QUESTRAN) PACK 4gm; POWD 4gm/dose	1	
cholestyramine light PACK 4gm	1	
cholestyramine light (generic of QUESTRAN LIGHT) POWD 4gm/dose	1	
colesevelam hcl (generic of WELCHOL) PACK 3.75gm; TABS 625mg	1	
colestipol hcl (generic of COLESTID) GRAN 5gm; PACK 5gm; TABS 1gm	1	
ezetimibe (generic of ZETIA) TABS 10mg	1	
ezetimibe-simvastatin tab 10-10 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
ezetimibe-simvastatin tab 10-20 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
ezetimibe-simvastatin tab 10-40 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

30

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ezetimibe-simvastatin tab 10-80 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg QL (60 tabs / 30 days)	1	QL
omega-3-acid ethyl esters cap 1 gm (generic of LOVAZA)	1	PA
prevalite PACK 4gm	1	
prevalite (generic of QUESTRAN LIGHT) POWD 4gm/dose	1	
REPATHA SOSY 140mg/ml	1	NM PA
REPATHA PUSHTRONEX SYSTEM SOCT 420mg/3.5ml	1	NM PA
REPATHA SURECLICK SOAJ 140mg/ml	1	NM PA
VASCEPA CAPS .5gm, 1gm	1	
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg (generic of TENORETIC 50)	1	
atenolol & chlorthalidone tab 100-25 mg (generic of TENORETIC 100)	1	
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	
metoprolol & hydrochlorothiazide tab 50-25 mg	1	
metoprolol & hydrochlorothiazide tab 100-25 mg	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
metoprolol & hydrochlorothiazide tab 100-50 mg	1	
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl CAPS 200mg, 400mg	1	
atenolol (generic of TENORMIN) TABS 25mg, 50mg, 100mg	1	
betaxolol hcl TABS 10mg, 20mg	1	
bisoprolol fumarate TABS 5mg, 10mg	1	
carvedilol (generic of COREG) TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	
labetalol hcl TABS 100mg, 200mg, 300mg	1	
metoprolol succinate (generic of TOPROL XL) TB24 25mg, 50mg, 100mg, 200mg	1	
metoprolol tartrate SOLN 5mg/5ml; TABS 25mg	1	
metoprolol tartrate (generic of LOPRESSOR) TABS 50mg, 100mg	1	
nadolol (generic of CORGARD) TABS 20mg, 40mg	1	
nadolol TABS 80mg	1	
nebivolol hcl (generic of BYSTOLIC) TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	1	QL
nebivolol hcl (generic of BYSTOLIC) TABS 20mg QL (60 tabs / 30 days)	1	QL
pindolol TABS 5mg, 10mg	1	
propranolol hcl (generic of INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>propranolol hcl</i> SOLN 20mg/5ml, 40mg/5ml; TABS 10mg, 20mg, 40mg, 60mg, 80mg	1	
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	1	
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>amlodipine besylate</i> (generic of NORVASC) TABS 2.5mg, 5mg, 10mg	1	
<i>cartia xt</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	1	
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	1	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg; SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml; TABS 90mg	1	
<i>diltiazem hcl</i> (generic of CARDIZEM) TABS 30mg, 60mg, 120mg	1	
<i>diltiazem hcl coated beads</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>diltiazem hcl extended release beads</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	1	
<i>isradipine</i> CAPS 2.5mg, 5mg	1	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	1	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	1	
<i>nifedipine</i> (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	1	
<i>nimodipine</i> CAPS 30mg	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>NYMALIZE</i> SOLN 6mg/ml	1	
<i>taztia xt</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>tiadylt er</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>verapamil hcl</i> CP24 100mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml; TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	1	
<i>verapamil hcl</i> (generic of VERELAN) CP24 120mg, 180mg, 240mg	1	
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
<i>acetazolamide</i> CP12 500mg; TABS 125mg, 250mg	1	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	
<i>amiloride hcl</i> TABS 5mg	1	
<i>bumetanide</i> SOLN .25mg/ml; TABS 1mg, 2mg	1	
<i>bumetanide</i> (generic of BUMEX) TABS .5mg	1	
<i>chlorthalidone</i> TABS 25mg, 50mg	1	
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml	1	
<i>furosemide</i> (generic of LASIX) TABS 20mg, 40mg, 80mg	1	
<i>furosemide inj</i> SOLN 10mg/ml	1	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	
<i>methazolamide</i> TABS 25mg, 50mg	1	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

32

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
spironolactone & hydrochlorothiazide tab 25-25 mg	1	
torsemide TABS 5mg, 10mg, 20mg, 100mg	1	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 75-50 mg (generic of MAXZIDE)	1	
MISCELLANEOUS		
aliskiren fumarate (generic of TEKTURNA) TABS 150mg, 300mg	1	
clonidine (generic of CATAPRES-TTS-1) PTWK .1mg/24hr	1	
clonidine (generic of CATAPRES-TTS-2) PTWK .2mg/24hr	1	
clonidine (generic of CATAPRES-TTS-3) PTWK .3mg/24hr	1	
clonidine hcl TABS .1mg, .2mg, .3mg	1	
CORLANOR SOLN 5mg/5ml QL (450 mL / 30 days)	1	QL
CORLANOR TABS 5mg, 7.5mg QL (60 tabs / 30 days)	1	QL
digoxin SOLN .05mg/ml 1		
digoxin (generic of LANOXIN) SOLN .25mg/ml 1		
digoxin (generic of LANOXIN) TABS 125mcg, 250mcg QL (30 tabs / 30 days)	1	QL
droxidopa (generic of NORTHERA) CAPS 100mg QL (90 caps / 30 days)	1	QL NM PA

Drug Name	Drug Requirements/ Tier	Limits
droxidopa (generic of NORTHERA) CAPS 200mg, 300mg QL (180 caps / 30 days)	1	QL NM PA
epinephrine (anaphylaxis) SOLN 1mg/ml 1		
guanfacine hcl TABS 1mg, 2mg PA if 70 years and older	1	PA
hydralazine hcl SOLN 20mg/ml; TABS 10mg, 25mg, 50mg, 100mg 1		
metyrosine (generic of DEMSER) CAPS 250mg 1		PA
midodrine hcl TABS 2.5mg, 5mg, 10mg 1		
minoxidil TABS 2.5mg, 10mg 1		
ranolazine TB12 500mg, 1000mg 1		
VERQUVO TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	1	QL
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg 1		
isosorbide dinitrate TABS 10mg, 20mg, 30mg 1		
isosorbide mononitrate TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg 1		
NITRO-BID OINT 2% 1		
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr 1		
nitroglycerin (generic of NITROLINGUAL) SOLN .4mg/spray 1		
nitroglycerin (generic of NITROSTAT) SUBL .3mg, .4mg, .6mg 1		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg QL (90 tabs / 30 days)	1	NM LA PA
ambrisentan (generic of LETAIRIS) TABS 5mg, 10mg QL (30 tabs / 30 days)	1	NM LA PA
bosentan (generic of TRACLEER) TABS 62.5mg, 125mg QL (60 tabs / 30 days)	1	NM LA PA
OPSUMIT TABS 10mg QL (30 tabs / 30 days)	1	NM LA PA
sildenafil citrate (pulmonary hypertension) (generic of REVATIO) TABS 20mg QL (360 tabs / 30 days)	1	NM PA
treprostinil SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	1	NM LA PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	1	NM LA PA
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
alprazolam (generic of XANAX) TABS .25mg, .5mg, 1mg, 2mg QL (150 tabs / 30 days)	1	QL
buspirone hcl TABS 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
fluvoxamine maleate TABS 25mg, 50mg, 100mg	1	
lorazepam CONC 2mg/ml QL (150 mL / 30 days)	1	QL
lorazepam (generic of ATIVAN) SOLN 2mg/ml, 4mg/ml	1	

Drug Name	Drug Requirements/ Tier	Limits
lorazepam (generic of ATIVAN) TABS .5mg, 1mg, 2mg QL (150 tabs / 30 days)	1	QL
lorazepam intensol CONC 2mg/ml QL (150 mL / 30 days)	1	QL
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride (generic of ARICEPT) TABS 5mg QL (30 tabs / 30 days)	1	QL
donepezil hydrochloride (generic of ARICEPT) TABS 10mg	1	
donepezil hydrochloride TBDP 5mg QL (30 tabs / 30 days)	1	QL
donepezil hydrochloride TBDP 10mg	1	
galantamine hydrobromide CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)	1	QL
galantamine hydrobromide SOLN 4mg/ml QL (200 mL / 30 days)	1	QL
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)	1	QL
memantine hcl CP24 7mg; SOLN 2mg/ml; TABS 5mg, 10mg PA applies if 29 years and younger	1	PA
memantine hcl (generic of NAMENDA XR) CP24 14mg, 21mg, 28mg PA applies if 29 years and younger	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i> (generic of NAMENDA TITRATION PAK) PA applies if 29 years and younger	1	PA
NAMZARIC CAP 7-10MG	1	
NAMZARIC CAP 14-10MG	1	
NAMZARIC CAP 21-10MG	1	
NAMZARIC CAP 28-10MG	1	
NAMZARIC CAP PACK	1	
<i>rivastigmine (generic of EXELON) PT24</i> 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	1	QL
<i>rivastigmine tartrate</i> CAPS 1.5mg, 3mg, 4.5mg, 6mg QL (60 caps / 30 days)	1	QL
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
<i>amitriptyline hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	1	
<i>amoxapine</i> TABS 25mg, 50mg, 100mg, 150mg	1	
AUVELITY TAB 45-105MG QL (60 tabs / 30 days)	1	QL PA
<i>bupropion hcl</i> TABS 75mg, 100mg	1	
<i>bupropion hcl (generic of WELLBUTRIN SR)</i> TB12 100mg, 150mg, 200mg QL (60 tabs / 30 days)	1	QL
<i>bupropion hcl (generic of WELLBUTRIN XL)</i> TB24 150mg QL (60 tabs / 30 days)	1	QL
<i>bupropion hcl (generic of WELLBUTRIN XL)</i> TB24 300mg QL (30 tabs / 30 days)	1	QL
<i>citalopram hydrobromide</i> SOLN 10mg/5ml	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>citalopram hydrobromide</i> (generic of CELEXA) TABS 10mg, 20mg, 40mg	1	
<i>clomipramine hcl</i> (generic of ANAFRANIL) CAPS 25mg, 50mg, 75mg	1	PA
<i>desipramine hcl</i> (generic of NORPRAMIN) TABS 10mg, 25mg	1	
<i>desipramine hcl</i> TABS 50mg, 75mg, 100mg, 150mg	1	
<i>desvenlafaxine succinate</i> (generic of PRISTIQ) TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)	1	QL PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	1	
<i> duloxetine hcl</i> (generic of CYMBALTA) CPEP 20mg, 30mg, 60mg QL (60 caps / 30 days)	1	QL
<i>EMSAM</i> PT24 6mg/24hr, 9mg/24hr, 12mg/24hr QL (30 patches / 30 days)	1	QL PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml	1	
<i>escitalopram oxalate</i> (generic of LEXAPRO) TABS 5mg, 10mg, 20mg	1	
<i>FETZIMA</i> CP24 20mg, 40mg QL (60 caps / 30 days)	1	QL PA
<i>FETZIMA</i> CP24 80mg, 120mg QL (30 caps / 30 days)	1	QL PA
<i>FETZIMA</i> CAP TITRATIO QL (2 packs / year)	1	QL PA
<i>fluoxetine hcl</i> (generic of PROZAC) CAPS 10mg, 20mg, 40mg	1	
<i>fluoxetine hcl</i> SOLN 20mg/5ml	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits	Drug Name	Drug Requirements/ Tier	Limits	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	1		TRINTELLIX TABS 5mg, 10mg, 20mg	1	QL QL (30 tabs / 30 days)	
MARPLAN TABS 10mg QL (180 tabs / 30 days)	1	QL	<i>venlafaxine hcl</i> (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg	1		
<i>mirtazapine</i> TABS 7.5mg, 45mg	1		<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	1		
<i>mirtazapine</i> (generic of REMERON) TABS 15mg, 30mg	1		<i>vilazodone hcl</i> (generic of VIIBRYD) TABS 10mg, 20mg, 40mg	1	QL QL (30 tabs / 30 days)	
<i>mirtazapine</i> (generic of REMERON SOLTAB) TBDP 15mg, 30mg, 45mg	1		ZURZUVAE CAPS 20mg, 25mg	1	QL NM LA PA QL (28 caps / 14 days)	
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	1		ZURZUVAE CAPS 30mg	1	QL NM LA PA QL (14 caps / 14 days)	
<i>nortriptyline hcl</i> (generic of PAMELOR) CAPS 10mg, 25mg, 50mg, 75mg	1		ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE			
<i>nortriptyline hcl</i> SOLN 10mg/5ml	1		<i>amantadine hcl</i> CAPS 100mg	1	QL QL (120 caps / 30 days)	
<i>paroxetine hcl</i> (generic of PAXIL) SUSP 10mg/5ml QL (900 mL / 30 days)	1	QL PA	<i>amantadine hcl</i> SOLN 50mg/5ml; TABS 100mg	1		
<i>paroxetine hcl</i> (generic of PAXIL) TABS 10mg, 20mg, 30mg, 40mg	1		<i>benztropine mesylate</i> SOLN 1mg/ml	1		
<i>phenelzine sulfate</i> (generic of NARDIL) TABS 15mg	1		<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg PA if 70 years and older	1	PA	
<i>protriptyline hcl</i> TABS 5mg, 10mg	1		<i>bromocriptine mesylate</i> (generic of PARLODEL) CAPS 5mg; TABS 2.5mg	1		
<i>sertraline hcl</i> (generic of ZOLOFT) CONC 20mg/ml; TABS 25mg, 50mg, 100mg	1		<i>carb/levo orally disintegrating</i> tab 10-100mg	1		
<i>tranylcypromine sulfate</i> (generic of PARNATE) TABS 10mg	1		<i>carb/levo orally disintegrating</i> tab 25-100mg	1		
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1		<i>carb/levo orally disintegrating</i> tab 25-250mg	1		
<i>trimipramine maleate</i> CAPS 25mg, 50mg QL (120 caps / 30 days)	1	QL	<i>carbidopa & levodopa tab 10-</i> <i>100 mg</i> (generic of SINEMET)	1		
<i>trimipramine maleate</i> CAPS 100mg QL (60 caps / 30 days)	1	QL	<i>carbidopa & levodopa tab 25-</i> <i>100 mg</i> (generic of SINEMET)	1		
			<i>carbidopa & levodopa tab 25-</i> <i>250 mg</i>	1		

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
carbidopa & levodopa tab er 25-100 mg	1	
carbidopa & levodopa tab er 50-200 mg	1	
carbidopa-levodopa- entacapone tabs 12.5-50-200 mg	1	
carbidopa-levodopa- entacapone tabs 18.75-75- 200 mg	1	
carbidopa-levodopa- entacapone tabs 25-100-200 mg	1	
carbidopa-levodopa- entacapone tabs 31.25-125- 200 mg	1	
carbidopa-levodopa- entacapone tabs 37.5-150- 200 mg (generic of STALEVO 150)	1	
carbidopa-levodopa- entacapone tabs 50-200-200 mg	1	
entacapone TABS 200mg	1	
INBRIJA CAPS 42mg	1	QL NM LA PA QL (300 caps / 30 days)
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	1	
pramipexole dihydrochloride	1	
TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg		
rasagiline mesylate (generic of AZILECT) TABS .5mg, 1mg	1	QL QL (30 tabs / 30 days)
ropinirole hydrochloride	1	
TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg		
selegiline hcl CAPS 5mg; TABS 5mg	1	

Drug Name	Drug Requirements/ Tier	Limits
trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg PA if 70 years and older	1	PA
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
ABILIFY MAINTENA PRSY 300mg, 400mg QL (1 syringe / 28 days)	1	QL
ABILIFY MAINTENA SRER 300mg, 400mg QL (1 injection / 28 days)	1	QL
ariPIPRAZOLE SOLN 1mg/ml QL (900 mL / 30 days)	1	QL
ariPIPRAZOLE (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg QL (30 tabs / 30 days)	1	QL
ariPIPRAZOLE TBDP 10mg, 15mg QL (60 tabs / 30 days)	1	QL
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	1	QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	1	QL
ARISTADA INITIO PRSY 675mg/2.4ml asenapine maleate (generic of 1 SAPHRIS) SUBL 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	1	QL
CAPLYTA CAPS 10.5mg, 21mg, 42mg QL (30 caps / 30 days)	1	QL
chlorpromazine hcl CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>clozapine</i> (generic of CLOZARIL) TABS 25mg, 50mg	1		INVEGA SUSTENNA SUSY	1	QL
<i>clozapine</i> (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30 days)	1	QL	39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml QL (1 syringe / 28 days)		
<i>clozapine</i> (generic of CLOZARIL) TABS 200mg QL (120 tabs / 30 days)	1	QL	INVEGA TRINZA SUSY	1	QL
<i>clozapine</i> TBDP 12.5mg, 25mg	1	PA	273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml QL (1 syringe / 90 days)		
<i>clozapine</i> TBDP 100mg QL (270 tabs / 30 days)	1	QL PA	<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	1	
<i>clozapine</i> TBDP 150mg QL (180 tabs / 30 days)	1	QL PA	<i>lurasidone hcl</i> (generic of LATUDA) TABS 20mg, 40mg, 60mg, 120mg QL (30 tabs / 30 days)	1	QL
<i>clozapine</i> TBDP 200mg QL (120 tabs / 30 days)	1	QL PA	<i>lurasidone hcl</i> (generic of LATUDA) TABS 80mg QL (60 tabs / 30 days)	1	QL
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	1	QL PA	<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	1	
FANAPT PAK QL (2 packs / year)	1	QL PA	NUPLAZID CAPS 34mg QL (30 caps / 30 days)	1	QL NM LA PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	1		NUPLAZID TABS 10mg QL (30 tabs / 30 days)	1	QL NM LA PA
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	1		<i>olanzapine</i> (generic of ZYPREXA) SOLR 10mg QL (3 vials / 1 day)	1	QL
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg			<i>olanzapine</i> (generic of ZYPREXA) TABS 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	1	QL
<i>haloperidol decanoate</i> (generic of HALDOL DECANOATE 50) SOLN 50mg/ml	1		<i>olanzapine</i> (generic of ZYPREXA) TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>haloperidol decanoate</i> (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	1		<i>olanzapine</i> (generic of ZYPREXA ZYDIS) TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	1		<i>olanzapine</i> (generic of ZYPREXA ZYDIS) TBDP 10mg QL (60 tabs / 30 days)	1	QL
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml QL (1 injection / 180 days)	1	QL	<i>paliperidone</i> TB24 1.5mg QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

38

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>paliperidone</i> (generic of INVEGA) TB24 3mg, 9mg QL (30 tabs / 30 days)	1	QL	<i>risperidone</i> (generic of RISPERDAL) SOLN 1mg/ml QL (240 mL / 30 days)	1	QL
<i>paliperidone</i> (generic of INVEGA) TB24 6mg QL (60 tabs / 30 days)	1	QL	<i>risperidone</i> (generic of RISPERDAL) TABS .5mg, 1mg, 2mg, 3mg, 4mg	1	
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	1		<i>risperidone</i> TABS .25mg	1	
PERSERIS PRSY 90mg, 120mg QL (1 syringe / 30 days)	1	QL	<i>risperidone</i> TBDP 1mg, 2mg, 3mg QL (60 tabs / 30 days)	1	QL
<i>pimozide</i> TABS 1mg, 2mg	1		<i>risperidone</i> TBDP 4mg QL (120 tabs / 30 days)	1	QL
<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 25mg QL (180 tabs / 30 days)	1	QL	<i>risperidone</i> TBDP .25mg, .5mg QL (90 tabs / 30 days)	1	QL
<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 50mg, 100mg, 200mg QL (90 tabs / 30 days)	1	QL	<i>risperidone microspheres</i> (generic of RISPERDAL CONSTA) SRER 12.5mg, 25mg, 37.5mg, 50mg QL (2 injections / 28 days)	1	QL
<i>quetiapine fumarate</i> TABS 150mg QL (90 tabs / 30 days)	1	QL	SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr QL (30 patches / 30 days)	1	QL
<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 300mg, 400mg QL (60 tabs / 30 days)	1	QL	<i>thioridazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	1	
<i>quetiapine fumarate</i> (generic of SEROQUEL XR) TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days)	1	QL PA	<i>thiothixene</i> CAPS 1mg, 2mg, 5mg, 10mg	1	
<i>quetiapine fumarate</i> (generic of SEROQUEL XR) TB24 150mg, 200mg QL (30 tabs / 30 days)	1	QL PA	<i>trifluoperazine hcl</i> TABS 1mg, 2mg, 5mg, 10mg	1	
REXULTI TABS 3mg, 4mg QL (30 tabs / 30 days)	1	QL	VERSACLOZ SUSP 50mg/ml QL (600 mL / 30 days)	1	QL PA
REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days)	1	QL	VRAYLAR CAPS 1.5mg QL (60 caps / 30 days)	1	QL
RISPERDAL CONSTA SRER 12.5mg, 25mg, 37.5mg, 50mg QL (2 injections / 28 days)	1	QL	VRAYLAR CAPS 3mg, 4.5mg, 6mg QL (30 caps / 30 days)	1	QL
			VRAYLAR CAP 1.5-3MG QL (2 packs / year)	1	QL
			<i>ziprasidone hcl</i> (generic of GEODON) CAPS 20mg, 40mg, 60mg, 80mg QL (60 caps / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

39

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ziprasidone mesylate (generic of GEODON) SOLR 20mg QL (6 injections / 3 days)	1	QL	clonazepam (generic of KLONOPI) TABS .5mg, 1mg QL (90 tabs / 30 days)	1	QL
ZYPREXA RELPREVV SUSR 210mg, 300mg QL (2 vials / 28 days)	1	QL NM PA	clonazepam TBDP 2mg QL (300 tabs / 30 days)	1	QL
ZYPREXA RELPREVV SUSR 405mg QL (1 vial / 28 days)	1	QL NM PA	clonazepam TBDP .125mg,.25mg, .5mg, 1mg QL (90 tabs / 30 days)	1	QL
ANTISEIZURE AGENTS			clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg QL (180 tabs / 30 days) PA if 65 years and older	1	QL PA
APTIOM TABS 200mg, 400mg QL (30 tabs / 30 days)	1	QL	DIACOMIT CAPS 250mg QL (360 caps / 30 days)	1	QL NM LA PA
APTIOM TABS 600mg, 800mg QL (60 tabs / 30 days)	1	QL	DIACOMIT CAPS 500mg QL (180 caps / 30 days)	1	QL NM LA PA
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	1	QL PA	DIACOMIT PACK 250mg QL (360 packets / 30 days)	1	QL NM LA PA
BRIVIACT SOLN 50mg/5ml 1	PA		DIACOMIT PACK 500mg QL (180 packets / 30 days)	1	QL NM LA PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days)	1	QL PA	diazepam SOLN 5mg/5ml QL (1200 mL / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA
carbamazepine CHEW 100mg	1		diazepam (generic of VALIUM) TABS 2mg, 5mg, 10mg QL (120 tabs / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA
carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg	1		diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	1	
carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml; TABS 200mg	1		diazepam inj SOLN 5mg/ml	1	
carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg	1		diazepam intensol CONC 5mg/ml QL (240 mL / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA
clobazam (generic of ONFI) SUSP 2.5mg/ml QL (480 mL / 30 days)	1	QL PA			
clobazam (generic of ONFI) TABS 10mg, 20mg QL (60 tabs / 30 days)	1	QL PA			
clonazepam (generic of KLONOPI) TABS 2mg QL (300 tabs / 30 days)	1	QL			

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

40

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
DILANTIN CAPS 30mg, 100mg	1		<i>gabapentin</i> (generic of NEURONTIN) SOLN 250mg/5ml, 300mg/6ml QL (2160 mL / 30 days)	1	QL
DILANTIN INFATABS CHEW 1 50mg	1		<i>gabapentin</i> (generic of NEURONTIN) TABS 600mg QL (180 tabs / 30 days)	1	QL
DILANTIN-125 SUSP 125mg/5ml	1		<i>gabapentin</i> (generic of NEURONTIN) TABS 800mg QL (120 tabs / 30 days)	1	QL
<i>divalproex sodium</i> (generic of DEPAKOTE SPRINKLES) CSDR 125mg	1		<i>lacosamide</i> (generic of VIMPAT) SOLN 200mg/20ml	1	
<i>divalproex sodium</i> (generic of DEPAKOTE ER) TB24 250mg, 500mg	1		<i>lacosamide</i> (generic of VIMPAT) TABS 50mg QL (120 tabs / 30 days)	1	QL
<i>divalproex sodium</i> (generic of DEPAKOTE) TBEC 125mg, 250mg, 500mg	1		<i>lacosamide</i> (generic of VIMPAT) TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	1	QL
EPIDIOLEX SOLN 100mg/ml QL (600 mL / 30 days)	1	QL NM LA PA	<i>lacosamide oral</i> (generic of VIMPAT) SOLN 10mg/ml QL (1200 mL / 30 days)	1	QL
<i>epitol</i> (generic of TEGRETOL) 1 TABS 200mg	1		<i>lamotrigine</i> (generic of LAMICTAL CHEWABLE DISPERS) CHEW 5mg, 25mg	1	
EPRONTIA SOLN 25mg/ml QL (480 mL / 30 days)	1	QL PA	<i>lamotrigine</i> (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	1	
<i>ethosuximide</i> (generic of ZARONTIN) CAPS 250mg; SOLN 250mg/5ml	1		<i>lamotrigine</i> (generic of LAMICTAL XR) TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	1	
<i>felbamate</i> SUSP 600mg/5ml	1		<i>levetiracetam</i> (generic of KEPPRA) SOLN 100mg/ml, 500mg/5ml; TABS 250mg, 500mg, 750mg, 1000mg	1	
<i>felbamate</i> (generic of FELBATOL) TABS 400mg, 600mg	1		<i>levetiracetam</i> (generic of KEPPRA XR) TB24 500mg, 750mg	1	
FINTEPLA SOLN 2.2mg/ml QL (360 mL / 30 days)	1	QL NM LA PA	<i>levetiracetam in sodium</i> <i>chloride iv soln</i> 500 mg/100ml (generic of LEVETIRACETAM)	1	
FYCOMPA SUSP .5mg/ml QL (720 mL / 30 days)	1	QL PA			
FYCOMPA TABS 2mg QL (60 tabs / 30 days)	1	QL PA			
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg QL (30 tabs / 30 days)	1	QL PA			
<i>gabapentin</i> (generic of NEURONTIN) CAPS 100mg, 300mg, 400mg QL (180 caps / 30 days)	1	QL			

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

41

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>levetiracetam in sodium chloride iv soln 1000 mg/100ml (generic of LEVETIRACETAM)</i>	1		<i>pregabalin (generic of LYRICA) CAPS 25mg, 50mg, 75mg, 100mg, 150mg QL (120 caps / 30 days)</i>	1	QL PA
<i>levetiracetam in sodium chloride iv soln 1500 mg/100ml (generic of LEVETIRACETAM)</i>	1		<i>pregabalin (generic of LYRICA) CAPS 200mg QL (90 caps / 30 days)</i>	1	QL PA
<i>methsuximide (generic of CELONTIN) CAPS 300mg NAYZILAM SOLN 5mg/0.1ml</i>	1		<i>pregabalin (generic of LYRICA) CAPS 225mg, 300mg QL (60 caps / 30 days)</i>	1	QL PA
<i>oxcarbazepine (generic of TRILEPTAL) SUSP 300mg/5ml; TABS 150mg, 300mg, 600mg phenobarbital ELIX 20mg/5ml QL (1500 mL / 30 days) PA if 70 years and older phenobarbital TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg QL (120 tabs / 30 days) PA if 70 years and older phenobarbital sodium SOLN 65mg/ml, 130mg/ml PA if 70 years and older phenytek CAPS 200mg, 300mg phenytoin (generic of DILANTIN INFATABS) CHEW 50mg phenytoin (generic of DILANTIN-125) SUSP 125mg/5ml phenytoin sodium SOLN 50mg/ml phenytoin sodium extended (generic of DILANTIN) CAPS 100mg phenytoin sodium extended CAPS 200mg, 300mg</i>	1	QL PA	<i>pregabalin (generic of LYRICA) SOLN 20mg/ml QL (900 mL / 30 days) primidone (generic of MYSOLINE) TABS 50mg, 250mg primidone TABS 125mg roweepra (generic of KEPPIRA) TABS 500mg rufinamide (generic of BANZEL) SUSP 40mg/ml QL (2400 mL / 30 days) rufinamide (generic of BANZEL) TABS 200mg QL (480 tabs / 30 days) rufinamide (generic of BANZEL) TABS 400mg QL (240 tabs / 30 days) SPRITAM TB3D 250mg QL (360 tabs / 30 days) SPRITAM TB3D 500mg QL (180 tabs / 30 days) SPRITAM TB3D 750mg QL (120 tabs / 30 days) SPRITAM TB3D 1000mg QL (90 tabs / 30 days) subvenite (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg SYMPAZAN FILM 5mg, 10mg, 20mg QL (60 films / 30 days)</i>	1	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	1	
<i>topiramate</i> (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	1	
<i>topiramate</i> (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg	1	
<i>valproate sodium</i> SOLN 100mg/ml, 250mg/5ml	1	
<i>valproic acid</i> CAPS 250mg	1	
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml	1	
VALTOCO 10 MG DOSE LIQD 10mg/0.1ml	1	
VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml	1	
VALTOCO 20 MG DOSE LQPK 10mg/0.1ml	1	
<i>vigabatrin</i> (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	1	QL NM LA PA
<i>vigabatrin</i> (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	1	QL NM LA PA
<i>vigadron</i> (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	1	QL NM LA PA
<i>vigadron</i> (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	1	QL NM LA PA
XCOPRI TABS 50mg, 100mg QL (30 tabs / 30 days)	1	QL
XCOPRI TABS 150mg, 200mg QL (60 tabs / 30 days)	1	QL
XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	1	QL
XCOPRI PAK 50-100MG QL (28 tabs / 28 days)	1	QL
XCOPRI PAK 100-150 QL (56 tabs / 28 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	1	QL
XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	1	QL
ZONISADE SUSP 100mg/5ml QL (900 mL / 30 days)	1	QL PA
<i>zonisamide</i> (generic of ZONEGRAN) CAPS 25mg, 100mg	1	
<i>zonisamide</i> CAPS 50mg	1	
ZTALMY SUSP 50mg/ml QL (1100 mL / 30 days)	1	QL NM LA PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
<i>amphetamine-</i> <i>dextroamphetamine cap er</i> 24hr 5 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA
<i>amphetamine-</i> <i>dextroamphetamine cap er</i> 24hr 10 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA
<i>amphetamine-</i> <i>dextroamphetamine cap er</i> 24hr 15 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA
<i>amphetamine-</i> <i>dextroamphetamine cap er</i> 24hr 20 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA
<i>amphetamine-</i> <i>dextroamphetamine cap er</i> 24hr 25 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
amphetamine- dextroamphetamine cap er 24hr 30 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	1	QL PA	dexamphetamine hcl (generic of FOCALIN) TABS 2.5mg, 5mg QL (120 tabs / 30 days)	1	QL PA
amphetamine- dextroamphetamine tab 5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	dexamphetamine hcl (generic of FOCALIN) TABS 10mg QL (60 tabs / 30 days)	1	QL PA
amphetamine- dextroamphetamine tab 7.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	guanfacine hcl (adhd) (generic of INTUNIV) TB24 1mg, 2mg, 4mg QL (30 tabs / 30 days) PA if 70 years and older	1	QL PA
amphetamine- dextroamphetamine tab 10 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	guanfacine hcl (adhd) (generic of INTUNIV) TB24 3mg QL (60 tabs / 30 days) PA if 70 years and older	1	QL PA
amphetamine- dextroamphetamine tab 12.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	methylphenidate hcl CHEW 2.5mg, 5mg, 10mg QL (180 tabs / 30 days)	1	QL PA
amphetamine- dextroamphetamine tab 15 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml QL (1800 mL / 30 days)	1	QL PA
amphetamine- dextroamphetamine tab 20 mg (generic of ADDERALL) QL (90 tabs / 30 days)	1	QL PA	methylphenidate hcl (generic of METHYLIN) SOLN 10mg/5ml QL (900 mL / 30 days)	1	QL PA
amphetamine- dextroamphetamine tab 30 mg (generic of ADDERALL) QL (60 tabs / 30 days)	1	QL PA	methylphenidate hcl (generic of RITALIN) TABS 5mg, 10mg QL (180 tabs / 30 days)	1	QL PA
atomoxetine hcl (generic of STRATTERA) CAPS 10mg, 18mg, 25mg QL (120 caps / 30 days)	1	QL	methylphenidate hcl (generic of RITALIN) TABS 20mg QL (90 tabs / 30 days)	1	QL PA
atomoxetine hcl (generic of STRATTERA) CAPS 40mg QL (60 caps / 30 days)	1	QL	methylphenidate hcl TBCR 10mg, 20mg QL (90 tabs / 30 days)	1	QL PA
atomoxetine hcl (generic of STRATTERA) CAPS 60mg, 80mg, 100mg QL (30 caps / 30 days)	1	QL	HYPNOTICS - DRUGS TO TREAT INSOMNIA DAYVIGO TABS 5mg, 10mg QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
doxepin hcl (sleep) (generic of SILENOR) TABS 3mg, 6mg QL (30 tabs / 30 days)	1	QL
eszopiclone (generic of LUNESTA) TABS 1mg, 2mg, 3mg QL (30 tabs / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year	1	QL PA
tasimelteon (generic of HETLIOZ) CAPS 20mg QL (30 caps / 30 days)	1	QL NM PA
temazepam (generic of RESTORIL) CAPS 7.5mg, 30mg QL (30 caps / 30 days) PA if 65 years and older	1	QL PA
temazepam (generic of RESTORIL) CAPS 15mg QL (60 caps / 30 days) PA if 65 years and older	1	QL PA
zaleplon CAPS 5mg QL (30 caps / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year	1	QL PA
zaleplon CAPS 10mg QL (60 caps / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year	1	QL PA
zolpidem tartrate (generic of AMBIEN) TABS 5mg, 10mg QL (30 tabs / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year	1	QL PA
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SOAJ 70mg/ml, 140mg/ml QL (1 pen / 30 days)	1	QL NM PA
dihydroergotamine mesylate SOLN 1mg/ml	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

45

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
dihydroergotamine mesylate (generic of MIGRANAL) SOLN 4mg/ml QL (8 mL / 30 days)	1	QL PA
ergotamine w/ caffeine tab 100 mg QL (40 tabs / 28 days)	1	QL PA
naratriptan hcl TABS 1mg, 2.5mg QL (12 tabs / 30 days)	1	QL
NURTEC TBDP 75mg QL (16 tabs / 30 days)	1	QL PA
QULIPTA TABS 10mg, 30mg, 60mg QL (30 tabs / 30 days)	1	QL PA
rizatriptan benzoate TABS 5mg; TBDP 5mg QL (18 tabs / 30 days)	1	QL
rizatriptan benzoate (generic of MAXALT) TABS 10mg QL (18 tabs / 30 days)	1	QL
rizatriptan benzoate (generic of MAXALT-MLT) TBDP 10mg QL (18 tabs / 30 days)	1	QL
sumatriptan SOLN 5mg/act QL (24 units / 30 days)	1	QL
sumatriptan SOLN 20mg/act QL (12 units / 30 days)	1	QL
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml QL (18 injections / 30 days)	1	QL
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml QL (12 injections / 30 days)	1	QL
sumatriptan succinate (generic of IMITREX STATDOSE REFILL) SOCT 6mg/0.5ml QL (12 injections / 30 days)	1	QL

Drug Name		Drug Requirements/ Tier	Drug Requirements/ Limits
<i>sumatriptan succinate</i> SOLN	1	QL	
6mg/0.5ml			
QL (12 injections / 30 days)			
<i>sumatriptan succinate</i>	1	QL	
(generic of IMITREX) TABS			
25mg, 50mg, 100mg			
QL (12 tabs / 30 days)			
UBRELVY TABS 50mg, 100mg	1	QL PA	
QL (16 tabs / 30 days)			
MISCELLANEOUS			
AUSTEDO TABS 6mg	1	QL NM LA PA	
QL (60 tabs / 30 days)			
AUSTEDO TABS 9mg, 12mg	1	QL NM LA PA	
QL (120 tabs / 30 days)			
AUSTEDO XR TB24 6mg	1	QL NM PA	
QL (90 tabs / 30 days)			
AUSTEDO XR TB24 12mg	1	QL NM PA	
QL (120 tabs / 30 days)			
AUSTEDO XR TB24 24mg	1	QL NM PA	
QL (60 tabs / 30 days)			
AUSTEDO XR TAB TITR KIT	1	QL NM PA	
QL (2 packs / year)			
LITHIUM SOLN 8meq/5ml	1		
<i>lithium carbonate</i> CAPS	1		
150mg, 300mg, 600mg; TABS			
300mg; TBCR 450mg			
<i>lithium carbonate</i> (generic of LITHOBID) TBCR 300mg	1		
NUEDEXTA CAP 20-10MG	1	QL PA	
QL (60 caps / 30 days)			
<i>pyridostigmine bromide</i>	1		
(generic of MESTINON)			
TABS 60mg			
<i>riluzole</i> (generic of RILUTEK)	1		
TABS 50mg			
<i>tetrabenazine</i> (generic of XENAZINE)	1	QL NM PA	
12.5mg			
QL (90 tabs / 30 days)			
<i>tetrabenazine</i> (generic of XENAZINE)	1	QL NM PA	
25mg			
QL (120 tabs / 30 days)			

Drug Name		Drug Requirements/ Tier	Drug Requirements/ Limits
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS			
BAFIERTAM CPDR	95mg	1	QL NM LA PA
QL (120 caps / 30 days)			
BETASERON KIT	.3mg	1	QL NM PA
QL (14 syringes / 28 days)			
<i>dalfampridine</i> (generic of AMPYRA)	TB12 10mg	1	QL NM PA
QL (60 tabs / 30 days)			
<i>fingolimod hcl</i> (generic of GILENYA)	CAPS .5mg	1	QL NM PA
QL (30 caps / 30 days)			
<i>glatiramer acetate</i> (generic of COPAXONE)	SOSY 20mg/ml	1	QL NM PA
QL (30 syringes / 30 days)			
<i>glatiramer acetate</i> (generic of COPAXONE)	SOSY 40mg/ml	1	QL NM PA
QL (12 syringes / 28 days)			
<i>glatopa</i> (generic of COPAXONE)	SOSY 20mg/ml	1	QL NM PA
QL (30 syringes / 30 days)			
<i>glatopa</i> (generic of COPAXONE)	SOSY 40mg/ml	1	QL NM PA
QL (12 syringes / 28 days)			
KESIMPTA SOAJ	20mg/0.4ml	1	QL NM LA PA
QL (16 pens / year)			
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS			
<i>baclofen</i> TABS 5mg		1	QL
QL (90 tabs / 30 days)			
<i>baclofen</i> TABS 10mg, 20mg		1	
<i>carisoprodol</i> (generic of SOMA)	TABS 350mg	1	QL PA
QL (120 tabs / 30 days)			
PA applies if 70 years and older after a 30 day supply in a calendar year			

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
cyclobenzaprine hcl TABS 5mg, 10mg QL (90 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year	1	QL PA	buprenorphine hcl SUBL 2mg, 8mg QL (90 tabs / 30 days)	1	QL PA
dantrolene sodium (generic of DANTRIUM) CAPS 25mg	1		buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	1	QL
dantrolene sodium CAPS 50mg, 100mg	1		buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	1	QL
methocarbamol TABS 500mg QL (360 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year	1	QL PA	buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	1	QL
methocarbamol TABS 750mg QL (240 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year	1	QL PA	buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE) QL (60 films / 30 days)	1	QL
tizanidine hcl TABS 2mg	1		buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv) QL (90 tabs / 30 days)	1	QL
tizanidine hcl (generic of ZANAFLEX) TABS 4mg	1		buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv) QL (90 tabs / 30 days)	1	QL
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS					
armodafinil (generic of NUVIGIL) TABS 50mg QL (60 tabs / 30 days)	1	QL PA	bupropion hcl (smoking deterrent) TB12 150mg QL (60 tabs / 30 days)	1	QL
armodafinil (generic of NUVIGIL) TABS 150mg, 200mg, 250mg QL (30 tabs / 30 days)	1	QL PA	disulfiram TABS 250mg, 500mg	1	
modafinil (generic of PROVIGIL) TABS 100mg QL (30 tabs / 30 days)	1	QL PA	naloxone hcl LIQD 4mg/0.1ml; SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	1	
modafinil (generic of PROVIGIL) TABS 200mg QL (60 tabs / 30 days)	1	QL PA	naltrexone hcl TABS 50mg	1	
SODIUM OXYBATE SOLN 500mg/ml QL (540 mL / 30 days)	1	QL NM LA PA	NICOTROL INHALER INHA 10mg	1	
PSYCHOTHERAPEUTIC-MISC					
acamprosate calcium TBEC 333mg	1		NICOTROL NS SOLN 10mg/ml	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

47

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
varenicline tartrate TABS .5mg, 1mg QL (56 tabs / 28 days)	1	QL PA
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack QL (2 packs / year)	1	QL PA
VIVITROL SUSR 380mg 1 NM		
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
depo-testosterone SOLN 100mg/ml, 200mg/ml	1	PA
methyltestosterone CAPS 10mg QL (600 caps / 30 days)	1	QL PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	1	QL PA
testosterone (generic of ANDROGEL PUMP) GEL 1.62% QL (150 gm / 30 days)	1	QL PA
testosterone cypionate SOLN 100mg/ml, 200mg/ml	1	PA
testosterone enanthate SOLN 200mg/ml	1	PA
ANTIDIABETICS		
acarbose TABS 25mg, 50mg, 100mg		
BYDUREON BCISE AUIJ 2mg/0.85ml QL (4 pens / 28 days)	1	QL PA
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml QL (1 pen / 30 days)	1	QL PA
FARXIGA TABS 5mg, 10mg QL (30 tabs / 30 days)	1	QL
glimepiride TABS 1mg, 2mg QL (90 tabs / 30 days)	1	QL
glimepiride TABS 4mg QL (60 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
glipizide TABS 5mg QL (240 tabs / 30 days)	1	QL
glipizide TABS 10mg QL (120 tabs / 30 days)	1	QL
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	QL
glipizide (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 2.5-250 mg QL (240 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 2.5-500 mg QL (120 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 5-500 mg QL (120 tabs / 30 days)	1	QL
GLYXAMBI TAB 10-5 MG QL (30 tabs / 30 days)	1	QL
GLYXAMBI TAB 25-5 MG QL (30 tabs / 30 days)	1	QL
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	1	QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 50-500MG QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 100-1000 QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
JANUVIA TABS 25mg, 50mg, 100mg QL (30 tabs / 30 days)	1	QL
JARDIANCE TABS 10mg, 25mg QL (30 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-1000 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB XR 2.5-1000MG QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB XR 5-1000MG QL (30 tabs / 30 days)	1	QL
metformin hcl TABS 500mg QL (150 tabs / 30 days)	1	QL
metformin hcl TABS 850mg QL (90 tabs / 30 days)	1	QL
metformin hcl TABS 1000mg QL (75 tabs / 30 days)	1	QL
metformin hcl TB24 500mg QL (120 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	QL
metformin hcl TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	QL
MOUNJARO SOPN 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml QL (4 pens / 28 days)	1	QL PA
nateglinide TABS 60mg, 120mg QL (90 tabs / 30 days)	1	QL
OZEMPIK (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml QL (1 pen / 28 days)	1	QL PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
OZEMPIK (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml QL (1 pen / 28 days)	1	QL PA
OZEMPIK (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	1	QL PA
OZEMPIK (2MG/DOSE) SOPN 8mg/3ml QL (1 pen / 28 days)	1	QL PA
pioglitazone hcl (generic of ACTOS) TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1	QL
pioglitazone hcl-metformin hcl tab 15-500 mg QL (90 tabs / 30 days)	1	QL
pioglitazone hcl-metformin hcl tab 15-850 mg (generic of ACTOPLUS MET) QL (90 tabs / 30 days)	1	QL
repaglinide TABS 2mg QL (240 tabs / 30 days)	1	QL
repaglinide TABS .5mg, 1mg QL (120 tabs / 30 days)	1	QL
RYBELSUS TABS 3mg, 7mg, 14mg QL (30 tabs / 30 days)	1	QL PA
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	1	QL
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY TAB 12.5-500 QL (60 tabs / 30 days)	1	QL
SYNJARDY TAB 12.5-1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 5-1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 10-1000 QL (60 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

49

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
SYNJARDY XR TAB 12.5-1000 QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 25-1000 QL (30 tabs / 30 days)	1	QL
TRADJENTA TABS 5mg QL (30 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG QL (60 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 10-5-1000MG QL (30 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG QL (60 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 25-5-1000MG QL (30 tabs / 30 days)	1	QL
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml QL (4 pens / 28 days)	1	QL PA
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 5-1000MG QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 10-500MG QL (30 tabs / 30 days)	1	QL
XIGDUO XR TAB 10-1000 QL (30 tabs / 30 days)	1	QL
ANTIDIABETICS, INSULINS		
ADMELOG SOLN 100unit/ml	1	V/I
ADMELOG SOLOSTAR SOPN 100unit/ml	1	V/I
BASAGLAR KWIKPEN SOPN 100unit/ml	1	V/I
BD ALCOHOL SWABS	1	
FIASP SOLN 100unit/ml	1	V/I
FIASP FLEXTOUCH SOPN 100unit/ml	1	V/I

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
FIASP PENFILL SOCT 100unit/ml	1	V/I
FIASP PUMPCART SOCT 100unit/ml	1	B/D
GAUZE PADS 2" X 2"	1	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	1	V/I B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	1	V/I
INSULIN PEN NEEDLES: BD/NOVO	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGES: BD	1	
LANTUS SOLN 100unit/ml	1	V/I
LANTUS SOLOSTAR SOPN 100unit/ml	1	V/I
NOVOLIN INJ 70/30 (brand RELION not covered)	1	V/I
NOVOLIN INJ 70/30 FP (brand RELION not covered)	1	V/I
NOVOLIN N SUSP 100unit/ml (brand RELION not covered)	1	V/I
NOVOLIN N FLEXPEN SUPN 100unit/ml (brand RELION not covered)	1	V/I
NOVOLIN R SOLN 100unit/ml (brand RELION not covered)	1	V/I
NOVOLIN R FLEXPEN SOPN 100unit/ml (brand RELION not covered)	1	V/I
NOVOLOG SOLN 100unit/ml (brand RELION not covered)	1	V/I

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

50

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
NOVOLOG FLEXPEN SOPN	1	V/I 100unit/ml (brand RELION not covered)
NOVOLOG MIX INJ 70/30	1	V/I (brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	1	V/I (brand RELION not covered)
NOVOLOG PENFILL SOCT	1	V/I 100unit/ml (brand RELION not covered)
OMNIPOD 5 G6 KIT INTRO	1	QL PA QL (1 kit / year)
OMNIPOD 5 G6 MIS PODS	1	QL PA QL (15 pods / 30 days)
OMNIPOD 5 G7 KIT INTRO	1	QL PA QL (1 kit / year)
OMNIPOD 5 G7 MIS PODS	1	QL PA QL (15 pods / 30 days)
OMNIPOD DASH KIT INTRO	1	QL PA QL (1 kit / year)
OMNIPOD DASH MIS PODS	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 10UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 15UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 20UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 25UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 30UNT/DY	1	QL PA QL (15 pods / 30 days)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
OMNIPOD GO KIT 35UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD GO KIT 40UNT/DY	1	QL PA QL (15 pods / 30 days)
OMNIPOD MIS CLASSIC	1	QL PA QL (15 pods / 30 days)
SOLIQUA INJ 100/33	1	V/I QL QL (5 pens / 25 days)
TOUJEAO MAX SOLOSTAR SOPN 300unit/ml	1	V/I
TOUJEAO SOLOSTAR SOPN 300unit/ml	1	V/I
TRESIBA SOLN 100unit/ml	1	V/I
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	1	V/I
V-GO 20 KIT	1	QL PA QL (30 devices / 30 days)
V-GO 30 KIT	1	QL PA QL (30 devices / 30 days)
V-GO 40 KIT	1	QL PA QL (30 devices / 30 days)
XULTOPHY INJ 100/3.6	1	V/I QL QL (5 pens / 30 days)
CALCIUM REGULATORS		
alendronate sodium SOLN 70mg/75ml; TABS 10mg, 35mg	1	
alendronate sodium (generic of FOSAMAX) TABS 70mg	1	
calcitonin (salmon) spray SOLN 200unit/act	1	B/D
ibandronate sodium TABS 150mg	1	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	1	LA PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	1	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml	1	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

51

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	1	QL NM
risedronate sodium TABS 5mg	1	
risedronate sodium (generic of 1 ACTONEL) TABS 35mg, 150mg	1	
risedronate sodium (generic of 1 ATELVIA) TBEC 35mg	1	
TERIPARATIDE SOPN 620mcg/2.48ml	1	NM PA
XGEVA SOLN 120mg/1.7ml	1	NM PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml	1	B/D NM
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	1	B/D NM
CHELATING AGENTS		
CHEMET CAPS 100mg	1	
deferasirox (generic of JADENU SPRINKLE) PACK 90mg, 180mg, 360mg	1	NM PA
deferasirox (generic of JADENU) TABS 90mg, 180mg, 360mg	1	NM PA
LOKELMA PACK 5gm, 10gm	1	
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	1	NM
sodium polystyrene sulfonate powder	1	
sps SUSP 15gm/60ml	1	
trientine hcl (generic of SYPRINE) CAPS 250mg	1	NM PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	1	
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
afirmelle	1	
altavera	1	
alyacen 1/35	1	
alyacen 7/7/7	1	
amethia	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
apri	1	
aranelle	1	
ashlyna	1	
aubra eq	1	
aurovela 1/20	1	
aurovela 24 fe	1	
aurovela fe 1.5/30	1	
aurovela fe 1/20	1	
aviane	1	
ayuna	1	
azurette	1	
balziva	1	
blisovi 24 fe	1	
blisovi fe 1.5/30	1	
briellyn	1	
camila TABS .35mg	1	
camrese	1	
camrese lo	1	
chateal eq	1	
cryselle-28	1	
cyred eq	1	
dasetta 1/35	1	
dasetta 7/7/7	1	
daysee	1	
deblitane TABS .35mg	1	
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml	1	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	1	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	1	
drospirenone-ethinyl estrad- levomefolate tab 3-0.03-0.451 mg (generic of SAFYRAL)	1	
drospirenone-ethinyl estradiol tab 3-0.02 mg (generic of YAZ)	1	
drospirenone-ethinyl estradiol tab 3-0.03 mg (generic of YASMIN 28)	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
elinest	1	
eluryng (generic of NUVARING)	1	
enilloring (generic of NUVARING)	1	
enpresse-28	1	
enskyce	1	
errin TABS .35mg	1	
estarylla	1	
ethynodiol diacetate & ethynil estradiol tab 1 mg-35 mcg	1	
ethynodiol diacetate & ethynil estradiol tab 1 mg-50 mcg	1	
etongestrel-ethynil estradiol va ring 0.120-0.015 mg/24hr (generic of NUVARING)	1	
falmina	1	
finzala	1	
hailey 1.5/30	1	
hailey 24 fe	1	
haloette (generic of NUVARING)	1	
heather TABS .35mg	1	
iclevia	1	
incassia TABS .35mg	1	
introvale	1	
isibloom	1	
jasmiel (generic of YAZ)	1	
jolessa	1	
juleber	1	
junel 1.5/30	1	
junel 1/20	1	
junel fe 1.5/30	1	
junel fe 1/20	1	
junel fe 24	1	
kaitlib fe	1	
kariva	1	
kelnor 1/35	1	
kelnor 1/50	1	
kurvelo	1	
larin 1.5/30	1	

Drug Name	Drug Requirements/ Tier	Limits
larin 1/20	1	
larin 24 fe	1	
larin fe 1.5/30	1	
larin fe 1/20	1	
layolis fe	1	
leena	1	
lessina	1	
levonest	1	
levonor-eth est tab 0.15- 0.02/0.025/0.03 mg ð est 0.01 mg	1	
levonorg-eth est tab 0.1- 0.02mg(84) & eth est tab 0.01mg(7)	1	
levonorg-eth est tab 0.15- 0.03mg(84) & eth est tab 0.01mg(7)	1	
levonorgestrel & ethynil estradiol (91-day) tab 0.15- 0.03 mg	1	
levonorgestrel & ethynil estradiol tab 0.1 mg-20 mcg	1	
levonorgestrel & ethynil estradiol tab 0.15 mg-30 mcg	1	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125- 30mg-mcg	1	
levora 0.15/30-28	1	
loestrin 1.5/30-21	1	
loestrin 1/20-21	1	
loestrin fe 1.5/30	1	
loestrin fe 1/20	1	
loryna (generic of YAZ)	1	
low-ogestrel	1	
lutra	1	
lyleq TABS .35mg	1	
lyza TABS .35mg	1	
marlissa	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
medroxyprogesterone acetate (contraceptive) (generic of DEPO-PROVERA CONTRACEPTIV) SUSP 150mg/ml; SUSY 150mg/ml	1	
mibelas 24 fe	1	
microgestin 1.5/30	1	
microgestin 1/20	1	
microgestin 24 fe	1	
microgestin fe 1.5/30	1	
microgestin fe 1/20	1	
milli	1	
mono-linyah	1	
necon 0.5/35-28	1	
nikki (generic of YAZ)	1	
nora-be TABS .35mg	1	
norelgestromin-ethynodiol estradiol td ptwk 150-35 mcg/24hr	1	
norethindrone & ethynodiol estradiol-fe chew tab 0.4 mg- 35 mcg	1	
norethindrone & ethynodiol estradiol-fe chew tab 0.8 mg- 25 mcg	1	
norethindrone (contraceptive) TABS .35mg	1	
norethindrone ac-ethynodiol estradiol tab 1-20/1-30/1-35 mg-mcg	1	
norethindrone ace & ethynodiol estradiol tab 1 mg-20 mcg	1	
norethindrone ace & ethynodiol estradiol tab 1.5 mg-30 mcg	1	
norethindrone ace & ethynodiol estradiol-fe tab 1 mg-20 mcg	1	
norethindrone ace-ethynodiol estradiol-fe chew tab 1 mg-20 mcg (24)	1	
norgestimate & ethynodiol estradiol tab 0.25 mg-35 mcg	1	
<hr/>		
norgestimate-ethynodiol estrad tab 0.18-25/0.215-25/0.25-25 mg- mcg (generic of ORTHO TRI- CYCLEN LO)	1	
norgestimate-ethynodiol estrad tab 0.18-35/0.215-35/0.25-35 mg- mcg	1	
norlyroc TABS .35mg	1	
nortrel 0.5/35 (28)	1	
nortrel 1/35 (21)	1	
nortrel 1/35 (28)	1	
nortrel 7/7/7	1	
nylia 1/35	1	
nylia 7/7/7	1	
nymyo	1	
ocella (generic of YASMIN 28)	1	
philith	1	
pimtrea	1	
portia-28	1	
reclipsen	1	
rivelsa	1	
setlakin	1	
sharobel TABS .35mg	1	
simliya	1	
simpesse	1	
sprintec 28	1	
sronyx	1	
syeda (generic of YASMIN 28)	1	
tarina 24 fe	1	
tarina fe 1/20 eq	1	
tilia fe	1	
tri-estarrylla	1	
tri-legest fe	1	
tri-linyah	1	
tri-lo-estarrylla (generic of ORTHO TRI-CYCLEN LO)	1	
tri-lo-marzia (generic of ORTHO TRI-CYCLEN LO)	1	
tri-lo-milli (generic of ORTHO TRI-CYCLEN LO)	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

54

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
tri-lo-sprintec (generic of ORTHO TRI-CYCLEN LO)	1	
tri-mili	1	
tri-nymyo	1	
tri-sprintec	1	
tri-vylibra	1	
tri-vylibra lo (generic of ORTHO TRI-CYCLEN LO)	1	
trivora-28	1	
turqoz	1	
tydemy (generic of SAFYRAL)	1	
velivet	1	
vestura (generic of YAZ)	1	
vienna	1	
viorele	1	
vyfemla	1	
vylibra	1	
wera	1	
wymzya fe	1	
xulane	1	
zafemy	1	
zovia 1/35	1	
zumandimine (generic of YASMIN 28)	1	
ENDOMETRIOSIS		
danazol CAPS 50mg, 100mg, 1 200mg		
SYNAREL SOLN 2mg/ml	1	PA
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
amabelz tab 0.5-0.1mg	1	
dotti (generic of VIVELLE- DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
estradiol (generic of VIVELLE- DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	

Drug Name	Drug Requirements/ Tier	Limits
estradiol (generic of CLIMARA) PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	1	
estradiol (generic of ESTRACE) TABS .5mg, 1mg, 2mg	1	
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	
estradiol & norethindrone acetate tab 1-0.5 mg (generic of ACTIVELLA)	1	
estradiol vaginal (generic of ESTRACE) CREA .1mg/gm	1	
estradiol vaginal (generic of VAGIFEM) TABS 10mcg	1	
estradiol valerate (generic of DELESTROGEN) OIL 10mg/ml, 20mg/ml, 40mg/ml	1	
fyavolv tab 0.5mg-2.5mcg	1	
fyavolv tab 1mg-5mcg	1	
jinteli	1	
lyllana (generic of MINIVELLE) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
mimvey (generic of ACTIVELLA)	1	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	1	
yuvafem (generic of VAGIFEM) TABS 10mcg	1	
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	1	B/D
DEXAMETHASONE INTENSOL CONC 1mg/ml	1	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	1	
fludrocortisone acetate TABS .1mg	1	
hydrocortisone (generic of CORTEF) TABS 5mg, 10mg, 20mg	1	
methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg	1	B/D
methylprednisolone TABS 32mg	1	B/D
methylprednisolone (generic of MEDROL DOSEPAK) TBPK 4mg	1	
methylprednisolone acetate (generic of DEPO-MEDROL) SUSP 40mg/ml, 80mg/ml	1	B/D
methylprednisolone sod succ SOLR 40mg, 125mg	1	B/D
methylprednisolone sod succ (generic of SOLU-MEDROL) SOLR 1000mg	1	B/D
prednisolone SOLN 15mg/5ml	1	B/D
prednisolone sodium phosphate (generic of PEDIAPRED) SOLN 5mg/5ml	1	B/D
prednisolone sodium phosphate SOLN 15mg/5ml, 25mg/5ml	1	B/D
prednisone SOLN 5mg/5ml; TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	1	B/D
prednisone TBPK 5mg, 10mg	1	
PREDNISONE INTENSOL CONC 5mg/ml	1	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	1	

Drug Name	Drug Requirements/ Tier	Limits
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
diazoxide (generic of PROGLYCEM) SUSP 50mg/ml	1	
GVOKE HYPOOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	1	
GVOKE KIT SOLN 1mg/0.2ml	1	
GVOKE PFS SOSY 1mg/0.2ml	1	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	1	NM LA PA
betaine powder for oral solution (generic of CYSTADANE)	1	NM LA
cabergoline TABS .5mg	1	
carglumic acid (generic of CARBAGLU) TBSO 200mg	1	NM LA PA
CERDELGA CAPS 84mg	1	NM LA PA
CEREZYME SOLR 400unit	1	NM LA PA
cinacalcet hcl (generic of SENSIPIAR) TABS 30mg, 60mg	1	B/D QL NM
QL (60 tabs / 30 days)		
cinacalcet hcl (generic of SENSIPIAR) TABS 90mg	1	B/D QL NM
QL (120 tabs / 30 days)		
CYSTAGON CAPS 50mg, 150mg	1	NM LA PA
desmopressin acetate (generic of DDAVP) SOLN 4mcg/ml; TABS .1mg, .2mg	1	
desmopressin acetate spray SOLN .01%	1	
desmopressin acetate spray refrigerated SOLN .01%	1	
FABRAZYME SOLR 5mg, 35mg	1	NM LA PA
GENOTROPIN CART 5mg, 12mg	1	NM PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
GENOTROPIN MINIQUICK	1	NM PA
PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg		
INCRELEX SOLN 40mg/4ml	1	NM LA PA
<i>javygtor</i> (generic of KUVAN)	1	NM LA PA
PACK 100mg, 500mg; TABS 100mg		
KORLYM TABS 300mg	1	NM LA PA
<i>levocarnitine (metabolic modifiers)</i> (generic of CARNITOR) SOLN 1gm/10ml; TABS 330mg	1	B/D
LUMIZYME SOLR 50mg	1	NM LA PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	1	NM PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	1	NM PA
LUPRON DEPOT-PED (6-MONTH KIT 45mg	1	NM PA
<i>mifepristone (hyperglycemia)</i> (generic of KORLYM) TABS 300mg	1	NM PA
<i> miglustat</i> (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	1	QL NM PA
NAGLAZYME SOLN 1mg/ml	1	NM LA PA
<i>nitisinone</i> (generic of ORFADIN) CAPS 2mg, 5mg, 10mg, 20mg	1	NM PA
<i>octreotide acetate</i> (generic of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM PA
<i>octreotide acetate</i> SOLN 200mcg/ml, 1000mcg/ml; SOSY 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM PA
<i>raloxifene hcl</i> (generic of EVISTA) TABS 60mg	1	
<i>sapropterin dihydrochloride</i> (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	1	NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	1	NM LA PA
<i>sodium phenylbutyrate</i> (generic of BUPHENYL) POWD 3gm/tsp; TABS 500mg	1	NM PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	1	NM LA PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	1	NM LA PA
<i>yargesa</i> (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	1	QL NM PA
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
<i>calcium acetate (phosphate binder)</i> CAPS 667mg QL (360 caps / 30 days)	1	QL
<i>calcium acetate (phosphate binder)</i> TABS 667mg QL (360 tabs / 30 days)	1	QL
<i>sevelamer carbonate</i> (generic of RENVELA) PACK 2.4gm QL (180 packets / 30 days)	1	QL
<i>sevelamer carbonate</i> (generic of RENVELA) PACK .8gm QL (540 packets / 30 days)	1	QL
<i>sevelamer carbonate</i> (generic of RENVELA) TABS 800mg QL (540 tabs / 30 days)	1	QL
VELPHORO CHEW 500mg QL (180 tabs / 30 days)	1	QL
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
<i>medroxyprogesterone acetate</i> (generic of PROVERA) TABS 2.5mg, 5mg, 10mg	1	
<i>megestrol acetate</i> SUSP 40mg/ml	1	
<i>megestrol acetate (appetite)</i> SUSP 625mg/5ml	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>norethindrone acetate</i> TABS 5mg	1	
<i>progesterone</i> (generic of PROMETRIUM) CAPS 100mg, 200mg	1	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
<i>euthyrox</i> (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
<i>levo-t</i> (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
<i>levothyroxine sodium</i> (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
<i>levoxyl</i> (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
<i>liothyronine sodium</i> (generic of CYTOMEL) TABS 5mcg, 25mcg, 50mcg	1	
<i>methimazole</i> TABS 5mg, 10mg	1	
<i>propylthiouracil</i> TABS 50mg SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>unithroid</i> (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
VITAMIN D ANALOGS		
<i>calcitriol</i> (generic of ROCALTROL) CAPS .25mcg, .5mcg	1	B/D
<i>calcitriol</i> (oral) (generic of ROCALTROL) SOLN 1mcg/ml	1	B/D
<i>paricalcitol</i> (generic of ZEMPLAR) CAPS 1mcg, 2mcg	1	B/D
<i>paricalcitol</i> CAPS 4mcg RAYALDEE CPCR 30mcg	1	B/D
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
<i>aprepitant</i> CAPS 40mg, 125mg	1	B/D
<i>aprepitant</i> (generic of EMEND) CAPS 80mg	1	B/D
<i>aprepitant capsule therapy</i> pack 80 & 125 mg	1	B/D
<i>compro</i> SUPP 25mg	1	
<i>dronabinol</i> (generic of MARINOL) CAPS 2.5mg QL (60 caps / 30 days)	1	B/D QL
<i>dronabinol</i> CAPS 5mg, 10mg QL (60 caps / 30 days)	1	B/D QL
<i>gransetron hcl</i> SOLN 1mg/ml, 4mg/4ml	1	
<i>gransetron hcl</i> TABS 1mg	1	B/D
<i>meclizine hcl</i> TABS 12.5mg, 25mg	1	
<i>metoclopramide hcl</i> SOLN 5mg/5ml, 5mg/ml	1	
<i>metoclopramide hcl</i> (generic of REGLAN) TABS 5mg, 10mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>ondansetron</i> TBDP 4mg, 8mg	1	B/D
<i>ondansetron hcl</i> SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	1	
<i>ondansetron hcl</i> SOLN 4mg/5ml; TABS 4mg, 8mg	1	B/D
<i>prochlorperazine</i> SUPP 25mg	1	
<i>prochlorperazine edisylate</i> SOLN 10mg/2ml	1	
<i>prochlorperazine maleate</i> TABS 5mg, 10mg	1	
<i>promethazine hcl</i> (generic of PHENERGAN) SOLN 25mg/ml, 50mg/ml PA if 70 years and older	1	PA
<i>promethazine hcl</i> SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg PA if 70 years and older	1	PA
<i>scopolamine</i> (generic of TRANSDERM-SCOP) PT72 1mg/3days QL (10 patches / 30 days) PA if 70 years and older	1	QL PA
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS		
<i>dicyclomine hcl</i> CAPS 10mg; SOLN 10mg/5ml; TABS 20mg	1	
<i>glycopyrrolate</i> (generic of ROBINUL) TABS 1mg QL (90 tabs / 30 days)	1	QL
<i>glycopyrrolate</i> (generic of ROBINUL FORTE) TABS 2mg QL (120 tabs / 30 days)	1	QL
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
<i>famotidine</i> SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	1	
<i>famotidine</i> SUSR 40mg/5ml QL (300 mL / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>famotidine</i> (generic of PEPCID) TABS 20mg QL (120 tabs / 30 days)	1	QL
<i>famotidine</i> (generic of PEPCID) TABS 40mg QL (60 tabs / 30 days)	1	QL
<i>famotidine in nacl 0.9% iv soln</i> 1 20 mg/50ml	1	
<i>nizatidine</i> CAPS 150mg, 300mg	1	
INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium</i> (generic of COLAZAL) CAPS 750mg	1	
<i>budesonide</i> CPEP 3mg QL (90 caps / 30 days)	1	QL PA
<i>budesonide</i> (generic of UCERIS) TB24 9mg QL (30 tabs / 30 days)	1	QL PA
<i>hydrocortisone (intrarectal)</i> 1 (generic of CORTENEMA) ENEM 100mg/60ml	1	
<i>mesalamine</i> (generic of APRISO) CP24 .375gm QL (120 caps / 30 days)	1	QL
<i>mesalamine</i> (generic of DELZICOL) CPDR 400mg QL (180 caps / 30 days)	1	QL
<i>mesalamine</i> ENEM 4gm	1	
<i>mesalamine</i> (generic of CANASA) SUPP 1000mg	1	
<i>mesalamine</i> (generic of LIALDA) TBEC 1.2gm QL (120 tabs / 30 days)	1	QL
<i>mesalamine w/ cleanser</i> 1 (generic of ROWASA) KIT 4gm	1	
<i>sulfasalazine</i> (generic of AZULFIDINE) TABS 500mg	1	
<i>sulfasalazine</i> (generic of AZULFIDINE EN-TABS) TBEC 500mg	1	
LAXATIVES		
<i>constulose</i> SOLN 10gm/15ml	1	
<i>enulose</i> SOLN 10gm/15ml	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
gavilyte-c	1	
gavilyte-g (generic of GOLYTELY)	1	
generlac SOLN 10gm/15ml	1	
lactulose SOLN 10gm/15ml	1	
lactulose (encephalopathy) SOLN 10gm/15ml	1	
peg 3350-kcl-na bicarb-nacl- na sulfate for soln 236 gm (generic of GOLYTELY)	1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
PLENUV SOL	1	
sod sulfate-pot sulf-mg sulf	1	
oral sol 17.5-3.13-1.6 gm/177ml (generic of SUPREP BOWEL PREP KIT)		
MISCELLANEOUS		
alosetron hcl (generic of LOTRONEX) TABS .5mg, 1mg	1	QL PA
		QL (60 tabs / 30 days)
cromolyn sodium	1	
(mastocytosis) (generic of GASTROCROM) CONC 100mg/5ml		
diphenoxylate w/ atropine liq	1	
2.5-0.025 mg/5ml		
diphenoxylate w/ atropine tab	1	
2.5-0.025 mg (generic of LOMOTIL)		
GATTEX KIT 5mg	1	NM LA PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	1	QL
		QL (30 caps / 30 days)
loperamide hcl CAPS 2mg	1	
misoprostol (generic of CYTOTEC) TABS 100mcg, 200mcg	1	
MOVANTIK TABS 12.5mg, 25mg	1	QL
		QL (30 tabs / 30 days)

Drug Name	Drug Requirements/ Tier	Limits
RELISTOR SOLN 8mg/0.4ml, 1 12mg/0.6ml	1	QL PA
		QL (28 syringes / 28 days)
sucralfate (generic of CARAFATE) TABS 1gm	1	
ursodiol CAPS 300mg	1	
ursodiol (generic of URSO 250) TABS 250mg	1	
ursodiol (generic of URSO FORTE) TABS 500mg	1	
XERMELO TABS 250mg	1	QL NM LA PA
		QL (84 tabs / 28 days)
XIFAXAN TABS 550mg	1	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	1	
CREON CAP 6000UNIT	1	
CREON CAP 12000UNT	1	
CREON CAP 24000UNT	1	
CREON CAP 36000UNT	1	
ZENPEP CAP 3000UNIT	1	
ZENPEP CAP 5000UNIT	1	
ZENPEP CAP 10000UNT	1	
ZENPEP CAP 15000UNT	1	
ZENPEP CAP 20000UNT	1	
ZENPEP CAP 25000UNT	1	
ZENPEP CAP 40000UNT	1	
ZENPEP CAP 60000UNT	1	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
esomeprazole magnesium (generic of NEXIUM) CPDR 20mg, 40mg	1	QL ST
		QL (30 caps / 30 days)
lansoprazole CPDR 15mg	1	QL
		QL (60 caps / 30 days)
lansoprazole (generic of PREVACID) CPDR 30mg	1	QL
		QL (60 caps / 30 days)
omeprazole CPDR 10mg, 20mg, 40mg	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
pantoprazole sodium (generic of PROTONIX) SOLR 40mg; TBEC 20mg, 40mg	1	
rabeprazole sodium (generic of ACIPHEX) TBEC 20mg QL (30 tabs / 30 days)	1	QL
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
alfuzosin hcl (generic of UROXATRAL) TB24 10mg QL (30 tabs / 30 days)	1	QL
dutasteride (generic of AVODART) CAPS .5mg QL (30 caps / 30 days)	1	QL
dutasteride-tamsulosin hcl cap 0.5-0.4 mg (generic of JALYN) QL (30 caps / 30 days)	1	QL
finasteride (generic of PROSCAR) TABS 5mg QL (30 tabs / 30 days)	1	QL
tamsulosin hcl (generic of FLOMAX) CAPS .4mg QL (60 caps / 30 days)	1	QL
MISCELLANEOUS		
acetic acid SOLN .25%	1	
bethanechol chloride TABS 5mg, 10mg, 25mg, 50mg	1	
potassium citrate (alkalinizer) (generic of UROCIT-K 15) TBCR 15meq	1	
potassium citrate (alkalinizer) (generic of UROCIT-K 5) TBCR 540mg	1	
potassium citrate (alkalinizer) (generic of UROCIT-K 10) TBCR 1080mg	1	

Drug Name	Drug Requirements/ Tier	Limits
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
fesoterodine fumarate (generic of TOVIAZ) TB24 4mg, 8mg QL (30 tabs / 30 days)	1	QL
GEMTESA TABS 75mg QL (30 tabs / 30 days)	1	QL
MYRBETRIQ SRER 8mg/ml QL (300 mL / 28 days)	1	QL
MYRBETRIQ TB24 25mg, 50mg QL (30 tabs / 30 days)	1	QL
oxybutynin chloride SOLN 5mg/5ml QL (600 mL / 30 days)	1	QL
oxybutynin chloride TABS 5mg QL (120 tabs / 30 days)	1	QL
oxybutynin chloride TB24 5mg QL (30 tabs / 30 days)	1	QL
oxybutynin chloride TB24 10mg, 15mg QL (60 tabs / 30 days)	1	QL
solifenacain succinate (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days)	1	QL
tolterodine tartrate (generic of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days)	1	QL ST
tolterodine tartrate (generic of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days)	1	QL
trospium chloride TABS 20mg QL (60 tabs / 30 days)	1	QL
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal (generic of CLEOCIN) CREA 2%	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

61

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>metronidazole vaginal</i> GEL .75%	1	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	1	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
<i>dabigatran etexilate mesylate</i> CAPS 75mg QL (60 caps / 30 days)	1	QL
<i>dabigatran etexilate mesylate</i> (generic of PRADAXA) CAPS 110mg QL (120 caps / 30 days)	1	QL
<i>dabigatran etexilate mesylate</i> (generic of PRADAXA) CAPS 150mg QL (60 caps / 30 days)	1	QL
<i>ELIQUIS</i> TABS 2.5mg QL (60 tabs / 30 days)	1	QL
<i>ELIQUIS</i> TABS 5mg QL (74 tabs / 30 days)	1	QL
<i>ELIQUIS</i> STARTER PACK TBPK 5mg QL (74 tabs / 30 days)	1	QL
<i>enoxaparin sodium</i> (generic of LOVENOX) SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	1	
<i>fondaparinux sodium</i> (generic of ARIXTRA) SOLN 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	1	
HEP SOD/D5W INJ 20000UNT	1	
HEP SOD/D5W INJ 25000UNT	1	
HEP SOD/NACL INJ 12500UNT	1	
HEP SOD/NACL INJ 25000UNT	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	1	B/D
<i>HEPARIN/NACL</i> INJ 25000UNT	1	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
<i>PRADAXA</i> CAPS 110mg QL (120 caps / 30 days)	1	QL
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
<i>XARELTO</i> SUSR 1mg/ml QL (620 mL / 30 days)	1	QL
<i>XARELTO</i> TABS 2.5mg QL (60 tabs / 30 days)	1	QL
<i>XARELTO</i> TABS 10mg, 15mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>XARELTO</i> STAR TAB 15/20MG QL (51 tabs / 30 days)	1	QL
HEMATOPOIETIC GROWTH FACTORS		
<i>PROCRIT</i> SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml	1	NM PA
<i>ZARXIO</i> SOSY 300mcg/0.5ml, 480mcg/0.8ml	1	NM PA
<i>ZIEXTENZO</i> SOSY 6mg/0.6ml QL (2 syringes / 28 days)	1	QL NM PA
MISCELLANEOUS		
<i>anagrelide hcl</i> CAPS 1mg	1	
<i>anagrelide hcl</i> (generic of AGRYLIN) CAPS .5mg	1	
<i>BERINERT</i> KIT 500unit QL (24 boxes / 30 days)	1	QL NM LA PA
<i>cilostazol</i> TABS 50mg, 100mg	1	
<i>DOPTELET</i> TABS 20mg	1	NM LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

62

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
DROXIA CAPS 200mg, 300mg, 400mg	1	
ENDARI PACK 5gm	1	NM LA PA
HAEGARDA SOLR 2000unit QL (30 vials / 30 days)	1	QL NM LA PA
HAEGARDA SOLR 3000unit QL (20 vials / 30 days)	1	QL NM LA PA
<i>icatibant acetate</i> (generic of FIRAZYR) SOSY 30mg/3ml QL (9 syringes / 30 days)	1	QL NM PA
<i>pentoxifylline</i> TBCR 400mg	1	
PROMACTA PACK 12.5mg QL (360 packets / 30 days)	1	QL NM LA PA
PROMACTA PACK 25mg QL (180 packets / 30 days)	1	QL NM LA PA
PROMACTA TABS 12.5mg, 25mg QL (30 tabs / 30 days)	1	QL NM LA PA
PROMACTA TABS 50mg, 75mg QL (60 tabs / 30 days)	1	QL NM LA PA
sajazir (generic of FIRAZYR) SOSY 30mg/3ml QL (9 syringes / 30 days)	1	QL NM LA PA
<i>tranexamic acid</i> (generic of CYKLOKAPRON) SOLN 1000mg/10ml	1	
<i>tranexamic acid</i> TABS 650mg	1	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	1	
BRILINTA TABS 60mg, 90mg	1	
clopidogrel bisulfate (generic of PLAVIX) TABS 75mg	1	
dipyridamole TABS 25mg, 50mg, 75mg PA if 70 years and older	1	PA
prasugrel hcl (generic of EFFIENT) TABS 5mg, 10mg	1	

Drug Name	Drug Requirements/ Tier	Limits
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
AUTOIMMUNE AGENTS		
ADALIMUMAB-AACF (2 PEN)	1	QL NM PA
AJKT 40mg/0.8ml QL (56 pens / 365 days)		
DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	1	NM PA
ENBREL SOLN 25mg/0.5ml QL (16 vials / 28 days)	1	QL NM PA
ENBREL SOSY 25mg/0.5ml QL (16 syringes / 28 days)	1	QL NM PA
ENBREL SOSY 50mg/ml QL (8 syringes / 28 days)	1	QL NM PA
ENBREL MINI SOCT 50mg/ml QL (8 cartridges / 28 days)	1	QL NM PA
ENBREL SURECLICK SOAJ 50mg/ml QL (8 pens / 28 days)	1	QL NM PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml QL (2 syringes / 28 days)	1	QL NM PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml QL (6 syringes / 28 days)	1	QL NM PA
HUMIRA PEDIA INJ CROHNS QL (2 syringes / 28 days)	1	QL NM PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml QL (3 syringes / 28 days)	1	QL NM PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

63

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml QL (6 pens / 28 days)	1	QL NM PA
HUMIRA PEN PNKT 80mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA
HUMIRA PEN KIT PS/UV QL (3 pens / 28 days)	1	QL NM PA
HUMIRA PEN-CD/UC/HS START PNKT 80mg/0.8ml QL (3 pens / 28 days)	1	QL NM PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA
IDACIO (2 PEN) AJKT 40mg/0.8ml QL (56 pens / 365 days)	1	QL NM PA
IDACIO (2 SYRINGE) PSKT 40mg/0.8ml QL (56 syringes / 365 days)	1	QL NM PA
IDACIO CROHN INJ DISEASE AJKT 40mg/0.8ml QL (2 packs / year)	1	QL NM PA
IDACIO PLAQU INJ PSORIASIS AJKT 40mg/0.8ml QL (2 packs / year)	1	QL NM PA
INFliximab SOLR 100mg	1	NM LA PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml QL (2 pens / 28 days)	1	QL NM PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml QL (2 syringes / 28 days)	1	QL NM PA
OTEZLA TABS 30mg QL (60 tabs / 30 days)	1	QL NM PA
OTEZLA TAB 10/20/30 QL (110 tabs / year)	1	QL NM PA
REMICADE SOLR 100mg	1	NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
RENFLEXIS SOLR 100mg	1	NM LA PA
RINVOQ TB24 15mg, 30mg QL (30 tabs / 30 days)	1	QL NM PA
RINVOQ TB24 45mg QL (168 tabs / year)	1	QL NM PA
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml QL (1 cartridge / 56 days)	1	QL NM PA
SKYRIZI SOLN 600mg/10ml QL (6 vials / year)	1	QL NM PA
SKYRIZI SOSY 150mg/ml QL (6 syringes / 365 days)	1	QL NM PA
SKYRIZI PEN SOAJ 150mg/ml QL (6 pens / 365 days)	1	QL NM PA
STELARA SOLN 45mg/0.5ml QL (1 vial / 28 days)	1	QL NM LA PA
STELARA SOLN 130mg/26ml	1	NM LA PA
STELARA SOSY 45mg/0.5ml, 90mg/ml QL (1 syringe / 28 days)	1	QL NM PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml QL (3 syringes / 28 days)	1	QL NM LA PA
XELJANZ SOLN 1mg/ml QL (480 mL / 24 days)	1	QL NM PA
XELJANZ TABS 5mg, 10mg QL (60 tabs / 30 days)	1	QL NM PA
XELJANZ XR TB24 11mg, 22mg QL (30 tabs / 30 days)	1	QL NM PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDs) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
hydroxychloroquine sulfate (generic of PLAQUENIL) TABS 200mg	1	
leflunomide (generic of ARAVA) TABS 10mg, 20mg QL (30 tabs / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

64

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>methotrexate sodium TABS</i>	1	
2.5mg		
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml, 10%	1	NM LA PA
FLEBOGAMMA DIF SOLN 5gm/100ml, 10gm/200ml, 20gm/400ml	1	NM PA
GAMASTAN INJ	1	B/D NM LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	1	NM PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	1	NM PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM LA PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 30gm/300ml	1	NM PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	1	NM LA PA
ARCALYST SOLR 220mg	1	NM LA PA

Drug Name	Drug Requirements/ Tier	Limits
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 .5mg, 1mg, 5mg	1	B/D NM
azathioprine (generic of IMURAN) TABS 50mg	1	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml QL (8 syringes / 28 days)	1	QL NM LA PA
BENLYSTA SOLR 120mg, 400mg	1	NM LA PA
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg; SOLN 50mg/ml	1	B/D NM
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	1	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg, .5mg, .75mg, 1mg	1	B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; SUSR 200mg/ml; TABS 500mg	1	B/D NM
mycophenolate sodium (generic of MYFORTIC) TBEC 180mg, 360mg	1	B/D NM
NULOJIX SOLR 250mg	1	B/D NM
PROGRAF PACK .2mg, 1mg	1	B/D NM
REZUROCK TABS 200mg	1	NM LA PA
SANDIMMUNE SOLN 100mg/ml	1	B/D NM
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml; TABS .5mg, 1mg, 2mg	1	B/D NM

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

65

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	1	B/D NM
VACCINES		
ABRYSVO SOLR 120mcg/0.5ml	1	V/I
ACTHIB INJ	1	V/I
ADACEL INJ	1	V/I
AREXVY SUSR 120mcg/0.5ml	1	V/I
BCG VACCINE SOLR 50mg	1	V/I
BEXSERO INJ	1	V/I
BOOSTRIX INJ	1	V/I
DAPTACEL INJ	1	
DENGVAXIA SUS	1	
DIP/TET PED INJ 25-5LFU	1	B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	V/I B/D
GARDASIL 9 INJ	1	V/I
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	V/I
HEPLISAV-B SOSY 20mcg/0.5ml	1	V/I B/D
HIBERIX SOLR 10mcg	1	V/I
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	V/I B/D
INFANRIX INJ	1	
IPOL INJ INACTIVE	1	V/I
IXIARO INJ	1	V/I
JYNNEOS SUSP .5ml	1	V/I B/D
KINRIX INJ	1	V/I
M-M-R II INJ	1	V/I
MENACTRA INJ	1	V/I
MENQUADFI INJ	1	V/I
MENVEO INJ	1	V/I
MENVEO SOL	1	V/I
PEDIARIX INJ 0.5ML	1	V/I
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	V/I
PENBRAYA INJ	1	V/I
PENTACEL INJ	1	V/I

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
PREHEVBRIOSUSP 10mcg/ml	1	V/I B/D
PRIORIX INJ	1	V/I
PROQUAD INJ	1	
QUADRACEL INJ	1	V/I
QUADRACEL INJ 0.5ML	1	V/I
RABAVERT INJ	1	V/I B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	1	V/I B/D
ROTARIX SUS	1	
ROTATEQ SOL	1	
SHINGRIX SUSR 50mcg/0.5ml	1	V/I QL QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	1	V/I B/D
TENIVAC INJ 5-2LF	1	V/I B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	1	V/I
TRUMENBA INJ	1	V/I
TWINRIX INJ	1	V/I
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	1	V/I
VAQTA SUSP 25unit/0.5ml, 50unit/ml	1	V/I
VARIVAX INJ 1350pfu/0.5ml	1	V/I
YF-VAX INJ	1	V/I
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS ELECTROLYTES/MINERALS, INJECTABLE		
D2.5W/NACL INJ 0.45%	1	
D5W/LYTES INJ #48	1	
D10W/NACL INJ 0.2%	1	
dextrose 2.5% w/ sodium chloride 0.45% (generic of DEXTROSE 2.5%/NACL 0.45%)	1	
dextrose 5% in lactated ringers	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

66

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
dextrose 5% w/ sodium chloride 0.2%	1	
dextrose 5% w/ sodium chloride 0.3% (generic of DEXTROSE 5%/NACL 0.3%)	1	
dextrose 5% w/ sodium chloride 0.9%	1	
dextrose 5% w/ sodium chloride 0.45%	1	
dextrose 5% w/ sodium chloride 0.225% (generic of DEXTROSE/SODIUM CHLORIDE)	1	
dextrose 10% w/ sodium chloride 0.45%	1	
ISOLYTE-P INJ /D5W	1	
ISOLYTE-S INJ	1	
ISOLYTE-S INJ PH 7.4	1	
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	1	
kcl 20 meq/l (0.15%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM)	1	
kcl 20 meq/l (0.15%) in nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM)	1	
kcl 20 meq/l (0.149%) in nacl 0.45% inj	1	
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	1	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj (generic of KCL 0.3%/D5W/NACL 0.9%)	1	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM)</i>	1	
KCL/D5W/NACL INJ 0.3/0.9%	1	
<i>lactated ringer's solution</i>	1	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	1	
<i>magnesium sulfate (generic of MAGNESIUM SULFATE) SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml</i>	1	
<i>magnesium sulfate SOLN 50%</i>	1	
<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml (generic of MAGNESIUM SULFATE IN D5W)</i>	1	
MG SO4/D5W INJ 10MG/ML	1	
<i>multiple electrolytes ph 5.5 (generic of PLASMA-LYTE- 148)</i>	1	
<i>multiple electrolytes ph 7.4 (generic of PLASMA-LYTE A)</i>	1	
PLASMA-LYTE INJ -148	1	
PLASMA-LYTE INJ -A	1	
POT CHL 20MEQ/L IN NACL 0.9% INJ	1	
POT CHL 20MEQ/L IN NACL 0.45% INJ	1	
POT CHL 40MEQ/L IN NACL 0.9% INJ	1	
<i>potassium chloride SOLN 2meq/ml</i>	1	
POTASSIUM CHLORIDE SOLN 10meq/50ml	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
potassium chloride (generic of POTASSIUM CHLORIDE) SOLN 10meq/100ml, 20meq/100ml, 20meq/50ml, 40meq/100ml	1	
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	1	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	1	
TPN ELECTROL INJ	1	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
klor-con PACK 20meq	1	
klor-con 8 TBCR 8meq	1	
klor-con 10 TBCR 10meq	1	
klor-con m10 TBCR 10meq	1	
klor-con m15 TBCR 15meq	1	
klor-con m20 TBCR 20meq	1	
M-NATAL PLUS TAB	1	
potassium chloride CPCR 8meq, 10meq; PACK 20meq; SOLN 10%, 20%; TBCR 8meq, 10meq	1	
potassium chloride (generic of K-TAB) TBCR 20meq	1	
potassium chloride microencapsulated crystals er TBCR 10meq, 15meq, 20meq	1	
PRENATAL TAB 27-1MG	1	
PRENATAL TAB PLUS	1	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	1	
IV NUTRITION		
CLINIMIX INJ 4.25/D5W	1	B/D
CLINIMIX INJ 4.25/D10	1	B/D
CLINIMIX INJ 5%/D15W	1	B/D
CLINIMIX INJ 5%/D20W	1	B/D
CLINIMIX INJ 6/5	1	B/D
CLINIMIX INJ 8/10	1	B/D
CLINIMIX INJ 8/14	1	B/D
clenisol sf 15%	1	B/D
CLINOLIPID EMU 20%	1	B/D

Drug Name	Drug Requirements/ Tier	Limits
dextrose SOLN 5%, 10%	1	
dextrose SOLN 50%, 70%	1	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	1	B/D
NUTRILIPID EMUL 20gm/100ml	1	B/D
plenamine	1	B/D
PREMASOL SOL 10%	1	B/D
PROSOL INJ 20%	1	B/D
TRAVASOL INJ 10%	1	B/D
TROPHAMINE INJ 10%	1	B/D
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
bacitracin-polymyxin- neomycin-hc ophth oint 1%	1	
neo-polycin hc ophth oint 1%	1	
neomycin-polymyxin- dexamethasone ophth oint 0.1% (generic of MAXITROL)	1	
neomycin-polymyxin- dexamethasone ophth susp 0.1% (generic of MAXITROL)	1	
neomycin-polymyxin-hc ophth susp	1	
sulfacetamide sodium- prednisolone ophth soln 10- 0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1%	1	
TOBRADEX ST SUS 0.3-0.05	1	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
ZYLET SUS 0.5-0.3%	1	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
bacitracin (ophthalmic) OINT 500unit/gm	1	
bacitracin-polymyxin b ophth oint	1	
BESIVANCE SUSP .6%	1	
CILOXAN OINT .3%	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

68

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
ciprofloxacin hcl (ophth) SOLN .3%	1	
erythromycin (ophth) OINT 5mg/gm	1	
gatifloxacin (ophth) SOLN .5%	1	
gentamicin sulfate (ophth) SOLN .3%	1	
moxifloxacin hcl (ophth) (generic of VIGAMOX) SOLN .5%	1	
NATACYN SUSP 5%	1	
neo-polycin 5(3.5)mg-400unt- 10000unt op oin	1	
neomycin-bacitrac zn-polymyx 1 5(3.5)mg-400unt-10000unt op oin	1	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt- mg/ml	1	
ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	1	
polycin ophth oint	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
sulfacetamide sodium (ophth) OINT 10%; SOLN 10%	1	
tobramycin (ophth) SOLN .3%	1	
trifluridine SOLN 1%	1	
ZIRGAN GEL .15%	1	

ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION

ALREX SUSP .2%	1
bromfenac sodium (ophth) (generic of PROLENSA) SOLN .07%	1
bromfenac sodium (ophth) (generic of BROMSITE) SOLN .075%	1
BROMSITE SOLN .075%	1
dexamethasone sodium phosphate (ophth) SOLN .1%	1

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

69

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
diclofenac sodium (ophth) SOLN .1%	1	
diluprednate (generic of DUREZOL) EMUL .05%	1	
EYSUVIS SUSP .25%	1	
FLAREX SUSP .1%	1	
fluorometholone (ophth) (generic of FML LIQUIFILM) SUSP .1%	1	
flurbiprofen sodium SOLN .03%	1	
ketorolac tromethamine (ophth) (generic of ACULAR LS) SOLN .4%	1	
ketorolac tromethamine (ophth) (generic of ACULAR) SOLN .5%	1	
LOTEMAX OINT .5%	1	
prednisolone acetate (ophth) (generic of PRED FORTE) SUSP 1%	1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	1	
PROLENSA SOLN .07%	1	
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
azelastine hcl (ophth) SOLN .05%	1	
cromolyn sodium (ophth) SOLN 4%	1	
ZERVIA TE SOLN .24%	1	
ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA		
betaxolol hcl (ophth) SOLN .5%	1	
BETOPTIC-S SUSP .25%	1	
brimonidine tartrate SOLN .2%	1	
brimonidine tartrate (generic of ALPHAGAN P) SOLN .15%	1	
brinzolamide (generic of AZOPT) SUSP 1%	1	

Drug Name	Drug Requirements/ Tier	Limits
carteolol hcl (ophth) SOLN 1%	1	
COMBIGAN SOLN 0.2/0.5%	1	
dorzolamide hcl SOLN 2%	1	
dorzolamide hcl-timolol	1	
maleate ophth soln 2-0.5% (generic of COSOPT)		
latanoprost (generic of XALATAN) SOLN .005%	1	
levobunolol hcl SOLN .5%	1	
LUMIGAN SOLN .01%	1	
pilocarpine hcl SOLN 1%, 2%, 4%	1	
RHOPRESSA SOLN .02%	1	
ROCKLATAN DRO	1	
SIMBRINZA SUS 1-0.2%	1	
timolol maleate (ophth) SOLG 1 .25%, .5%; SOLN .25%, .5%	1	
VYZULTA SOLN .024%	1	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1 1%		
atropine sulfate (ophthalmic) SOLN 1%	1	
CYSTADROPS SOLN .37%	1	NM LA PA
CYSTARAN SOLN .44%	1	NM LA PA
proparacaine hcl (generic of ALCAINE) SOLN .5%	1	
RESTASIS EMUL .05%	1	
RESTASIS MULTIDOSE EMUL .05%	1	
TYRVAYA SOLN .03mg/act	1	
XIIDRA SOLN 5%	1	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
OTIC AGENTS		
acetic acid (otic) SOLN 2%	1	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
flac (generic of DERMOTIC) OIL .01%	1	

Drug Name	Drug Requirements/ Tier	Limits
fluocinolone acetonide (otic) (generic of DERMOTIC) OIL .01%	1	
neomycin-polymyxin-hc otic soln 1%	1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml- 1%	1	
ofloxacin (otic) SOLN .3%	1	
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPT AER 62.5-25	1	QL QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	1	QL QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE	1	QL QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	1	QL QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	1	QL QL (2 inhalers / 30 days)
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	1	QL QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	1	QL QL (60 blisters / 30 days)
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
ATROVENT HFA AERS 17mcg/act	1	QL QL (2 inhalers / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
INCRUSE ELLIPTA AEPB 62.5mcg/inh QL (30 blisters / 30 days)	1	QL
<i>ipratropium bromide</i> SOLN .02%	1	B/D
<i>ipratropium bromide (nasal)</i> SOLN .03%, .06%	1	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
<i>azelastine hcl</i> SOLN .1%	1	
<i>cetirizine hcl</i> SOLN 1mg/ml QL (300 mL / 30 days)	1	QL
<i>cyproheptadine hcl</i> SYRP 2mg/5ml; TABS 4mg PA if 70 years and older	1	PA
<i>diphenhydramine hcl</i> SOLN 50mg/ml hydroxyzine hcl SOLN 25mg/ml, 50mg/ml; SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg PA if 70 years and older	1	PA
<i>hydroxyzine pamoate</i> (generic of VISTARIL) CAPS 25mg PA if 70 years and older	1	PA
<i>hydroxyzine pamoate</i> CAPS 50mg PA if 70 years and older	1	PA
<i>levocetirizine dihydrochloride</i> SOLN 2.5mg/5ml QL (300 mL / 30 days)	1	QL
<i>levocetirizine dihydrochloride</i> TABS 5mg QL (30 tabs / 30 days)	1	QL
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
<i>albuterol sulfate</i> AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proair HFA)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
<i>albuterol sulfate</i> AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Ventolin HFA)	1	QL
<i>albuterol sulfate</i> (generic of PROVENTIL HFA) AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proventil HFA)	1	QL
<i>albuterol sulfate</i> NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	1	B/D
<i>albuterol sulfate</i> SYRP 2mg/5ml; TABS 2mg, 4mg	1	
<i>levalbuterol hcl</i> NEBU .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	1	B/D
<i>levalbuterol tartrate</i> AERO 45mcg/act QL (2 inhalers / 30 days)	1	QL ST
SEREVENT DISKUS AEPB 50mcg/dose QL (60 inhalations / 30 days)	1	QL
<i>terbutaline sulfate</i> TABS 2.5mg, 5mg	1	
VENTOLIN HFA AERS 108mcg/act QL (2 inhalers / 30 days)	1	QL
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act QL (6 inhalers / 30 days)	1	QL
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> (generic of SINGULAIR) CHEW 4mg, 5mg; PACK 4mg; TABS 10mg	1	
<i>zafirlukast</i> (generic of ACCOLATE) TABS 10mg, 20mg	1	
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	1	B/D

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ARALAST NP SOLR 500mg, 1000mg	1	NM LA PA
BRONCHITOL CAPS 40mg QL (560 caps / 28 days)	1	QL NM LA PA
cromolyn sodium NEBU 20mg/2ml	1	B/D
epinephrine (anaphylaxis) (generic of EPIPEN 2-PAK)	1	
SOAJ .3mg/0.3ml (generic of EpiPen)		
epinephrine (anaphylaxis) (generic of EPIPEN-JR 2-PAK) SOAJ .15mg/0.3ml (generic of EpiPen)	1	
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)	1	
FASENRA SOSY 30mg/ml	1	NM LA PA
FASENRA PEN SOAJ 30mg/ml	1	NM LA PA
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg QL (56 packs / 28 days)	1	QL NM LA PA
KALYDECO TABS 150mg QL (60 tabs / 30 days)	1	QL NM LA PA
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)	1	QL NM LA PA
ORKAMBI GRA 75-94MG QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI GRA 100-125 QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI GRA 150-188 QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI TAB 100-125 QL (112 tabs / 28 days)	1	QL NM LA PA
ORKAMBI TAB 200-125 QL (112 tabs / 28 days)	1	QL NM LA PA
pirfenidone (generic of ESBRIET) CAPS 267mg QL (270 caps / 30 days)	1	QL NM PA
pirfenidone (generic of ESBRIET) TABS 267mg QL (270 tabs / 30 days)	1	QL NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
pirfenidone TABS 534mg QL (90 tabs / 30 days)	1	QL NM PA
pirfenidone (generic of ESBRIET) TABS 801mg QL (90 tabs / 30 days)	1	QL NM PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	1	NM LA PA
PULMOZYME SOLN 2.5mg/2.5ml	1	NM PA
roflumilast (generic of DALIRESP) TABS 250mcg QL (56 tabs / year)	1	QL
roflumilast (generic of DALIRESP) TABS 500mcg QL (30 tabs / 30 days)	1	QL
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	1	QL NM LA PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	1	QL NM LA PA
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	1	
theophylline ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 100mg, 200mg, 300mg, 450mg; TB24 400mg, 600mg	1	
TRIKAFTA PAK 59.5MG QL (56 packs / 28 days)	1	QL NM LA PA
TRIKAFTA PAK 75MG QL (56 packs / 28 days)	1	QL NM LA PA
TRIKAFTA TAB 50-25-37.5MG & 75MG QL (84 tabs / 28 days)	1	QL NM LA PA
TRIKAFTA TAB 100-50-75MG & 150MG QL (84 tabs / 28 days)	1	QL NM LA PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	1	NM LA PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	1	NM LA PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) SOLN .025%	1	QL QL (3 bottles / 30 days)
fluticasone propionate (nasal) SUSP 50mcg/act	1	QL QL (1 bottle / 30 days)
XHANCE EXHU 93mcg/act	1	QL PA QL (32 mL / 30 days)
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	1	QL QL (30 inhalations / 30 days)
budesonide (inhalation) (generic of PULMICORT) SUSP .25mg/2ml, .5mg/2ml	1	B/D
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
ADVAIR HFA AER 45/21	1	QL QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	1	QL QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	1	QL QL (1 inhaler / 30 days)
BREO ELLIPTA INH 50-25MCG	1	QL QL (60 blisters / 30 days)
BREO ELLIPTA INH 100-25	1	QL QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	1	QL QL (60 blisters / 30 days)
DULERA AER 50-5MCG	1	QL QL (3 inhalers / 30 days)
DULERA AER 100-5MCG	1	QL QL (3 inhalers / 30 days)

Drug Name	Drug Requirements/ Tier	Limits
DULERA AER 200-5MCG	1	QL QL (3 inhalers / 30 days)
fluticasone-salmeterol aer powder ba 100-50 mcg/act (generic of ADVAIR DISKUS)	1	QL QL (60 inhalations / 30 days) (generic PRASCO not covered)
fluticasone-salmeterol aer powder ba 250-50 mcg/act (generic of ADVAIR DISKUS)	1	QL QL (60 inhalations / 30 days) (generic PRASCO not covered)
fluticasone-salmeterol aer powder ba 500-50 mcg/act (generic of ADVAIR DISKUS)	1	QL QL (60 inhalations / 30 days) (generic PRASCO not covered)
wixela inhba (generic of ADVAIR DISKUS)	1	QL QL (60 inhalations / 30 days)
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
accutane CAPS 10mg, 20mg, 30mg, 40mg	1	PA
amnesteem CAPS 10mg, 20mg, 40mg	1	PA
benzoyl peroxide- erythromycin gel 5-3% (generic of BENZAMYCIN)	1	QL QL (46.6 gm / 30 days)
claravis CAPS 10mg, 20mg, 30mg, 40mg	1	PA
clindamycin phosphate (topical) GEL 1% QL (75 gm / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
clindamycin phosphate (topical) (generic of CLEOCIN-T) LOTN 1% QL (60 mL / 30 days)	1	QL
clindamycin phosphate (topical) SOLN 1% QL (60 mL / 30 days)	1	QL
ery PADS 2% QL (60 pledges / 30 days)	1	QL
erythromycin (acne aid) (generic of ERYGEL) GEL 2% QL (60 gm / 30 days)	1	QL
erythromycin (acne aid) SOLN 2% QL (60 mL / 30 days)	1	QL
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	1	PA
sulfacetamide sodium (acne) (generic of KLARON) LOTN 10% QL (118 mL / 30 days)	1	QL
tretinoin (generic of RETIN-A) CREA .025%, .05%, .1%; GEL .01%, .025% QL (45 gm / 30 days)	1	QL PA
zenatane CAPS 10mg, 20mg, 1 30mg, 40mg		PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) CREA .1%; OINT .1% QL (30 gm / 30 days)	1	QL
mupirocin OINT 2% QL (220 gm / 30 days)	1	QL
silver sulfadiazine (generic of SILVADENE) CREA 1%	1	
ssd (generic of SILVADENE) CREA 1%	1	
SULFAMYLYON CREA 85mg/gm QL (453.6 gm / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
DERMATOLOGY, ANTIFUNGALS		
ciclopirox olamine CREA .77% QL (90 gm / 30 days)	1	QL
ciclopirox olamine SUSP .77% QL (60 mL / 30 days)	1	QL
clotrimazole (topical) CREA 1% QL (45 gm / 30 days)	1	QL
clotrimazole (topical) SOLN 1% QL (30 mL / 30 days)	1	QL
clotrimazole w/ betamethasone cream 1- 0.05% QL (45 gm / 30 days)	1	QL
ketoconazole (topical) CREA 2% QL (60 gm / 30 days)	1	QL
klayesta POWD 100000unit/gm QL (60 gm / 30 days)	1	QL
nyamyc POWD 100000unit/gm QL (60 gm / 30 days)	1	QL
nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm QL (30 gm / 30 days)	1	QL
nystatin (topical) POWD 100000unit/gm QL (60 gm / 30 days)	1	QL
nystop POWD 100000unit/gm QL (60 gm / 30 days)	1	QL
DERMATOLOGY, ANTI-PSORIATICS		
acitretin CAPS 10mg, 17.5mg, 25mg	1	PA
calcipotriene CREA .005%; OINT .005% QL (120 gm / 30 days)	1	QL PA
calcipotriene SOLN .005% QL (120 mL / 30 days)	1	QL PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
calcitrene OINT .005% QL (120 gm / 30 days)	1	QL PA
tazarotene (generic of TAZORAC) CREA .1% QL (60 gm / 30 days)	1	QL PA
TAZORAC CREA .05% QL (60 gm / 30 days)	1	QL PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) SHAM 2% QL (120 mL / 30 days)	1	QL
selenium sulfide LOTN 2.5%	1	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort CREA 1%, 2.5%	1	
alclometasone dipropionate CREA .05%; OINT .05% QL (60 gm / 30 days)	1	QL
betamethasone dipropionate (topical) CREA .05%; OINT .05% QL (120 gm / 30 days)	1	QL
betamethasone dipropionate (topical) LOTN .05% QL (120 mL / 30 days)	1	QL
betamethasone dipropionate augmented CREA .05%; GEL .05% QL (120 gm / 30 days)	1	QL
betamethasone dipropionate augmented (generic of DIPROLENE) OINT .05% QL (120 gm / 30 days)	1	QL
betamethasone valerate CREA .1%; OINT .1% QL (120 gm / 30 days)	1	QL
betamethasone valerate LOTN .1% QL (120 mL / 30 days)	1	QL
clobetasol propionate CREA .05%; GEL .05%; OINT .05% QL (60 gm / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
clobetasol propionate SOLN .05% QL (50 mL / 30 days)	1	QL
clobetasol propionate e CREA .05% QL (60 gm / 30 days)	1	QL
ENSTILAR AER QL (120 gm / 30 days)	1	QL PA
fluocinolone acetonide CREA .01% QL (60 gm / 30 days)	1	QL
fluocinolone acetonide (generic of SYNALAR) CREA .025%; OINT .025% QL (120 gm / 30 days)	1	QL
fluocinolone acetonide (generic of DERMA-SMOOTH/FS BODY) OIL .01% QL (118.28 mL / 30 days)	1	QL
fluocinolone acetonide (generic of DERMA-SMOOTH/FS SCALP) OIL .01% QL (118.28 mL / 30 days)	1	QL
fluocinolone acetonide SOLN .01% QL (90 mL / 30 days)	1	QL
fluocinonide CREA .05% QL (120 gm / 30 days)	1	QL
fluocinonide GEL .05%; OINT .05% QL (60 gm / 30 days)	1	QL
fluocinonide SOLN .05% QL (60 mL / 30 days)	1	QL
fluocinonide emulsified base CREA .05% QL (120 gm / 30 days)	1	QL
fluticasone propionate CREA .05%; OINT .005%	1	
halobetasol propionate CREA .05%; OINT .05% QL (50 gm / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

order **B/D** - Covered under Medicare B or D

LA - Limited Access **V/I** - Vaccines / Insulins (see below)

75

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Drug Name	Drug Requirements/ Tier	Limits
<i>hydrocortisone (topical)</i>	1	
CREA 1%, 2.5%; LOTN 2.5%; OINT 2.5%		
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	1	
<i>triamcinolone acetonide</i> (topical) CREA .025%, .1%, .5%	1	QL QL (454 gm / 30 days)
<i>triamcinolone acetonide</i> (topical) LOTN .025%, .1%; OINT .025%, .1%, .5%	1	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i> PRSY 2%	1	QL PA QL (60 mL / 30 days)
<i>lidocaine</i> OINT 5%	1	QL PA QL (50 gm / 30 days)
<i>lidocaine</i> (generic of LIDODERM) PTCH 5%	1	QL PA QL (3 patches / 1 day)
<i>lidocaine hcl</i> SOLN 4%	1	QL PA QL (50 mL / 30 days)
<i>lidocaine-prilocaine cream</i> 2.5-2.5%	1	B/D QL QL (30 gm / 30 days)
<i>lidocan iii</i> (generic of LIDODERM) PTCH 5%	1	QL PA QL (3 patches / 1 day)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>bexarotene (topical)</i> (generic of TARGRETIN) GEL 1%	1	QL NM PA QL (60 gm / 30 days)
<i>diclofenac sodium (topical)</i> GEL 1%	1	QL QL (1000 gm / 30 days)
<i>fluorouracil (topical)</i> (generic of EFUDEX) CREA 5%	1	QL QL (40 gm / 30 days)
<i>fluorouracil (topical)</i> SOLN 2%, 5%	1	QL QL (10 mL / 30 days)

Drug Name	Drug Requirements/ Tier	Limits
<i>hydrocortisone (rectal)</i> (generic of PROCTOCORT) CREA 1%	1	
<i>hydrocortisone (rectal)</i> (generic of ANUSOL-HC) CREA 2.5%	1	
<i>imiquimod</i> CREA 5% QL (24 packets / 30 days)	1	QL
<i>lactic acid (ammonium lactate)</i> CREA 12%; LOTN 12%	1	
<i>metronidazole (topical)</i> (generic of METROCREAM) CREA .75% QL (45 gm / 30 days)	1	QL
<i>metronidazole (topical)</i> .75% QL (45 gm / 30 days)	1	QL
<i>metronidazole (topical)</i> (generic of METROLOTION) LOTN .75% QL (59 mL / 30 days)	1	QL
PANRETIN GEL .1% QL (60 gm / 30 days)	1	QL PA
<i>podofilox</i> SOLN .5% QL (7 mL / 28 days)	1	QL
<i>procto-med hc</i> (generic of ANUSOL-HC) CREA 2.5%	1	
<i>procosol hc</i> (generic of ANUSOL-HC) CREA 2.5%	1	
<i>protozozone-hc</i> (generic of ANUSOL-HC) CREA 2.5%	1	
RECTIV OINT .4% QL (30 gm / 30 days)	1	QL
<i>tacrolimus (topical)</i> OINT .03%, .1% QL (100 gm / 30 days)	1	QL
VALCHLOR GEL .016% QL (60 gm / 30 days)	1	QL NM LA PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i> LOTN .5% QL (59 mL / 30 days)	1	QL

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

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

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **V/I** - Vaccines / Insulins (see below)

V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than \$35 for a one-month supply. Call Customer Service for your estimated cost.

Index

- A**
- abacavir sulfate.....14
abacavir sulfate-lamivudine
tab 600-300 mg.....14
- ABELCET13
- ABILIFY
 see aripiprazole.....37
- ABILIFY MAINTENA.....37
- abiraterone acetate.....19
- ABRYSVO66
- acamprosate calcium.....47
- acarbose.....48
- ACCOLATE
 see zafirlukast.....71
- ACCUPRIL
 see quinapril hcl27
- accutane73
- acebutolol hcl.....31
- acetaminophen w/ codeine
 soln 120-12 mg/5ml....10
- acetaminophen w/ codeine
 tab 300-15 mg.....10
- acetaminophen w/ codeine
 tab 300-30 mg.....10
- acetaminophen w/ codeine
 tab 300-60 mg.....10
- acetazolamide32
- acetic acid.....61
- acetic acid (otic).....70
- acetylcysteine71
- ACIPHEX
 see rabeprazole sodium
.....61
- acitretin74
- ACTHIB INJ66
- ACTIMMUNE65
- ACTIVELLA
 see estradiol &
 norethindrone acetate
 tab 1-0.5 mg55
 see mimvey.....55
- ACTONEL
 see risedronate sodium
.....52
- ACTOPLUS MET
- see pioglitazone hcl-
 metformin hcl tab 15-
 850 mg49
- ACTOS
 see pioglitazone hcl....49
- ACULAR
 see ketorolac
 tromethamine (ophth)
 69
- ACULAR LS
 see ketorolac
 tromethamine (ophth)
 69
- acyclovir.....15
- acyclovir sodium15
- ADACEL INJ66
- ADALIMUMAB-AACF (2
 PEN)63
- ADDERALL
 see amphetamine-
 dextroamphetamine
 tab 10 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 12.5 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 15 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 20 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 30 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 5 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 7.5 mg.....44
- ADDERALL XR
 see amphetamine-
 dextroamphetamine
 cap er 24hr 10 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 15 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 20 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 25 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 30 mg ...44
- see amphetamine-
 dextroamphetamine
 cap er 24hr 5 mg43
- adefovir dipivoxil15
- ADEMPAS34
- ADMELOG50
- ADMELOG SOLOSTAR .50
- ADVAIR DISKUS
 see fluticasone-
 salmeterol aer powder
 ba 100-50 mcg/act...73
- see fluticasone-
 salmeterol aer powder
 ba 250-50 mcg/act...73
- see fluticasone-
 salmeterol aer powder
 ba 500-50 mcg/act...73
- see wixela inhub.....73
- ADVAIR HFA AER 115/21
.....73
- ADVAIR HFA AER 230/21
.....73
- ADVAIR HFA AER 45/21 73
- AFINITOR
 see everolimus22
- AFINITOR DISPERZ
 see everolimus22
- afirmelle52
- AGRYLIN
 see anagrelide hcl.....62
- AIMOVIG45
- AKEEGA TAB 100/500 ..20
- AKEEGA TAB 50/500MG
.....19
- ala-cort.....75
- albendazole11
- albuterol sulfate71
- ALCAINE

see proparacaine hcl	70	amoxicillin & k clavulanate																																																																													
alclometasone dipropionate	75	for susp 250-62.5 mg/5ml																																																																													
ALDACTONE		.....	18																																																																											
see spironolactone	27	amoxicillin & k clavulanate																																																																													
ALDURAZYME	56	for susp 400-57 mg/5ml																																																																													
ALECENSA	21	.....	18																																																																											
alendronate sodium	51	amoxicillin & k clavulanate																																																																													
alfuzosin hcl	61	for susp 600-42.9 mg/5ml																																																																													
ALIMTA		.....	18																																																																											
see pemetrexed		amoxicillin & k clavulanate																																																																													
disodium	19	tab 250-125 mg	18																																																																												
ALINIA		amoxicillin & k clavulanate																																																																													
see nitazoxanide	12	tab 500-125 mg	18																																																																												
aliskiren fumarate	33	amoxicillin & k clavulanate																																																																													
allopurinol	9	tab 875-125 mg	18																																																																												
alosetron hcl	60	amoxicillin & k clavulanate																																																																													
ALPHAGAN P		tab er 12hr 1000-62.5 mg																																																																													
see brimonidine tartrate		.....	18																																																																											
.....	69	amphetamine-																																																																													
alprazolam	34	dextroamphetamine cap																																																																													
ALREX	69	er 24hr 10 mg	43																																																																												
ALTACE		amphetamine-																																																																													
see ramipril	27	dextroamphetamine cap																																																																													
altavera	52	er 24hr 15 mg	43																																																																												
ALUNBRIG	21	amphetamine-																																																																													
ALUNBRIG PAK	21	dextroamphetamine cap																																																																													
alyacen 1/35	52	er 24hr 20 mg	43																																																																												
alyacen 7/7/7	52	amabelz tab 0.5-0.1mg	55	amphetamine-		amantadine hcl	36	dextroamphetamine cap		AMBIEN		er 24hr 25 mg	43	see zolpidem tartrate	45	AMBISOME		amphetamine-		see amphotericin b		dextroamphetamine cap		liposome	13	er 24hr 30 mg	44	ambrisentan	34	amphetamine-		amethia	52	dextroamphetamine cap		amikacin sulfate	11	er 24hr 5 mg	43	amiloride &		hydrochlorothiazide tab		amphetamine-		5-50 mg	32	dextroamphetamine tab		amiloride hcl	32	10 mg	44	amiodarone hcl	29	amphetamine-		amitriptyline hcl	35	dextroamphetamine tab		amlodipine besylate	32	15 mg	44	amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44
amabelz tab 0.5-0.1mg	55	amphetamine-																																																																													
amantadine hcl	36	dextroamphetamine cap																																																																													
AMBIEN		er 24hr 25 mg	43																																																																												
see zolpidem tartrate	45	AMBISOME		amphetamine-		see amphotericin b		dextroamphetamine cap		liposome	13	er 24hr 30 mg	44	ambrisentan	34	amphetamine-		amethia	52	dextroamphetamine cap		amikacin sulfate	11	er 24hr 5 mg	43	amiloride &		hydrochlorothiazide tab		amphetamine-		5-50 mg	32	dextroamphetamine tab		amiloride hcl	32	10 mg	44	amiodarone hcl	29	amphetamine-		amitriptyline hcl	35	dextroamphetamine tab		amlodipine besylate	32	15 mg	44	amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44														
AMBISOME		amphetamine-																																																																													
see amphotericin b		dextroamphetamine cap																																																																													
liposome	13	er 24hr 30 mg	44																																																																												
ambrisentan	34	amphetamine-		amethia	52	dextroamphetamine cap		amikacin sulfate	11	er 24hr 5 mg	43	amiloride &		hydrochlorothiazide tab		amphetamine-		5-50 mg	32	dextroamphetamine tab		amiloride hcl	32	10 mg	44	amiodarone hcl	29	amphetamine-		amitriptyline hcl	35	dextroamphetamine tab		amlodipine besylate	32	15 mg	44	amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44																												
amphetamine-																																																																															
amethia	52	dextroamphetamine cap																																																																													
amikacin sulfate	11	er 24hr 5 mg	43																																																																												
amiloride &		hydrochlorothiazide tab		amphetamine-		5-50 mg	32	dextroamphetamine tab		amiloride hcl	32	10 mg	44	amiodarone hcl	29	amphetamine-		amitriptyline hcl	35	dextroamphetamine tab		amlodipine besylate	32	15 mg	44	amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44																																								
hydrochlorothiazide tab		amphetamine-																																																																													
5-50 mg	32	dextroamphetamine tab																																																																													
amiloride hcl	32	10 mg	44																																																																												
amiodarone hcl	29	amphetamine-		amitriptyline hcl	35	dextroamphetamine tab		amlodipine besylate	32	15 mg	44	amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44																																																						
amphetamine-																																																																															
amitriptyline hcl	35	dextroamphetamine tab																																																																													
amlodipine besylate	32	15 mg	44																																																																												
amlodipine besylate-		benazepril hcl cap 10-20		amphetamine-		mg	26	dextroamphetamine tab				20 mg	44																																																																		
benazepril hcl cap 10-20		amphetamine-																																																																													
mg	26	dextroamphetamine tab																																																																													
		20 mg	44																																																																												

amphetamine-	
dextroamphetamine tab	
30 mg	44
amphetamine-	
dextroamphetamine tab 5	
mg.....	44
amphetamine-	
dextroamphetamine tab 7.5 mg.....	44
amphotericin b.....	13
amphotericin b liposome.....	13
ampicillin.....	18
ampicillin & sulbactam	
sodium for inj 1.5 (1-0.5) gm.....	18
ampicillin & sulbactam	
sodium for inj 3 (2-1) gm	18
ampicillin & sulbactam	
sodium for iv soln 1.5 (1-0.5) gm.....	18
ampicillin & sulbactam	
sodium for iv soln 15 (10-5) gm.....	18
ampicillin & sulbactam	
sodium for iv soln 3 (2-1) gm.....	18
ampicillin sodium	18
AMPYRA	
see <i>dalfampridine</i>	46
ANAFRANIL	
see <i>clomipramine hcl</i> ..35	
anagrelide hcl	62
ANAPROX DS	
see <i>naproxen sodium</i>9	
anastrozole	20
ANCOBON	
see <i>flucytosine</i>	13
ANDROGEL PUMP	
see <i>testosterone</i>	48
ANORO ELLIPT AER 62.5-25	70
ANUSOL-HC	
see <i>hydrocortisone (rectal)</i>	76
see <i>procto-med hc</i>	76
see <i>proctosol hc</i>	76
see <i>protozone-hc</i>	76
aprepitant.....	58
aprepitant capsule therapy	
pack 80 & 125 mg	58
api.....	52
APRISO	
see <i>mesalamine</i>	59
APTIOM	40
APTIVUS	14
ARALAST NP	72
aranelle.....	52
ARAVA	
see <i>leflunomide</i>	64
ARCALYST	65
AREXVY	66
ARICEPT	
see <i>donepezil hydrochloride</i>	34
ARIMIDEX	
see <i>anastrozole</i>	20
ariPIPRAZOLE	37
ARISTADA.....	37
ARISTADA INITIO	37
ARIIXTRA	
see <i>fondaparinux sodium</i>	62
armodafinil.....	47
ARNUTITY ELLIPTA.....	73
AROMASIN	
see <i>exemestane</i>	20
asenapine maleate	37
ashlyna	52
aspirin-dipyridamole cap er 12hr	
25-200 mg.....	63
ASTAGRAF XL	65
ATACAND	
see <i>candesartan cilexetil</i>	29
ATACAND HCT	
see <i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	28
see <i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	28
see <i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	28
atazanavir sulfate.....	14
ATELVIA	
see risedronate sodium	52
atenolol.....	31
atenolol & chlorthalidone tab 100-25 mg	31
atenolol & chlorthalidone tab 50-25 mg	31
ATIVAN	
see <i>lorazepam</i>	34
atomoxetine hcl.....	44
atorvastatin calcium.....	30
atovaquone	11
atovaquone-proguanil hcl tab 250-100 mg	13
atovaquone-proguanil hcl tab 62.5-25 mg	13
ATRIPLA	
see <i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	15
ATROPINE SULFATE	70
atropine sulfate (ophthalmic)	70
ATROVENT HFA	70
aubra eq	52
AUGMENTIN	
see <i>amoxicillin & k clavulanate tab 500-125 mg</i>	18
AUGMENTIN ES-600	
see <i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	18
AUGTYRO	21
aurovela 1/20	52
aurovela 24 fe	52
aurovela fe 1.5/30	52
aurovela fe 1/20	52
AUSTEDO	46
AUSTEDO XR	46
AUSTEDO XR TAB TITR KIT	46
AUVELITY TAB 45-105MG	35
AVALIDE	
see <i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	28

see <i>irbesartan</i> - hydrochlorothiazide tab 300-12.5 mg	28
AVAPRO	
see <i>irbesartan</i>	29
aviane	52
AVODART	
see <i>dutasteride</i>	61
ayuna.....	52
AYVAKIT	21
<i>azacitidine</i>	19
AZACTAM	
see <i>aztreonam</i>	11
azathioprine	65
azelastine hcl.....	71
azelastine hcl (ophth).....	69
AZILECT	
see <i>rasagiline mesylate</i>	37
azithromycin	17
AZOPT	
see <i>brinzolamide</i>	69
AZOR	
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 10-20 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 10-40 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 5-20 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 5-40 mg</i>	27
aztreonam.....	11
AZULFIDINE	
see <i>sulfasalazine</i>	59
AZULFIDINE EN-TABS	
see <i>sulfasalazine</i>	59
azurette.....	52
B	
<i>bacitracin (ophthalmic)</i>	68
<i>bacitracin-polymyxin b</i> <i>ophth oint</i>	68
<i>bacitracin-polymyxin-</i> <i>neomycin-hc ophth oint</i> 1%.....	68
<i>baclofen</i>	46
BACTRIM	
see <i>sulfamethoxazole-</i> <i>trimethoprim tab 400-</i> <i>80 mg</i>	12
BACTRIM DS	
see <i>sulfamethoxazole-</i> <i>trimethoprim tab 800-</i> <i>160 mg</i>	12
BAFIERTAM	46
<i>balsalazide disodium</i>	59
BALVERSA.....	21
<i>balziva</i>	52
BANZEL	
see <i>rufinamide</i>	42
BARACLUDE	16
see <i>entecavir</i>	16
BASAGLAR KWIKPEN...50	
BCG VACCINE	66
BD ALCOHOL SWABS...50	
<i>benazepril &</i> hydrochlorothiazide tab 10-12.5 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 20-12.5 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 20-25 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 5-6.25mg	26
<i>benazepril hcl</i>	27
BENDEKA	19
BENICAR	
see <i>olmesartan</i> <i>medoxomil</i>	29
BENICAR HCT	
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 20-12.5 mg	28
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 40-12.5 mg	28
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 40-25 mg	28
BENLYSTA	65
BENZAMYCIN	
see <i>benzoyl peroxide-</i> <i>erythromycin gel 5-3%</i>	73
<i>benzoyl peroxide-</i> erythromycin gel 5-3% 73	
benztropine mesylate.....	36
BERINERT	62
BESIVANCE	68
BESREMI.....	20
<i>betaine powder for oral</i> <i>solution</i>	56
<i>betamethasone</i>	
<i>dipropionate (topical)</i> ...75	
<i>betamethasone</i>	
<i>dipropionate augmented</i>	75
<i>betamethasone valerate</i> .75	
BETAPACE	
see <i>sorine</i>	30
see <i>sotalol hcl</i>	30
BETAPACE AF	
see <i>sotalol hcl (afib/afl)</i> 30	
BETASERON.....	46
<i>betaxolol hcl</i>	31
<i>betaxolol hcl (ophth)</i>	69
<i>bethanechol chloride</i>	61
BETOPTIC-S	69
BEVESPI AER 9-4.8MCG	
.....	70
bexarotene.....	20
bexarotene (<i>topical</i>)	76
BEXSERO INJ	66
BIAXIN XL	
see <i>clarithromycin</i>	17
<i>bicalutamide</i>	20
BICILLIN L-A.....	18
BIKTARVY TAB 30-120-15	
MG	15
BIKTARVY TAB 50-200-25	
MG	15
BILTRICIDE	
see <i>praziquantel</i>	12
<i>bisoprolol &</i>	
<i>hydrochlorothiazide tab</i> 10-6.25 mg	31

<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>.....31	<i>buprenorphine hcl</i>.....47	<i>candesartan cilexetil</i>.....29
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>.....31	<i>buprenorphine hcl- naloxone hcl sl film 12-3 mg (base equiv)</i>.....47	<i>candesartan cilexetil- hydrochlorothiazide tab 16-12.5 mg</i>.....28
<i>bisoprolol fumarate</i>.....31	<i>buprenorphine hcl- naloxone hcl sl film 2-0.5 mg (base equiv)</i>.....47	<i>candesartan cilexetil- hydrochlorothiazide tab 32-12.5 mg</i>.....28
BIVIGAM.....65	<i>buprenorphine hcl- naloxone hcl sl film 4-1 mg (base equiv)</i>.....47	<i>candesartan cilexetil- hydrochlorothiazide tab 32-25 mg</i>.....28
<i>blisovi 24 fe</i>.....52	<i>buprenorphine hcl- naloxone hcl sl film 8-2 mg (base equiv)</i>.....47	CAPLYTA .....37
<i>blisovi fe 1.5/30</i>.....52	<i>buprenorphine hcl- naloxone hcl sl tab 2-0.5 mg (base equiv)</i>.....47	CAPRELSA .....21
BOOSTRIX INJ.....66	<i>buprenorphine hcl- naloxone hcl sl tab 8-2 mg (base equiv)</i>.....47	captopril .....27
<i>bortezomib</i>.....21	<i>bupropion hcl</i>.....35	captopril &
BORTEZOMIB .....21	<i>bupropion hcl (smoking deterrent)</i>.....47	<i>hydrochlorothiazide tab 25-15 mg</i>.....26
<i>bosentan</i>.....34	<i>buspirone hcl</i>.....34	captopril &
BOSULIF .....21	<i>butorphanol tartrate</i>.....10	<i>hydrochlorothiazide tab 50-15 mg</i>.....26
BRAFTOVI.....21	BYDUREON BCISE.....48	captopril &
BREO ELLIPTA INH 100-25 .....73	BYETTA.....48	<i>hydrochlorothiazide tab 50-25 mg</i>.....26
BREO ELLIPTA INH 200-25 .....73	BYSTOLIC see <i>nebivolol hcl</i>.....31	CARAFATE see <i>sucralfate</i>.....60
BREO ELLIPTA INH 50-25MCG .....73	C	carb/levo orally <i>disintegrating tab 10-100mg</i>.....36
BREZTRI AERO AER SPHERE .....70	<i>cabergoline</i>.....56	carb/levo orally <i>disintegrating tab 25-100mg</i>.....36
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK) .....70	CABOMETYX .....21	carb/levo orally <i>disintegrating tab 25-250mg</i>.....36
<i>briellyn</i> .....52	<i>calcipotriene</i>.....74	CARBAGLU see <i>carglumic acid</i> .....56
BRILINTA .....63	<i>calcitonin (salmon) spray</i>.....51	carbamazepine .....40
<i>brimonidine tartrate</i>.....69	<i>calcitrene</i>.....75	CARBATROL see <i>carbamazepine</i>....40
<i>brinzolamide</i> .....69	<i>calcitriol</i>.....58	<i>carbidopa & levodopa tab 10-100 mg</i>.....36
BRIVIACT .....40	<i>calcitriol (oral)</i>.....58	<i>carbidopa & levodopa tab 25-100 mg</i>.....36
<i>bromfenac sodium (ophth)</i> .....69	<i>calcium acetate (phosphate binder)</i>.....57	<i>carbidopa & levodopa tab 25-250 mg</i>.....36
<i>bromocriptine mesylate</i> ...36	CALQUENCE .....21	CARBAGLU see <i>carglumic acid</i> .....56
BROMSITE .....69	<i>camila</i> .....52	carbamazepine .....40
see <i>bromfenac sodium (ophth)</i> .....69	CAMPTOSAR see <i>irinotecan hcl</i>.....20	CARBATROL see <i>carbamazepine</i>....40
BRONCHITOL .....72	camrese .....52	<i>carbidopa & levodopa tab 10-100 mg</i>.....36
BRUKINSA .....21	camrese lo .....52	<i>carbidopa & levodopa tab 25-100 mg</i>.....36
<i>budesonide</i> .....59	CANASA see <i>mesalamine</i>.....59	<i>carbidopa & levodopa tab 25-250 mg</i>.....36
<i>budesonide (inhalation)</i> ..73	CANCIDAS see <i>caspofungin acetate</i> .....13	<i>carbidopa & levodopa tab er 25-100 mg</i>.....37
<i>bumetanide</i>.....32		
BUMEX see <i>bumetanide</i>.....32		
BUPHENYL see <i>sodium phenylbutyrate</i>.....57		

<i>carbidopa & levodopa tab er</i> 50-200 mg.....37	<i>cefaclor</i>.....16	CIPRO
<i>carbidopa-levodopa-entacapone tabs</i> 12.5-50-200 mg.....37	CEFACLOR ER .....16	<i>see ciprofloxacin hcl</i>....17
<i>carbidopa-levodopa-entacapone tabs</i> 18.75-75-200 mg.....37	<i>cefadroxil</i> .....16	<i>ciprofloxacin 200 mg/100ml in d5w</i>.....17
<i>carbidopa-levodopa-entacapone tabs</i> 25-100-200 mg.....37	CEFAZOLIN.....16	<i>ciprofloxacin 400 mg/200ml in d5w</i>.....17
<i>carbidopa-levodopa-entacapone tabs</i> 31.25-125-200 mg.....37	CEFAZOLIN INJ	<i>ciprofloxacin hcl</i>.....17
<i>carbidopa-levodopa-entacapone tabs</i> 37.5-150-200 mg.....37	1GM/50ML .....16	<i>ciprofloxacin hcl (ophth)</i> ..69
<i>carbidopa-levodopa-entacapone tabs</i> 50-200-200 mg.....37	<i>cefazolin sodium</i>.....16	<i>ciprofloxacin-</i>
<i>carboplatin</i>.....19	CEFAZOLIN SOLN	<i>dexamethasone otic susp</i>
CARDIZEM	2GM/100ML-4% .....16	0.3-0.1%.....70
<i>see diltiazem hcl</i>.....32	<i>cefdinir</i>.....16	<i>cisplatin</i>.....19
CARDIZEM CD	<i>cefepime hcl</i>.....16	<i>citalopram hydrobromide</i> 35
<i>see cartia xt</i>.....32	<i>cefixime</i> .....16	<i>claravis</i> .....73
<i>see diltiazem hcl coated beads</i>.....32	<i>cefoxitin sodium</i>.....16	<i>clarithromycin</i>.....17
CARDURA	<i>cefpodoxime proxetil</i>.....16	CLEOCIN
<i>see doxazosin mesylate</i>	<i>cefprozil</i> .....17	<i>see clindamycin hcl</i>....11
.....27	<i>ceftazidime</i> .....17	<i>see clindamycin</i>
<i>carglumic acid</i>.....56	<i>ceftriaxone sodium</i>.....17	<i>phosphate vaginal</i> ..61
<i>carisoprodol</i>.....46	<i>cefuroxime axetil</i>.....17	CLEOCIN PEDIATRIC
CARNITOR	<i>cefuroxime sodium</i>.....17	GRANULE
<i>see levocarnitine (metabolic modifiers)</i>	CELEBREX	<i>see clindamycin</i>
.....57	<i>see celecoxib</i> .....9	<i>palmitate hydrochloride</i>
<i>carteolol hcl (ophth)</i>.....70	CELEXA	.....11
<i>cartia xt</i>.....32	<i>see citalopram</i>	CLEOCIN PHOSPHATE
<i>carvedilol</i>.....31	<i>hydrobromide</i>.....35	<i>see clindamycin</i>
CASODEX	CELLCEPT	<i>phosphate</i>.....11
<i>see bicalutamide</i> .....20	<i>see mycophenolate mofetil</i>.....65	CLEOCIN-T
<i>caspofungin acetate</i>.....13	CELONTIN	<i>see clindamycin</i>
CATAPRES-TTS-1	<i>see methsuximide</i> .....42	<i>phosphate (topical)</i> ..74
<i>see clonidine</i> .....33	<i>cephalexin</i> .....17	CLIMARA
CATAPRES-TTS-2	CERDELGA.....56	<i>see estradiol</i>.....55
<i>see clonidine</i> .....33	CEREZYME.....56	<i>clindamycin hcl</i> .....11
CATAPRES-TTS-3	<i>cetirizine hcl</i>.....71	<i>clindamycin palmitate</i>
<i>see clonidine</i> .....33	<i>cevimeline hcl</i>.....77	<i>hydrochloride</i>.....11
CAYSTON	<i>chateal eq</i>.....52	<i>clindamycin phosphate</i> ..11
11	CHEMET .....52	<i>clindamycin phosphate</i>
	<i>chlorhexidine gluconate (mouth-throat)</i>	<i>(topical)</i> .....73, 74
	.....77	<i>clindamycin phosphate in</i>
	<i>chloroquine phosphate</i> ..13	<i>d5w iv soln 300 mg/50ml</i>
	<i>chlorpromazine hcl</i>.....37	.....11
	<i>chlorthalidone</i> .....32	<i>clindamycin phosphate in</i>
	<i>cholestyramine</i>.....30	<i>d5w iv soln 600 mg/50ml</i>
	<i>cholestyramine light</i>.....30	.....11
	<i>ciclopirox olamine</i> .....74	<i>clindamycin phosphate in</i>
	<i>cilostazol</i>.....62	<i>d5w iv soln 900 mg/50ml</i>
	CILOXAN.....68	.....11
	CIMDUO TAB 300-300 ...15	<i>clindamycin phosphate</i>
	<i>cinacalcet hcl</i> .....56	<i>vaginal</i>.....61

CLINDMYC/NAC INJ	
300/50ML	11
CLINDMYC/NAC INJ	
600/50ML	11
CLINDMYC/NAC INJ	
900/50ML	11
CLINIMIX INJ 4.25/D10 ..	68
CLINIMIX INJ 4.25/D5W.	68
CLINIMIX INJ 5%/D15W.	68
CLINIMIX INJ 5%/D20W.	68
CLINIMIX INJ 6/5.....	68
CLINIMIX INJ 8/10.....	68
CLINIMIX INJ 8/14.....	68
<i>clinisol sf 15%</i>	68
CLINOLIPID EMU 20%....	68
clobazam	40
clobetasol propionate.....	75
clobetasol propionate e...	75
clomipramine hcl.....	35
clonazepam	40
clonidine	33
clonidine hcl.....	33
clopидогrel bisulfate.....	63
clorazepate dipotassium.	40
clotrimazole	77
clotrimazole (topical).....	74
clotrimazole w/	
betamethasone cream 1-0.05%.....	74
clozapine	38
CLOZARIL	
see clozapine	38
COARTEM TAB 20-120MG	
.....	13
COLAZAL	
see balsalazide disodium	59
colchicine.....	9
colchicine w/ probenecid	
tab 0.5-500 mg	9
colesevelam hcl	30
COLESTID	
see colestipol hcl.....	30
colestipol hcl.....	30
colistimethate sodium	11
COLY-MYCIN M	
see colistimethate sodium.....	11
COMBIGAN SOL 0.2/0.5%	
.....	70
COMBIVENT AER 20-100	
.....	70
COMETRIQ (60MG DOSE)	
.....	21
COMETRIQ KIT 100MG	.22
COMETRIQ KIT 140MG	.22
COMPLERA TAB.....	15
<i>compro</i>	58
<i>constulose</i>	59
COPAXONE	
see glatiramer acetate.	46
see glatopa.....	46
COPIKTRA	22
COREG	
see carvedilol	31
CORGARD	
see nadolol.....	31
CORLANOR	33
CORTEF	
see hydrocortisone.....	56
CORTENEMA	
see hydrocortisone (intrarectal)	59
COSOPT	
see dorzolamide hcl-timolol maleate ophth soln 2-0.5%.....	70
COTELLIC	22
COZAAR	
see losartan potassium	29
CREON CAP 12000UNT	60
CREON CAP 24000UNT	60
CREON CAP 3000UNIT	.60
CREON CAP 36000UNT	60
CREON CAP 6000UNIT	.60
CRESTOR	
see rosuvastatin calcium	30
cromolyn sodium.....	72
cromolyn sodium	
(mastocytosis).....	60
cromolyn sodium (ophth)	69
crysselle-28	52
cyclobenzaprine hcl	47
cyclophosphamide	19
CYCLOPHOSPHAMIDE	.19
CYKLOKAPRON	
see tranexamic acid ...	63
CYMBALTA	
see duloxetine hcl	35
cyroheptadine hcl.....	71
cyred eq.....	52
CYSTADANE	
see betaine powder for oral solution	56
CYSTADROPS	70
CYSTAGON.....	56
CYSTARAN	70
cytarabine	19
CYTOMEL	
see liothyronine sodium	58
CYTOTEC	
see misoprostol	60
D	
D10W/NACL INJ 0.2%....	66
D2.5W/NACL INJ 0.45%.	66
D5W/LYTES INJ #48	66
dabigatran etexilate	
mesylate.....	62
dalfampridine	46
DALIRESP	
see roflumilast.....	72
danazol	55
DANTRIUM	
see dantrolene sodium	47
dantrolene sodium	47
dapsone	11
DAPTACEL INJ	66
daptomycin	12
DAPTONYCIN.....	11
see daptomycin	12
darunavir	14
dasetta 1/35.....	52
dasetta 7/7/7.....	52
DAURISMO	22
daysee	52
DAYVIGO	44
DDAVP	

see <i>desmopressin acetate</i>.....56	<i>desmopressin acetate</i>.....56	<i>see dextrose 5% w/ sodium chloride 0.3%</i>.....67
<i>deblitane</i>.....52	<i>desmopressin acetate spray</i>.....56	DEXTROSE/SODIUM CHLORIDE
<i>deferasirox</i>.....52	<i>desmopressin acetate spray refrigerated</i>.....56	<i>see dextrose 5% w/ sodium chloride 0.225%</i>.....67
DELESTROGEN	<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>.....52	DIACOMIT.....40
<i>see estradiol valerate</i> ..55	<i>desogestrel & ethynodiol estradiol tab 0.15 mg-30 mcg</i>.....52	<i>diazepam</i>.....40
DELSTRIGO TAB.....15	<i>desvenlafaxine succinate</i>.....35	<i>diazepam (anticonvulsant)</i>.....40
DELZICOL	DETROL	<i>diazepam inj.</i>.....40
<i>see mesalamine</i>.....59	<i>see tolterodine tartrate</i>.....61	<i>diazepam intensol</i>.....40
DEM SER	DETROL LA	<i>diazoxide</i>.....56
<i>see metyrosine</i>.....33	<i>see tolterodine tartrate</i>.....61	<i>diclofenac potassium</i>.....9
DENGVAXIA SUS.....66	<i>dexamethasone</i>.....55	<i>diclofenac sodium</i>.....9
DEPAKOTE	DEXAMETHASONE INTENSOL	<i>diclofenac sodium (ophth)</i>.....69
<i>see divalproex sodium</i>.....41	<i>see dexamethasone sodium phosphate</i>.....56	<i>diclofenac sodium (topical)</i>.....76
DEPAKOTE ER	<i>see dexamethasone sodium phosphate (ophth)</i>.....69	<i>dicloxacillin sodium</i>.....18
<i>see divalproex sodium</i>.....41	<i>dexamethasone sodium phosphate hcl</i>.....44	<i>dicyclomine hcl</i>.....59
DEPAKOTE SPRINKLES	<i>dextrose</i>.....68	DIFICID.....17
<i>see divalproex sodium</i>.....41	<i>dextrose 10% w/ sodium chloride 0.45%</i>.....67	DIFLUCAN
DEPEN TITRATABS	<i>dextrose 2.5% w/ sodium chloride 0.45%</i>.....66	<i>see fluconazole</i>.....13
<i>see penicillamine</i>.....52	<i>dextrose 5% in lactated ringers</i>.....66	<i>diflunisal</i>.....9
DEPO-MEDROL	<i>dextrose 5% w/ sodium chloride 0.2%</i>.....67	<i>difluprednate</i>.....69
<i>see methylprednisolone acetate</i>.....56	<i>dextrose 5% w/ sodium chloride 0.225%</i>.....67	<i>digoxin</i>.....33
DEPO-PROVERA CONTRACEPTIV	<i>dextrose 5% w/ sodium chloride 0.3%</i>.....67	<i>dihydroergotamine mesylate</i>.....45
<i>see medroxyprogesterone acetate (contraceptive)</i>.....54	DEXTROSE 2.5%/NACL	DILANTIN.....41
DEPO-SUBQ PROVERA	<i>see dextrose 2.5% w/ sodium chloride 0.45%</i>.....66	<i>see phenytoin sodium extended</i>.....42
104.....52	<i>dextrose 5% in lactated ringers</i>.....66	DILANTIN INFATABS.....41
<i>depo-testosterone</i>.....48	<i>dextrose 5% w/ sodium chloride 0.2%</i>.....67	<i>see phenytoin</i>.....42
DERMA-SMOOTH/FS BODY	<i>dextrose 5% w/ sodium chloride 0.3%</i>.....67	DILANTIN-125.....41
<i>see fluocinolone acetonide</i>.....75	<i>dextrose 5% w/ sodium chloride 0.45%</i>.....67	<i>see phenytoin</i>.....42
DERMA-SMOOTH/FS SCALP	<i>dextrose 5% w/ sodium chloride 0.9%</i>.....67	DILAUDID
<i>see fluocinolone acetonide</i>.....75	<i>dextrose 5% w/ sodium chloride 0.3%</i>.....67	<i>see hydromorphone hcl</i>.....10
DERMOTIC	DEXTROSE 5%/NACL 0.3%	<i>diltiazem hcl</i>.....32
<i>see flac</i>.....70		<i>diltiazem hcl coated beads</i>.....32
<i>see fluocinolone acetonide (otic)</i>.....70		<i>diltiazem hcl extended release beads</i>.....32
DESCOVY TAB 120-15MG		<i>dilt-xr</i>.....32
.....15		DIOVAN
DESCOVY TAB 200/25MG		<i>see valsartan</i>.....29
.....15		
<i>desipramine hcl</i>.....35		

DIOVAN HCT	<i>see valsartan-</i>
<i>hydrochlorothiazide tab</i>	
160-12.5 mg	29
see <i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
160-25 mg	29
see <i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
320-12.5 mg	29
see <i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
320-25 mg	29
see <i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
80-12.5 mg	29
DIP/TET PED INJ 25-5LFU	.....66
diphenhydramine hcl.....71	
diphenoxylate w/ atropine	
<i>liq 2.5-0.025 mg/5ml</i>....60	
diphenoxylate w/ atropine	
<i>tab 2.5-0.025 mg</i>.....60	
DIPROLENE	
<i>see betamethasone</i>	
<i>dipropionate</i>	
<i>augmented</i>.....75	
dipyridamole	63
disopyramide phosphate.....29	
disulfiram	47
divalproex sodium.....41	
docetaxel	21
DOCETAXEL.....21	
<i>see docetaxel</i>.....21	
dofetilide	30
donepezil hydrochloride..34	
DOPTELET.....62	
dorzolamide hcl.....70	
<i>dorzolamide hcl-timolol</i>	
<i>maleate ophth soln 2-0.5%</i>.....70	
dotti.....55	
DOVATO TAB 50-300MG	.....15
doxazosin mesylate	27
doxepin hcl	35
<i>doxepin hcl (sleep)</i>.....45	
DOXIL	
<i>see doxorubicin hcl</i>	
<i>liposomal</i>	19
<i>doxorubicin hcl</i>.....19	
<i>doxorubicin hcl liposomal</i> 19	
<i>doxy 100</i>.....18	
<i>doxycycline (monohydrate)</i>	
.....18	
<i>doxycycline hyclate</i> ...18, 19	
<i>dronabinol</i>.....58	
<i>drospirenone-ethinyl</i>	
<i>estradiol tab 3-0.02 mg</i> 52	
<i>drospirenone-ethinyl</i>	
<i>estradiol tab 3-0.03 mg</i> 52	
<i>drospirenone-ethinyl</i>	
<i>estradiol-levomefolate tab</i>	
<i>3-0.03-0.451 mg</i>.....52	
<i>DROXIA</i>.....63	
<i>droxidopa</i>.....33	
<i>DULERA AER 100-5MCG</i>	
.....73	
<i>DULERA AER 200-5MCG</i>	
.....73	
<i>DULERA AER 50-5MCG</i> 73	
<i>duloxetine hcl</i>.....35	
<i>DUPIXENT</i>.....63	
<i>DUREZOL</i>	
<i>see difluprednate</i>.....69	
<i>dutasteride</i>.....61	
<i>dutasteride-tamsulosin hcl</i>	
<i>cap 0.5-0.4 mg</i>	61
E	
<i>e.e.s. 400</i>.....17	
<i>EC-NAPROSYN</i>	
<i>see ec-naproxen</i>	9
<i>see naproxen</i>	9
<i>ec-naproxen</i>.....9	
<i>EDURANT</i>.....14	
<i>efavirenz</i>.....14	
<i>efavirenz-emtricitabine-</i>	
<i>tenofovir df tab 600-200-300 mg</i>.....15	
<i>efavirenz-lamivudine-</i>	
<i>tenofovir df tab 400-300-300 mg</i>	15
<i>efavirenz-lamivudine-</i>	
<i>tenofovir df tab 600-300-300 mg</i>	15
EFFEXOR XR	
<i>see venlafaxine hcl</i>.....36	
EFFIENT	
<i>see prasugrel hcl</i>.....63	
EFUDEX	
<i>see fluorouracil (topical)</i>	
.....76	
ELIGARD	.....20
<i>elinet</i>.....53	
ELIQUIS	.....62
ELIQUIS STARTER PACK	.....62
ELLENCE	.....19
<i>eluryng</i>.....53	
EMCYT	.....20
EMEND	
<i>see aprepitant</i> .....58	
EMSAM	.....35
emtricitabine	14
emtricitabine-tenofovir	
<i>disoproxil fumarate tab</i>	
<i>100-150 mg</i>.....15	
<i>emtricitabine-tenofovir</i>	
<i>disoproxil fumarate tab</i>	
<i>133-200 mg</i>.....15	
<i>emtricitabine-tenofovir</i>	
<i>disoproxil fumarate tab</i>	
<i>167-250 mg</i>.....15	
<i>emtricitabine-tenofovir</i>	
<i>disoproxil fumarate tab</i>	
<i>200-300 mg</i>.....15	
EMTRIVA	.....14
<i>see emtricitabine</i>.....14	
EMVERM	.....12
enalapril maleate	27
enalapril maleate &	
<i>hydrochlorothiazide tab</i>	
<i>10-25 mg</i>.....26	
enalapril maleate &	
<i>hydrochlorothiazide tab</i>	
<i>5-12.5 mg</i>.....26	
ENBREL	.....63
ENBREL MINI	.....63
ENBREL SURECLICK....63	
ENDARI	.....63
endocet tab 10-325mg....10	
endocet tab 2.5-325mg...10	
endocet tab 5-325mg.....10	
endocet tab 7.5-325mg...10	
ENGERIX-B	66
enilloring	53

enoxaparin sodium	62
enpresse-28.....	53
enskyce	53
ENSTILAR AER.....	75
entacapone.....	37
entecavir.....	16
ENTRESTO TAB 24-26MG	28
ENTRESTO TAB 49-51MG	28
ENTRESTO TAB 97-103MG	28
enulose.....	59
EPCLUSA PAK 150-37.516	
EPCLUSA PAK 200-50MG	16
EPCLUSA TAB 200-50MG	16
EPCLUSA TAB 400-100.16	
EPIDIOLEX.....	41
epinephrine (<i>anaphylaxis</i>)	33, 72
EPIPEN 2-PAK see epinephrine (<i>anaphylaxis</i>)	72
EPIPEN-JR 2-PAK see epinephrine (<i>anaphylaxis</i>)	72
epitol.....	41
EPIVIR see lamivudine	14
eplerenone.....	27
EPRONTIA	41
EPZICOM see abacavir sulfate- lamivudine tab 600- 300 mg	14
ergotamine w/ caffeine tab 1-100 mg.....	45
ERIVEDGE	22
ERLEADA.....	20
erlotinib hcl	22
errin	53
ertapenem sodium.....	12
ery.....	74
ERYGEL see erythromycin (<i>acne aid</i>)	74
ery-tab	17
ERYTHROCIN LACTOBIONATE	17
see erythromycin lactobionate	17
erythrocin stearate.....	17
erythromycin (<i>acne aid</i>)	74
erythromycin (<i>ophth</i>).....	69
erythromycin base	17
erythromycin ethylsuccinate	17
erythromycin lactobionate	17
ESBRIET see pirfenidone.....	72
escitalopram oxalate.....	35
esomeprazole magnesium	60
estarrylla	53
ESTRACE see estradiol.....	55
see estradiol vaginal	55
estradiol	55
estradiol & norethindrone acetate tab 0.5-0.1 mg	55
estradiol & norethindrone acetate tab 1-0.5 mg	55
estradiol vaginal.....	55
estradiol valerate	55
eszopiclone.....	45
ethambutol hcl	15
ethosuximide.....	41
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	53
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	53
etodolac	9
etonogestrel-ethinyl estradiol va ring 0.120- 0.015 mg/24hr.....	53
etoposide	21
etravirine.....	14
EULEXIN	20
euthyrox.....	58
everolimus	22
everolimus (<i>immunosuppressant</i>)	65
EVISTA	
see raloxifene hcl	57
EVOTAZ TAB 300-150	15
EVOXAC see cevimeline hcl.....	77
EXELON see rivastigmine	35
exemestane	20
EXFORGE see amlodipine besylate- valsartan tab 10-160 mg	27
see amlodipine besylate- valsartan tab 10-320 mg	28
see amlodipine besylate- valsartan tab 5-160 mg	27
see amlodipine besylate- valsartan tab 5-320 mg	27
EXKIVITY	22
EYSUVIS	69
ezetimibe	30
ezetimibe-simvastatin tab 10-10 mg	30
ezetimibe-simvastatin tab 10-20 mg	30
ezetimibe-simvastatin tab 10-40 mg	30
ezetimibe-simvastatin tab 10-80 mg	31
F	
FABRAZYME	56
falmina	53
famciclovir.....	16
famotidine	59
famotidine in nacl 0.9% iv soln 20 mg/50ml.....	59
FANAPT	38
FANAPT PAK	38
FARESTON see toremifene citrate..	20
FARXIGA	48
FASENRA	72
FASENRA PEN	72
FASLODEX see fulvestrant.....	20
felbamate	41
FELBATOL	

see <i>felbamate</i>	41	<i>fluoxetine hcl</i>	35	<i>galantamine hydrobromide</i>	
FELDENE		<i>fluphenazine decanoate</i> ..	38	.....	34
see <i>piroxicam</i>	9	<i>fluphenazine hcl</i>	38	GAMASTAN INJ	65
<i>felodipine</i>	32	<i>flurbiprofen</i>	9	GAMMAGARD LIQUID ..	65
FEMARA		<i>flurbiprofen sodium</i>	69	GAMMAGARD S/D IGA	
see <i>letrozole</i>	20	<i>fluticasone propionate</i>	75	LESS TH	65
<i>fenofibrate</i>	30	<i>fluticasone propionate</i>		GAMMAKED	65
<i>fenofibrate micronized</i> ...	30	(nasal)	73	GAMMAPLEX	65
<i>fentanyl</i>	9	<i>fluticasone-salmeterol aer</i>		GAMUNEX-C	65
<i>fentanyl citrate</i>	10	<i>powder ba 100-50</i>		<i>ganciclovir sodium</i>	16
<i>fesoterodine fumarate</i>	61	<i>mcg/act</i>	73	GARDASIL 9 INJ	66
FETZIMA	35	<i>fluticasone-salmeterol aer</i>		GASTROCROM	
FETZIMA CAP TITRATIO		<i>powder ba 250-50</i>		see <i>cromolyn sodium</i>	
.....	35	<i>mcg/act</i>	73	(mastocytosis)	60
FIASP	50	<i>fluticasone-salmeterol aer</i>		<i>gatifloxacin (ophth)</i>	69
FIASP FLEXTOUCH.....	50	<i>powder ba 500-50</i>		GATTEX	60
FIASP PENFILL.....	50	<i>mcg/act</i>	73	GAUZE PADS 2.....	50
FIASP PUMPCART	50	<i>fluvoxamine maleate</i>	34	<i>gavilyte-c</i>	60
<i>finasteride</i>	61	FML LIQUIFILM		<i>gavilyte-g</i>	60
<i> fingolimod hcl</i>	46	see <i>fluorometholone</i>		GAVRETO	22
FINTEPLA	41	(ophth)	69	<i>gefitinib</i>	22
<i>finzala</i>	53	FOCALIN		<i>gemcitabine hcl</i>	19
FIRAZYR		see <i>dexmethylphenidate</i>		GEMCITABINE	
see <i>icatibant acetate</i>	63	<i>hcl</i>	44	HYDROCHLORIDE	
see <i>sajazir</i>	63	<i>fondaparinux sodium</i>	62	see <i>gemcitabine hcl</i>	19
FIRMAGON	20	FOSAMAX		<i>gemfibrozil</i>	30
<i>flac</i>	70	see <i>alendronate sodium</i>		GEMTESA	61
FLAREX.....	69	.....	51	<i>generlac</i>	60
FLEBOGAMMA DIF.....	65	<i>fosamprenavir calcium</i>	14	<i>genograf</i>	65
<i>flecainide acetate</i>	30	<i>fosinopril sodium</i>	27	GENOTROPIN.....	56
FLOMAX		<i>fosinopril sodium &</i>		GENOTROPIN MINIQUICK	
see <i>tamsulosin hcl</i>	61	<i>hydrochlorothiazide tab</i>		.....	57
<i>fluconazole</i>	13	<i>10-12.5 mg</i>	26	<i>gentamicin in saline inj 0.8</i>	
<i>fluconazole in nacl 0.9% inj</i>		<i>fosinopril sodium &</i>		<i>mg/ml</i>	12
<i>200 mg/100ml</i>	13	<i>hydrochlorothiazide tab</i>		<i>gentamicin in saline inj 1</i>	
<i>fluconazole in nacl 0.9% inj</i>		<i>20-12.5 mg</i>	26	<i>mg/ml</i>	12
<i>400 mg/200ml</i>	13	FOTIVDA	22	<i>gentamicin in saline inj 1.2</i>	
<i>flucytosine</i>	13	FRUZAQLA.....	22	<i>mg/ml</i>	12
<i>fludrocortisone acetate</i>	56	<i>fulvestrant</i>	20	<i>gentamicin in saline inj 1.6</i>	
<i>flunisolide (nasal)</i>	73	<i>furosemide</i>	32	<i>mg/ml</i>	12
<i>fluocinolone acetonide</i>	75	<i>furosemide inj</i>	32	<i>gentamicin in saline inj 2</i>	
<i>fluocinolone acetonide</i>		FUZEON.....	14	<i>mg/ml</i>	12
(<i>otic</i>)	70	<i>fyavolv tab 0.5mg-2.5mcg</i>		<i>gentamicin sulfate</i>	12
<i>fluocinonide</i>	75	.....	55	<i>gentamicin sulfate (ophth)</i>	
<i>fluocinonide emulsified</i>		<i>fyavolv tab 1mg-5mcg</i>	55	.....	69
<i>base</i>	75	FYCOMPA.....	41	<i>gentamicin sulfate (topical)</i>	
<i>fluorometholone (ophth)</i> ..	69	G		.....	74
<i>fluorouracil</i>	19	<i>gabapentin</i>	41	GENVOYA TAB	15
<i>fluorouracil (topical)</i>	76			GEODON	

see <i>ziprasidone hcl</i>	39	HUMIRA PEN	64
see <i>ziprasidone mesylate</i>		HUMIRA PEN KIT PS/UV	
.....	40	.....	64
GILENYA		HUMIRA PEN-CD/UC/HS	
see <i>fingolimod hcl</i>	46	START	64
GILOTrif	22	HUMIRA PEN-PEDIATRIC	
<i>glatiramer acetate</i>	46	UC S	64
<i>glatopa</i>	46	HUMIRA PEN-PS/UV	
GLEEVEC		STARTER	64
see <i>imatinib mesylate</i> ..	22	HUMULIN R U-500	
GLEOSTINE	19	(CONCENTR.....	50
<i>glimepiride</i>	48	HUMULIN R U-500	
<i>glipizide</i>	48	KWIKPEN.....	50
<i>glipizide xl</i>	48	hydralazine hcl	33
<i>glipizide-metformin hcl tab</i>		HYDREA	
2.5-250 mg.....	48	see <i>hydroxyurea</i>	20
<i>glipizide-metformin hcl tab</i>		<i>hydrochlorothiazide</i>	32
2.5-500 mg.....	48	<i>hydrocodone bitartrate</i>	9
<i>glipizide-metformin hcl tab</i>		<i>hydrocodone-</i>	
5-500 mg.....	48	<i>acetaminophen soln</i> 7.5-	
GLUCOTROL XL		325 mg/15ml	10
see <i>glipizide</i>	48	<i>hydrocodone-</i>	
see <i>glipizide xl</i>	48	<i>acetaminophen tab</i> 10-	
<i>glycopyrrolate</i>	59	325 mg	10
<i>glydo</i>	76	<i>hydrocodone-</i>	
GLYXAMBI TAB 10-5 MG		<i>acetaminophen tab</i> 5-325	
.....	48	mg	10
GLYXAMBI TAB 25-5 MG		<i>hydrocodone-</i>	
.....	48	<i>acetaminophen tab</i> 7.5-	
GOLYTELY		325 mg	10
see <i>gavilyte-g</i>	60	<i>hydrocodone-ibuprofen tab</i>	
see <i>peg 3350-kcl-na</i>		7.5-200 mg	10
bicarb-nacl-na sulfate		<i>hydrocortisone</i>	56
for soln 236 gm.....	60	<i>hydrocortisone (intrarectal)</i>	
<i>gransetron hcl</i>	58	.....	59
<i>griseofulvin microsize</i>	13	<i>hydrocortisone (rectal)</i>	76
<i>griseofulvin ultramicrosize</i>		<i>hydrocortisone (topical)</i> ..	76
.....	13	<i>hydromorphone hcl</i>	10
<i>guanfacine hcl</i>	33	<i>hydroxychloroquine sulfate</i>	
<i>guanfacine hcl (adhd)</i>	44	.....	64
GVOKE HYPOOPEN 2-		<i>hydroxyurea</i>	20
PACK	56	<i>hydroxyzine hcl</i>	71
GVOKE KIT	56	<i>hydroxyzine pamoate</i>	71
GVOKE PFS	56	HYSINGLA ER	9
H		HYZAAR	
HAEGARDA	63	see <i>losartan potassium &</i>	
<i>hailey 1.5/30</i>	53	<i>hydrochlorothiazide tab</i>	
<i>hailey 24 fe</i>	53	100-12.5 mg	28

<i>see losartan potassium & hydrochlorothiazide tab 100-25 mg</i> 28	INCRUSE ELLIPTA 71	ISOLYTE-S INJ 67
<i>see losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i> 28	<i>indapamide</i> 32	ISOLYTE-S INJ PH 7.4 67
I	INDERAL LA <i>see propranolol hcl</i> 31	<i>isoniazid</i> 15
<i>ibandronate sodium</i> 51	INFANRIX INJ 66	ISORDIL TITRADOSE <i>see isosorbide dinitrate</i> 33
IBRANCE 22	INFLIXIMAB 64	<i>isosorbide dinitrate</i> 33
<i>ibu</i> 9	INLYTA 23	<i>isosorbide mononitrate</i> 33
<i>ibuprofen</i> 9	INQOVI TAB 35-100MG 19	<i>isotretinoin</i> 74
<i>icatibant acetate</i> 63	INREBIC 23	<i>isradipine</i> 32
<i>iclevia</i> 53	INSPRA <i>see eplerenone</i> 27	<i>itraconazole</i> 13
ICLUSIG 22	INSULIN PEN NEEDLES: BD/NOVO 50	<i>ivermectin</i> 12
IDACIO (2 PEN) 64	INSULIN SAFETY NEEDLES 50	IWILFIN 21
IDACIO (2 SYRINGE) 64	INSULIN SYRINGES: BD 50	IXIARO INJ 66
IDACIO CROHN INJ DISEASE 64	INTELENCE 14 <i>see etravirine</i> 14	J
IDACIO PLAQU INJ PSORIASIS 64	INTRALIPID 68	JADENU <i>see deferasirox</i> 52
IDHIFA 22	<i>intovale</i> 53	JADENU SPRINKLE <i>see deferasirox</i> 52
<i>imatinib mesylate</i> 22	INTUNIV <i>see guanfacine hcl (adhd)</i> 44	JAKAFI 23
IMBRUVICA 22	INVEGA <i>see paliperidone</i> 39	JALYN <i>see dutasteride- tamsulosin hcl cap 0.5- 0.4 mg</i> 61
<i>imipenem-cilastatin intravenous for soln 250 mg</i> 12	INVEGA HAFYERA 38	jantoven 62
<i>imipenem-cilastatin intravenous for soln 500 mg</i> 12	INVEGA SUSTENNA 38	JANUMET TAB 50-1000 48
<i>imipramine hcl</i> 36	INVEGA TRINZA 38	JANUMET TAB 50-500MG 48
<i>imiquimod</i> 76	IPOL INJ INACTIVE 66	JANUMET XR TAB 100- 1000 48
IMITREX <i>see sumatriptan succinate</i> 46	<i>ipratropium bromide</i> 71	JANUMET XR TAB 50- 1000 48
IMITREX STATDOSE REFILL <i>see sumatriptan succinate</i> 45	<i>ipratropium bromide (nasal)</i> 71	JANUMET XR TAB 50- 500MG 48
IMITREX STATDOSE SYSTEM <i>see sumatriptan succinate</i> 45	<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i> 70	JANUVIA 49
IMOVAX RABIES (H.D.C.V.) 66	<i>irbesartan</i> 29	JARDIANC E 49
IMURAN <i>see azathioprine</i> 65	<i>irbesartan-</i> <i>hydrochlorothiazide tab 150-12.5 mg</i> 28	<i>jasmiel</i> 53
INBRIJA 37	<i>irbesartan-</i> <i>hydrochlorothiazide tab 300-12.5 mg</i> 28	<i>javygtor</i> 57
<i>incassia</i> 53	IRESSA <i>see gefitinib</i> 22	JAYPIRCA 23
INCRELEX 57	<i>irinotecan hcl</i> 20, 21	JENTADUETO TAB 2.5- 1000 49
	ISENTRESS 14	JENTADUETO TAB 2.5- 500 49
	ISENTRESS HD 14	JENTADUETO TAB 2.5- 850 49
	<i>isibloom</i> 53	JENTADUETO TAB XR 2.5-1000MG 49
	ISOLYTE-P INJ /D5W 67	JENTADUETO TAB XR 5- 1000MG 49

jinteli	55
jolessa	53
juleber.....	53
JULUCA TAB 50-25MG ..	15
junel 1.5/30.....	53
junel 1/20.....	53
junel fe 1.5/30.....	53
junel fe 1/20.....	53
junel fe 24.....	53
JYNNEOS.....	66
K	
KADCYLA.....	23
kaitlib fe	53
KALETRA see <i>lopinavir-ritonavir</i> <i>solv 400-100 mg/5ml</i> <i>(80-20 mg/ml)</i>	15
see <i>lopinavir-ritonavir tab</i> <i>100-25 mg</i>	15
see <i>lopinavir-ritonavir tab</i> <i>200-50 mg</i>	15
KALYDECO	72
KANJINTI.....	23
kariva	53
KCL 0.3%/D5W/NACL 0.9% see <i>kcl 40 meq/l (0.3%)</i> <i>in dextrose 5% & nacl</i> <i>0.9% inj.</i>	67
<i>kcl 10 meq/l (0.075%) in</i> <i>dextrose 5% & nacl</i> <i>0.45% inj.</i>	67
<i>kcl 20 meq/l (0.149%) in</i> <i>nacl 0.45% inj.</i>	67
<i>kcl 20 meq/l (0.15%) in</i> <i>dextrose 5% & nacl 0.2%</i> <i>inj.</i>	67
<i>kcl 20 meq/l (0.15%) in</i> <i>dextrose 5% & nacl</i> <i>0.45% inj.</i>	67
<i>kcl 20 meq/l (0.15%) in</i> <i>dextrose 5% & nacl 0.9%</i> <i>inj.</i>	67
<i>kcl 20 meq/l (0.15%) in nacl</i> <i>0.45% inj.</i>	67
<i>kcl 20 meq/l (0.15%) in nacl</i> <i>0.9% inj.</i>	67
kcl 30 meq/l (0.224%) in <i>dextrose 5% & nacl</i> <i>0.45% inj.</i>	67
<i>kcl 40 meq/l (0.3%) in</i> <i>dextrose 5% & nacl</i> <i>0.45% inj.</i>	67
<i>kcl 40 meq/l (0.3%) in</i> <i>dextrose 5% & nacl 0.9%</i> <i>inj.</i>	67
<i>kcl 40 meq/l (0.3%) in nacl</i> <i>0.9% inj.</i>	67
KCL/D5W/NACL INJ 0.3/0.9%.....	67
kelnor 1/35.....	53
kelnor 1/50.....	53
KEPPRA see <i>levetiracetam</i>.....41	
see <i>roweepra</i>	42
KEPPRA XR see <i>levetiracetam</i>.....41	
KERENDIA	27
KESIMPTA	46
ketocconazole.....	13
ketocconazole (<i>topical</i>)....74, 75	
ketorolac tromethamine (<i>ophth</i>).....	69
KEVZARA.....	64
KEYTRUDA	23
KINRIX INJ	66
KISQALI 200 DOSE.....	23
KISQALI 200 PAK FEMARA	21
KISQALI 400 DOSE.....	23
KISQALI 400 PAK FEMARA	21
KISQALI 600 DOSE.....	23
KISQALI 600 PAK FEMARA	21
KITABIS PAK see <i>tobramycin</i>.....13	
KLARON see <i>sulfacetamide</i> <i>sodium (acne)</i>.....74	
klayesta	74
KLONOPIN see <i>clonazepam</i>.....40	
klor-con.....	68
klor-con 10.....	68
klor-con 8.....	68
klor-con m10.....	68
klor-con m15.....	68
klor-con m20.....	68
KORLYM.....	57
<i>see mifepristone</i> <i>(hyperglycemia)</i>.....57	
KOSELUGO.....	23
kourzeq.....	77
KRAZATI.....	23
K-TAB <i>see potassium chloride</i> 68	
kurvelo.....	53
KUVAN <i>see javygtor</i>.....57	
<i>see sapropterin</i> <i>dihydrochloride</i>	57
L	
labetalol hcl.....	31
lacosamide.....	41
lacosamide oral.....	41
lactated ringer's solution	67
lactic acid (ammonium lactate)	76
lactulose	60
lactulose (<i>encephalopathy</i>)	60
LAMICTAL <i>see lamotrigine</i>.....41	
<i>see subvenite</i>.....42	
LAMICTAL CHEWABLE DISPERS <i>see lamotrigine</i>.....41	
LAMICTAL XR <i>see lamotrigine</i>.....41	
lamivudine.....	14
lamivudine (<i>hbv</i>)	16
lamivudine-zidovudine tab <i>150-300 mg</i>	15
lamotrigine	41
LANOXIN <i>see digoxin</i>.....33	
lansoprazole	60
LANTUS	50
LANTUS SOLOSTAR	50
lapatinib ditosylate	23
larin 1.5/30.....	53
larin 1/20.....	53
larin 24 fe.....	53

<i>larin fe</i> 1.5/30.....	53	<i>levetiracetam in sodium chloride iv soln</i>		<i>see fosamprenavir calcium</i>
<i>larin fe</i> 1/20.....	53	<i>chloride iv soln 1500 mg/100ml</i>	42	14
LASIX		<i>levetiracetam in sodium chloride iv soln</i>		LIALDA
<i>see furosemide</i>	32	<i>chloride iv soln 500 mg/100ml</i>	41	<i>see mesalamine</i>
<i>latanoprost</i>	70	<i>levobunolol hcl</i>	70	59
LATUDA		<i>levocarnitine (metabolic modifiers)</i>	57	<i>lidocaine</i>
<i>see lurasidone hcl</i>	38	<i>levocetirizine dihydrochloride</i>	71	76
<i>layolis fe</i>	53	<i>levofloxacin</i>	17	<i>lidocaine hcl</i>
<i>leena</i>	53	<i>levofloxacin in d5w iv soln</i>		<i>(local anesth.)</i>
<i>leflunomide</i>	64	<i>250 mg/50ml</i>	17	11
<i>lenalidomide</i>	20	<i>levofloxacin in d5w iv soln</i>		<i>lidocaine hcl (mouth-throat)</i>
LENVIMA 10 MG DAILY		<i>500 mg/100ml</i>	17	77
DOSE	23	<i>levofloxacin in d5w iv soln</i>		<i>lidocaine-prilocaine cream</i>
LENVIMA 12MG DAILY		<i>750 mg/150ml</i>	17	2.5-2.5%.....
DOSE	23	<i>levonest</i>	53	76
LENVIMA 20 MG DAILY		<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	53	<i>lidocan iii</i>
DOSE	23	<i>levonorgestrel & ethynodiol (91-day) tab 0.15-0.03 mg</i>	53	76
LENVIMA 4 MG DAILY		<i>levonorgestrel & ethynodiol tab 0.1 mg-20 mcg</i>	53	LIDODERM
DOSE	23	<i>levonorgestrel & ethynodiol tab 0.15 mg-30 mcg</i>	53	<i>see lidocaine</i>
LENVIMA 8 MG DAILY		<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	53	<i>see lidocan iii</i>
DOSE	23	<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	53	
LENVIMA CAP 14 MG....	23	<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	53	<i>lisinopril</i>
LENVIMA CAP 18 MG....	23	<i>levora 0.15/30-28</i>	53	27
LENVIMA CAP 24 MG....	23	<i>levo-t</i>	58	<i>lisinopril &</i>
<i>lessina</i>	53	<i>levothyroxine sodium</i>	58	<i>hydrochlorothiazide tab 10-12.5 mg</i>
LETAIRIS		<i>levoxyl</i>	58	26
<i>see ambrisentan</i>	34	<i>LEXAPRO</i>		<i>lisinopril &</i>
<i>letrozole</i>	20	<i>see escitalopram oxalate</i>		<i>hydrochlorothiazide tab 20-12.5 mg</i>
<i>leucovorin calcium</i>	26	.....	35	26
LEUKERAN	19	<i>LEXIVA</i>	14	<i>lisinopril &</i>
<i>leuprolide acetate</i>	20			<i>hydrochlorothiazide tab 20-25 mg</i>
<i>levalbuterol hcl</i>	71			27
<i>levalbuterol tartrate</i>	71			<i>LITHIUM</i>
<i>levetiracetam</i>	41			46
LEVETIRACETAM				<i>lithium carbonate</i>
<i>see levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>	42			46
<i>see levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>	42			<i>LITHOBID</i>
<i>see levetiracetam in sodium chloride iv soln 500 mg/100ml</i>	41			<i>see lithium carbonate</i>
levetiracetam in sodium chloride iv soln 1000 mg/100ml	42			46
levetiracetam in sodium chloride iv soln 1500 mg/100ml	42			LODINE
levetiracetam in sodium chloride iv soln 500 mg/100ml	41			<i>see etodolac</i>
LEXAPRO				9
<i>see escitalopram oxalate</i>				<i>loestrin 1.5/30-21</i>
LEXIVA				53
.....				<i>loestrin 1/20-21</i>
				53
				<i>loestrin fe 1.5/30</i>
				53
				<i>loestrin fe 1/20</i>
				53
LOKELMA				52
LOMOTIL				
<i>see diphenoxylate w/ atropine tab 2.5-0.025 mg</i>				
LONSURF TAB 15-6.14				60
19				

LONSURF TAB 20-8.19	.19
loperamide hcl	.....60
LOPID	
see gemfibrozil	.....30
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	.....15
lopinavir-ritonavir tab 100-25 mg	.....15
lopinavir-ritonavir tab 200-50 mg	.....15
LOPRESSOR	
see metoprolol tartrate	31
lorazepam	.....34
lorazepam intensol	.....34
LORBRENA	.....23
loryna	.....53
losartan potassium	.....29
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	.....28
losartan potassium & hydrochlorothiazide tab 100-25 mg	.....28
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	.....28
LOTEMAX	.....69
LOTENSIN	
see benazepril hcl	.....27
LOTENSIN HCT	
see benazepril & hydrochlorothiazide tab 10-12.5 mg	.....26
see benazepril & hydrochlorothiazide tab 20-12.5 mg	.....26
see benazepril & hydrochlorothiazide tab 20-25 mg	.....26
LOTREL	
see amlodipine besylate- benazepril hcl cap 10-20 mg	.....26
see amlodipine besylate- benazepril hcl cap 10-40 mg	.....26
see amlodipine besylate- benazepril hcl cap 5-10 mg	.....26
see amlodipine besylate- benazepril hcl cap 5-20 mg	.....26
LOTRONEX	
see alosetron hcl	.....60
lovastatin	.....30
LOVAZA	
see omega-3-acid ethyl esters cap 1 gm	.....31
LOVENOX	
see enoxaparin sodium	
.....62	
low-ogestrel	.....53
loxapine succinate	.....38
LUMAKRAS	.....23
LUMIGAN	.....70
LUMIZYME	.....57
LUNESTA	
see eszopiclone	.....45
LUPRON DEPOT (1-MONTH)	.....20
LUPRON DEPOT (3-MONTH)	.....20
LUPRON DEPOT-PED (1-MONTH)	.....57
LUPRON DEPOT-PED (3-MONTH)	.....57
LUPRON DEPOT-PED (6-MONTH)	.....57
lurasidone hcl	.....38
lutera	.....53
lyleq	.....53
lyllana	.....55
LYNPARZA	.....23
LYRICA	
see pregabalin	.....42
LYSODREN	.....20
LYTGOBI (12 MG DAILY DOSE)	.....23
LYTGOBI (16 MG DAILY DOSE)	.....23
LYTGOBI (20 MG DAILY DOSE)	.....23
lyza	.....53
M	
MACROBID	
see nitrofurantoin monohyd macro	.....12
MACRODANTIN	
see nitrofurantoin macrocystal	.....12
magnesium sulfate	.....67
MAGNESIUM SULFATE	.....67
see magnesium sulfate	.....67
MAGNESIUM SULFATE IN D5W	
see magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	.....67
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	.....67
MALARONE	
see atovaquone-proguanil hcl tab 250-100 mg	.....13
see atovaquone-proguanil hcl tab 62.5-25 mg	.....13
malathion	.....76
maraviroc	.....14
MARINOL	
see dronabinol	.....58
marlissa	.....53
MARPLAN	.....36
MATULANE	.....21
MAVYRET PAK 50-20MG	.....16
MAVYRET TAB 100-40MG	.....16
MAXALT	
see rizatriptan benzoate	.....45
MAXALT-MLT	
see rizatriptan benzoate	.....45
MAXITROL	
see neomycin-polymyxin-dexamethasone ophth oint 0.1%	.....68
see neomycin-polymyxin-dexamethasone ophth susp 0.1%	.....68
MAXZIDE	

see triamterene & hydrochlorothiazide tab 75-50 mg	33
meclizine hcl	58
MEDROL	
see methylprednisolone	56
MEDROL DOSEPAK	
see methylprednisolone	56
medroxyprogesterone acetate	57
medroxyprogesterone acetate (contraceptive)	54
mefloquine hcl	13
megestrol acetate	20, 57
megestrol acetate (appetite)	57
MEKINIST	23
MEKTOVI	23
meloxicam	9
memantine hcl	34
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	35
MENACTRA INJ	66
MENQUADFI INJ	66
MENVEO INJ	66
MENVEO SOL	66
MEPRON	
see atovaquone	11
mercaptopurine	19
meropenem	12
mesalamine	59
mesalamine w/ cleanser	59
MESNEX	26
MESTINON	
see pyridostigmine bromide	46
metformin hcl	49
methadone hcl	10
methadone hydrochloride i	10
METHADOSE	
see methadone hydrochloride i	10
methazolamide	32
methenamine hippurate	12
methimazole	58
methocarbamol	47
methotrexate sodium	19, 65
methsuximide	42
METHYLIN	
see methylphenidate hcl	44
methylphenidate hcl	44
methylprednisolone	56
methylprednisolone acetate	56
methylprednisolone sod succ	56
methyltestosterone	48
metoclopramide hcl	58
metolazone	32
metoprolol &	
hydrochlorothiazide tab 100-25 mg	31
metoprolol &	
hydrochlorothiazide tab 100-50 mg	31
metoprolol &	
hydrochlorothiazide tab 50-25 mg	31
metoprolol succinate	31
metoprolol tartrate	31
METROCREAM	
see metronidazole (topical)	76
METROLOTION	
see metronidazole (topical)	76
metronidazole	12
METRONIDAZOLE	
see metronidazole	12
metronidazole (topical)	76
metronidazole vaginal	62
metyrosine	33
MG SO4/D5W INJ 10MG/ML	67
mibetas 24 fe	54
micafungin sodium	13
MICARDIS	
see telmisartan	29
MICARDIS HCT	
see telmisartan- hydrochlorothiazide tab 40-12.5 mg	29
see telmisartan-	
hydrochlorothiazide tab 80-12.5 mg	29
see telmisartan-	
hydrochlorothiazide tab 80-25 mg	29
microgestin 1.5/30	54
microgestin 1/20	54
microgestin 24 fe	54
microgestin fe 1.5/30	54
microgestin fe 1/20	54
midodrine hcl	33
mifepristone (hyperglycemia)	57
miglustat	57
MIGRALAN	
see dihydroergotamine mesylate	45
mihi	54
mimvey	55
MINIPRESS	
see prazosin hcl	27
MINIVELLE	
see lyllana	55
minocycline hcl	19
minoxidil	33
mirtazapine	36
misoprostol	60
MITIGARE	9
M-M-R II INJ	66
M-NATAL PLUS TAB	68
modafinil	47
moexipril hcl	27
molindone hcl	38
mometasone furoate	76
MONJUVI	23
mono-linyah	54
montelukast sodium	71
morphine sulfate	10
MORPHINE SULFATE ..	10
MORPHINE SULFATE/SODIUM C.	10
MOUNJARO	49
MOVANTIK	60
moxifloxacin hcl	17
moxifloxacin hcl (ophth) ..	69
moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj	17

MS CONTIN	
see <i>morphine sulfate</i> ...10	
MULTAQ.....30	
multiple electrolytes ph 5.5	
.....67	
multiple electrolytes ph 7.4	
.....67	
mupirocin.....74	
MYAMBUTOL	
see <i>ethambutol hcl</i>....15	
MYCAMINE	
see <i>micafungin sodium</i> 13	
MYCOBUTIN	
see <i>rifabutin</i>	15
mycophenolate mofetil....65	
mycophenolate sodium...65	
MYFORTIC	
see <i>mycophenolate</i>	
<i>sodium</i>.....65	
MYRBETRIQ .....61	
mysoline	
see <i>primidone</i>.....42	
N	
<i>nabumetone</i>.....9	
<i>nadolol</i>.....31	
<i>nafcillin sodium</i> .....18	
NAGLAZYME .....57	
<i>nalbuphine hcl</i> .....11	
<i>naloxone hcl</i> .....47	
<i>naltrexone hcl</i> .....47	
NAMENDA TITRATION	
PAK	
see <i>memantine hcl tab</i>	
<i>28 x 5 mg & 21 x 10</i>	
<i>mg titration pack</i>.....35	
NAMENDA XR	
see <i>memantine hcl</i>.....34	
NAMZARIC CAP 14-10MG	
.....35	
NAMZARIC CAP 21-10MG	
.....35	
NAMZARIC CAP 28-10MG	
.....35	
NAMZARIC CAP 7-10MG	
.....35	
NAMZARIC CAP PACK..35	
NAPROSYN	
see <i>naproxen</i> .....9	
naproxen.....9	
naproxen sodium .....9	
<i>naratriptan hcl</i>.....45	
NARDIL	
see <i>phenelzine sulfate</i> 36	
NATACYN .....69	
<i>nateglinide</i> .....49	
NATPARA.....51	
NAYZILAM.....42	
<i>nebivolol hcl</i>.....31	
NEBUPENT	
see <i>pentamidine</i>	
<i>isethionate inh</i> .....12	
<i>necon 0.5/35-28</i>.....54	
<i>nefazodone hcl</i> .....36	
<i>neomycin sulfate</i>.....12	
<i>neomycin-bacitrac zn-</i>	
<i>polymyx 5(3.5)mg-</i>	
<i>400unt-1000unt op oin</i>	
.....69	
<i>neomycin-polymy-gramicid</i>	
<i>op sol 1.75-10000-</i>	
<i>0.025mg-unt-mg/ml</i>....69	
<i>neomycin-polymyxin-</i>	
<i>dexamethasone ophth</i>	
<i>oint 0.1%</i> .....68	
<i>neomycin-polymyxin-</i>	
<i>dexamethasone ophth</i>	
<i>susp 0.1%</i> .....68	
<i>neomycin-polymyxin-hc</i>	
<i>ophth susp</i>.....68	
<i>neomycin-polymyxin-hc otic</i>	
<i>soln 1%</i> .....70	
<i>neomycin-polymyxin-hc otic</i>	
<i>susp 3.5 mg/ml-10000</i>	
<i>unit/ml-1%</i> .....70	
<i>neo-polycin 5(3.5)mg-</i>	
<i>400unt-1000unt op oin</i>	
.....69	
<i>neo-polycin hc ophth oint</i>	
<i>1%</i>.....68	
NEORAL	
see <i>cyclosporine</i>	
<i>modified (for</i>	
<i>microemulsion)</i> .....65	
<i>see gengraf</i> .....65	
NERLYNX.....24	
NEUPRO .....37	
NEURONTIN	
<i>see gabapentin</i>.....41	
nevirapine .....14	
NEXAVAR.....24	
<i>see sorafenib tosylate</i> 24	
NEXIUM	
<i>see esomeprazole</i>	
<i>magnesium</i>.....60	
niacin (<i>antihyperlipidemic</i>)	
.....31	
nicardipine hcl.....32	
NICOTROL INHALER....47	
NICOTROL NS .....47	
<i>nifedipine</i> .....32	
<i>nikki</i> .....54	
NILANDRON	
<i>see nilutamide</i>.....20	
<i>nilutamide</i> .....20	
<i>nimodipine</i> .....32	
NINLARO.....24	
<i>nitazoxanide</i>.....12	
<i>nitisinone</i> .....57	
NITRO-BID .....33	
<i>nitrofurantoin macrocrystal</i>	
.....12	
<i>nitrofurantoin monohyd</i>	
<i>macro</i> .....12	
<i>nitroglycerin</i> .....33	
NITROLINGUAL	
<i>see nitroglycerin</i>.....33	
NITROSTAT	
<i>see nitroglycerin</i>.....33	
<i>nizatidine</i> .....59	
<i>nora-be</i> .....54	
<i>norelgestromin-ethinyl</i>	
<i>estradiol td ptwk 150-35</i>	
<i>mcg/24hr</i> .....54	
<i>norethindrone & ethinyl</i>	
<i>estradiol-fe chew tab 0.4</i>	
<i>mg-35 mcg</i> .....54	
<i>norethindrone & ethinyl</i>	
<i>estradiol-fe chew tab 0.8</i>	
<i>mg-25 mcg</i> .....54	
<i>norethindrone</i>	
<i>(contraceptive)</i> .....54	
<i>norethindrone ace & ethinyl</i>	
<i>estradiol tab 1 mg-20</i>	
<i>mcg</i> .....54	
<i>norethindrone ace & ethinyl</i>	
<i>estradiol tab 1.5 mg-30</i>	
<i>mcg</i> .....54	

<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	54
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	54
<i>norethindrone acetate</i>	58
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	55
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	55
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	54
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	54
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	54
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	54
<i>norlyroc</i>	54
NORPACE <i>see disopyramide phosphate</i>	29
NORPACE CR	30
NORPRAMIN <i>see desipramine hcl</i>	35
NORTHERA <i>see droxidopa</i>	33
<i>nortrel 0.5/35 (28)</i>	54
<i>nortrel 1/35 (21)</i>	54
<i>nortrel 1/35 (28)</i>	54
<i>nortrel 7/7/7</i>	54
<i>nortriptyline hcl</i>	36
NORVASC <i>see amlodipine besylate</i>	32
NORVIR	14
<i>see ritonavir</i>	14
NOVOLIN INJ 70/30	50
NOVOLIN INJ 70/30 FP	50
NOVOLIN N	50
NOVOLIN N FLEXPEN	50
NOVOLIN R	50
NOVOLIN R FLEXPEN	50
NOVOLOG	50
NOVOLOG FLEXPEN	51
NOVOLOG MIX INJ 70/30	51
NOVOLOG MIX INJ FLEXPEN	51
NOVOLOG PENFILL	51
NOXAFILE <i>see posaconazole</i>	13
NUBEQA	20
NUEDEXTA CAP 20-10MG	46
NULOJIX	65
NUPLAZID	38
NURTEC	45
NUTRILIPID	68
NUVARING <i>see eluryng</i>	53
<i>see enilloring</i>	53
<i>see etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	53
<i>see haloette</i>	53
NUVIGIL <i>see armodafinil</i>	47
NUZYRA	19
<i>nyamyc</i>	74
<i>nylia 1/35</i>	54
<i>nylia 7/7/7</i>	54
NYMALIZE	32
<i>nymyo</i>	54
<i>nystatin</i>	13
<i>nystatin (mouth-throat)</i>	77
<i>nystatin (topical)</i>	74
<i>nystop</i>	74
O	
<i>ocella</i>	54
OCTAGAM	65
<i>octreotide acetate</i>	57
OCUFLOX <i>see ofloxacin (ophth)</i>	69
ODEFSEY TAB	15
ODOMZO	24
OFEV	72
<i>ofloxacin (ophth)</i>	69
<i>ofloxacin (otic)</i>	70
OGIVRI	24
OGIVRI INJ 420MG	24
OGSIVEO	24
OJJAARA	24
<i>olanzapine</i>	38
<i>olmesartan medoxomil</i>	29
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	28
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	28
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	28
<i>omega-3-acid ethyl esters cap 1 gm</i>	31
omeprazole	60
OMNIPOD 5 G6 KIT INTRO	51
OMNIPOD 5 G6 MIS PODS	51
OMNIPOD 5 G7 KIT INTRO	51
OMNIPOD 5 G7 MIS PODS	51
OMNIPOD DASH KIT INTRO	51
OMNIPOD DASH MIS PODS	51
OMNIPOD GO KIT 10UNT/DY	51
OMNIPOD GO KIT 15UNT/DY	51
OMNIPOD GO KIT 20UNT/DY	51

OMNIPOD GO KIT	
25UNT/DY.....	51
OMNIPOD GO KIT	
30UNT/DY.....	51
OMNIPOD GO KIT	
35UNT/DY.....	51
OMNIPOD GO KIT	
40UNT/DY.....	51
OMNIPOD MIS CLASSIC	
.....	51
ondansetron.....	59
ondansetron hcl.....	59
ONFI	
see clobazam.....	40
ONTRUZANT	24
ONUREG	19
OPSUMIT	34
ORFADIN	
see nitisinone.....	57
ORGOVYX	20
ORKAMBI GRA 100-125	72
ORKAMBI GRA 150-188	72
ORKAMBI GRA 75-94MG	
.....	72
ORKAMBI TAB 100-125	.72
ORKAMBI TAB 200-125	.72
ORSERDU.....	20
ORTHO TRI-CYCLEN LO	
see norgestimate-eth	
estradiol tab 0.18-	
25/0.215-25/0.25-25	
mg-mcg	54
see tri-lo-estarylla.....	54
see tri-lo-marzia	54
see tri-lo-mili.....	54
see tri-lo-sprintec.....	55
see tri-vylibra lo.....	55
oseltamivir phosphate.....	16
OTEZLA.....	64
OTEZLA TAB 10/20/30...	64
oxacillin sodium	18
oxaliplatin.....	19
oxcarbazepine	42
oxybutynin chloride.....	61
oxycodone hcl.....	11
oxycodone w/	
acetaminophen tab 10-	
325 mg	11
oxycodone w/	
acetaminophen tab 2.5-	
325 mg	11
oxycodone w/	
acetaminophen tab 5-325	
mg	11
oxycodone w/	
acetaminophen tab 7.5-	
325 mg	11
OZEMPIC (0.25 OR 0.5	
MG/DOSE)	49
OZEMPIC (0.25 OR	
0.5MG/DOSE)	49
OZEMPIC (1MG/DOSE) .49	
OZEMPIC (2MG/DOSE) .49	
P	
pacerone.....	30
paclitaxel.....	21
paclitaxel protein-bound	
particles for iv susp 100	
mg	21
paliperidone	38, 39
PAMELOR	
see nortriptyline hcl	36
pamidronate disodium	51
PAMIDRONATE	
DISODIUM	51
PANRETIN	76
pantoprazole sodium	61
PANZYGA	65
paraplatin.....	19
paricalcitol.....	58
PARLODEL	
see bromocriptine	
mesylate	36
PARNATE	
see tranylcypromine	
sulfate	36
paroxetine hcl	36
PAXIL	
see paroxetine hcl.....	36
PAXLOVID TAB 150-10016	
PAXLOVID TAB 300-10016	
pazopanib hcl.....	24
PEDIAPRED	
see prednisolone sodium	
phosphate.....	56
PEDIARIX INJ 0.5ML.....	66
PEDVAX HIB	66
peg 3350-kcl-na bicarb-	
nacl-na sulfate for soln	
236 gm	60
peg 3350-kcl-sod bicarb-	
nacl for soln 420 gm...60	
PEGASYS.....	16
PEMAZYRE	24
pemetrexed disodium	19
PEN GK/DEXTR INJ	
40000/ML	18
PEN GK/DEXTR INJ	
60000/ML	18
PENBRAYA INJ.....	66
penicillamine	52
penicillin g potassium.....	18
penicillin g sodium	18
penicillin v potassium.....	18
PENTACEL INJ	66
PENTAM 300	
see pentamidine	
isethionate inj.....	12
pentamidine isethionate inh	
.....	12
pentamidine isethionate inj	
.....	12
pentoxifylline	63
PEPCID	
see famotidine.....	59
PERCOCET	
see endocet tab 10-	
325mg.....	10
see endocet tab 2.5-	
325mg.....	10
see endocet tab 5-325mg	
.....	10
see endocet tab 7.5-	
325mg.....	10
see oxycodone w/	
acetaminophen tab 10-	
325 mg	11
see oxycodone w/	
acetaminophen tab	
2.5-325 mg	11
see oxycodone w/	
acetaminophen tab 5-	
325 mg.....	11
see oxycodone w/	
acetaminophen tab	
7.5-325 mg	11

PERIDEX	PIQRAY 200MG DAILY	POTASSIUM
see <i>chlorhexidine</i>	DOSE 24	CHLORIDE/SODIUM
<i>gluconate (mouth-</i>	PIQRAY 250MG TAB	see <i>kcl 20 meq/l (0.15%)</i>
<i>throat)</i> 77	DOSE 24	<i>in nacl 0.45% inj</i> 67
see <i>periogard</i> 77	PIQRAY 300MG DAILY	see <i>kcl 20 meq/l (0.15%)</i>
<i>perindopril erbumine</i> 27	DOSE 24	<i>in nacl 0.9% inj</i> 67
<i>periogard</i> 77	<i>pirfenidone</i> 72	see <i>kcl 40 meq/l (0.3%)</i>
<i>permethrin</i> 77	<i>piroxicam</i> 9	<i>in nacl 0.9% inj</i> 67
<i>perphenazine</i> 39	PLAQUENIL	potassium citrate
PERSERIS 39	<i>see hydroxychloroquine</i>	<i>(alkalinizer)</i> 61
<i>pfiberpen</i> 18	<i>sulfate</i> 64	PRADAXA 62
<i>phenelzine sulfate</i> 36	PLASMA-LYTE A	<i>see dabigatran etexilate</i>
PHENERGAN	<i>see multiple electrolytes</i>	<i>mesylate</i> 62
<i>see promethazine hcl</i> 59	<i>ph 7.4</i> 67	<i>pramipexole</i>
<i>phenobarbital</i> 42	PLASMA-LYTE INJ -148 67	<i>dihydrochloride</i> 37
<i>phenobarbital sodium</i> 42	PLASMA-LYTE INJ -A 67	<i>prasugrel hcl</i> 63
<i>phenytek</i> 42	PLASMA-LYTE-148	<i>pravastatin sodium</i> 30
<i>phenytoin</i> 42	<i>see multiple electrolytes</i>	<i>praziquantel</i> 12
<i>phenytoin sodium</i> 42	<i>ph 5.5</i> 67	<i>prazosin hcl</i> 27
<i>phenytoin sodium extended</i>	PLAVIX	PRED FORTE
..... 42	<i>see clopidogrel bisulfate</i>	<i>see prednisolone acetate</i>
PHESGO SOL 24	..... 63	<i>(ophth)</i> 69
<i>philith</i> 54	plenamine 68	<i>prednisolone</i> 56
PIFELTRO 14	PLENU SOL 60	<i>prednisolone acetate</i>
<i>pilocarpine hcl</i> 70	podofilox 76	<i>(ophth)</i> 69
<i>pilocarpine hcl (oral)</i> 77	<i>polycin ophth oint</i> 69	PREDNISOLONE SODIUM
<i>pimozide</i> 39	<i>polymyxin b-trimethoprim</i>	PHOSP 69
<i>pimtrea</i> 54	<i>ophth soln 10000 unit/ml-</i>	<i>prednisolone sodium</i>
<i>pindolol</i> 31	<i>0.1%</i> 69	<i>phosphate</i> 56
<i>pioglitazone hcl</i> 49	POMALYST 20	<i>prednisone</i> 56
<i>pioglitazone hcl-metformin</i>	<i>portia-28</i> 54	PREDNISONE INTENSOL
<i>hcl tab 15-500 mg</i> 49	<i>posaconazole</i> 13	..... 56
<i>pioglitazone hcl-metformin</i>	POT CHL 20MEQ/L IN	<i>pregabalin</i> 42
<i>hcl tab 15-850 mg</i> 49	<i>NACL 0.45% INJ</i> 67	PREHEVBARIO 66
<i>piperacillin sod-tazobactam</i>	POT CHL 20MEQ/L IN	PREMASOL SOL 10% .. 68
<i>na for inj 3.375 gm (3-</i>	<i>NACL 0.9% INJ</i> 67	PRENATAL TAB 27-1MG
<i>0.375 gm)</i> 18	POT CHL 40MEQ/L IN	..... 68
<i>piperacillin sod-tazobactam</i>	<i>NACL 0.9% INJ</i> 67	PRENATAL TAB PLUS .. 68
<i>sod for inj 13.5 gm (12-</i>	<i>potassium chloride</i> 67, 68	PREVACID
<i>1.5 gm)</i> 18	POTASSIUM CHLORIDE	<i>see lansoprazole</i> 60
<i>piperacillin sod-tazobactam</i>	..... 67	<i>prevalite</i> 31
<i>sod for inj 2.25 gm (2-</i>	<i>see potassium chloride</i> 68	<i>PREVYTMIS</i> 16
<i>0.25 gm)</i> 18	<i>potassium chloride 20</i>	<i>PREZCOBIX TAB 800-150</i>
<i>piperacillin sod-tazobactam</i>	<i>meq/l (0.15%) in</i>	..... 15
<i>sod for inj 4.5 gm (4-0.5</i>	<i>dextrose 5% inj</i> 68	PREZISTA 14
<i>gm)</i> 18	<i>potassium chloride</i>	<i>see darunavir</i> 14
<i>piperacillin sod-tazobactam</i>	<i>microencapsulated</i>	PRIFTIN 15
<i>sod for inj 40.5 gm (36-</i>	<i>crystals er</i> 68	<i>primaquine phosphate</i> ... 13
<i>4.5 gm)</i> 18		

PRIMAQUINE	
PHOSPHATE	13
see <i>primaquine phosphate</i>	13
PRIMAXIN IV	
see <i>imipenem-cilastatin intravenous for soln</i>	
500 mg	12
primidone	42
PRIORIX INJ	66
PRISTIQ	
see <i>desvenlafaxine succinate</i>	35
PRIVIGEN	65
probeneclid.....	9
PROCARDIA XL	
see <i>nifedipine</i>	32
prochlorperazine	59
<i>prochlorperazine edisylate</i>	59
<i>prochlorperazine maleate</i>	59
PROCRT	62
PROCTOCORT	
see <i>hydrocortisone (rectal)</i>	76
procto-med hc.....	76
proctosol hc	76
proctozone-hc.....	76
progesterone	58
PROGLYCEM	
see <i>diazoxide</i>	56
PROGRAF	65
see <i>tacrolimus</i>	66
PROLASTIN-C.....	72
PROLENSA	69
see <i>bromfenac sodium (ophth)</i>	69
PROLIA	52
PROMACTA	63
promethazine hcl	59
PROMETRIUM	
see <i>progesterone</i>	58
propafenone hcl.....	30
proparacaine hcl	70
propranolol hcl	31, 32
propylthiouracil	58
PROQUAD INJ	66
PROSCAR	
<i>see finasteride</i>	61
PROSOL INJ 20%	68
PROTONIX	
<i>see pantoprazole sodium</i>	61
protriptyline hcl.....	36
PROVENTIL HFA	
<i>see albuterol sulfate</i>	71
PROVERA	
<i>see medroxyprogesterone acetate</i>	57
PROVIGIL	
<i>see modafinil</i>	47
PROZAC	
<i>see fluoxetine hcl</i>	35
PULMICORT	
<i>see budesonide (inhalation)</i>	73
PULMOZYME	72
PURIXAN.....	19
pyrazinamide	15
pyridostigmine bromide...46	
Q	
QINLOCK	24
QUADRACEL INJ	66
QUADRACEL INJ 0.5ML	66
QUALAQUIN	
<i>see quinine sulfate</i>	14
QUESTRAN	
<i>see cholestyramine</i>	30
QUESTRAN LIGHT	
<i>see cholestyramine light</i>	30
<i>see prevalite</i>	31
quetiapine fumarate.....	39
quinapril hcl	27
quinidine sulfate.....	30
quinine sulfate.....	14
QULIPTA	45
R	
RABAVERT INJ	66
rabeprazole sodium	61
raloxifene hcl.....	57
ramipril.....	27
ranolazine	33
RAPAMUNE	
<i>see sirolimus</i>	65
rasagiline mesylate.....	37
RAYALDEE.....	58
RECLAST	
<i>see zoledronic acid</i>	52
reclipsen	54
RECOMBIVAX HB	66
RECTIV	76
REGLAN	
<i>see metoclopramide hcl</i>	58
REGRANEX.....	77
RELENZA DISKHALER..16	
RELISTOR.....	60
REMERON	
<i>see mirtazapine</i>	36
REMERON SOLTAB	
<i>see mirtazapine</i>	36
REMICADE	64
RENFLEXIS	64
RENVELA	
<i>see sevelamer carbonate</i>	57
repaglinide	49
REPATHA	31
REPATHA PUSHTRONEX SYSTEM	31
REPATHA SURECLICK ..1	31
RESTASIS	70
RESTASIS MULTIDOSE	70
RESTORIL	
<i>see temazepam</i>	45
RETEVMO	24
RETIN-A	
<i>see tretinoin</i>	74
RETROVIR	
<i>see zidovudine</i>	14
REVATIO	
<i>see sildenafil citrate (pulmonary hypertension)</i>	34
REVLIMID	20
REXULTI	39
REYATAZ	14
<i>see atazanavir sulfate</i> ..14	
REZLIDHIA	24
REZUROCK	65
RHOPRESSA	70
ribavirin (<i>hepatitis c</i>).....	16
rifabutin	15
RIFADIN	

see *rifampin* 15
rifampin 15
RILUTEK
 see *riluzole* 46
riluzole 46
rimantadine hydrochloride
 16
RINVOQ 64
risedronate sodium 52
RISPERDAL
 see *risperidone* 39
RISPERDAL CONSTA 39
 see *risperidone*
 microspheres 39
risperidone 39
risperidone microspheres 39
RITALIN
 see *methylphenidate hcl*
 44
ritonavir 14
rivastigmine 35
rivastigmine tartrate 35
rivelsa 54
rizatriptan benzoate 45
ROBINUL
 see *glycopyrrolate* 59
ROBINUL FORTE
 see *glycopyrrolate* 59
ROCALTROL
 see *calcitriol* 58
 see *calcitriol (oral)* 58
ROCKLATAN DRO 70
roflumilast 72
ropinirole hydrochloride 37
rosuvastatin calcium 30
ROTARIX SUS 66
ROTATEQ SOL 66
ROWASA
 see *mesalamine w/ cleanser* 59
roweepra 42
ROXICODONE
 see *oxycodone hcl* 11
ROZLYTREK 24
RUBRACA 24
rufinamide 42
RUKOBIA 14
RYBELSUS 49
RYDAPT 24

S
SABRIL
 see *vigabatrin* 43
 see *vigadron* 43
SAFYRAL
 see *drospirenone-ethynodiol-estradiol-levomefetamine*
 tab 3-0.03-0.451 mg 52
 see *tydemy* 55
sajazir 63
SALAGEN
 see *pilocarpine hcl (oral)*
 77
SANDIMMUNE 65
 see *cyclosporine* 65
SANDOSTATIN
 see *octreotide acetate* 57
SANTYL 77
SAPHRIS
 see *asenapine maleate*
 37
sapropterin dihydrochloride
 57
SCEMBLIX 24
scopolamine 59
SECUADO 39
selegiline hcl 37
.selenium sulfide 75
SELZENTRY 14
 see *maraviroc* 14
SENSIPAR
 see *cinacalcet hcl* 56
SEREVENT DISKUS 71
SEROQUEL
 see *quetiapine fumarate*
 39
SEROQUEL XR
 see *quetiapine fumarate*
 39
sertraline hcl 36
setlakin 54
sevelamer carbonate 57
sharobel 54
SHINGRIX 66
SIGNIFOR 57
sildenafil citrate (pulmonary hypertension) 34
SILENOR
 see *doxepin hcl (sleep)*
 45
SILVADENE
 see *silver sulfadiazine* 74
 see *ssd* 74
silver sulfadiazine 74
SIMBRINZA SUS 1-0.2%70
simliya 54
simpesse 54
simvastatin 30
SINEMET
 see *carbidopa & levodopa tab 10-100 mg* 36
 see *carbidopa & levodopa tab 25-100 mg* 36
SINGULAIR
 see *montelukast sodium*
 71
sirolimus 65
SIRTURO 15
SIVEXTRO 12
SKYRIZI 64
SKYRIZI PEN 64
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml 60
sodium chloride 68
sodium chloride (gu irrigant) 77
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln 68
SODIUM OXYBATE 47
sodium phenylbutyrate 57
sodium polystyrene sulfonate powder 52
solifenacin succinate 61
SOLIQUA INJ 100/33 51
SOLTAMOX 20
SOLU-CORTEF 56
SOLU-MEDROL
 see *methylprednisolone sod succ* 56
SOMA
 see *carisoprodol* 46
SOMATULINE DEPOT 57
SOMAVERT 57
sorafenib tosylate 24

sorine.....	30	sulfadiazine.....	12	SYNJARDY TAB 12.5-	
sotalol hcl.....	30	sulfamethoxazole-		1000MG	49
sotalol hcl (afib/afl).....	30	<i>trimethoprim iv soln 400-</i>		SYNJARDY TAB 12.5-500	
spironolactone	27	<i>80 mg/5ml</i>	12	.....	49
spironolactone &		sulfamethoxazole-		SYNJARDY TAB 5-	
<i>hydrochlorothiazide tab</i>		<i>trimethoprim susp 200-40</i>		1000MG	49
<i>25-25 mg</i>	33	<i>mg/5ml</i>	12	SYNJARDY TAB 5-500MG	
SPORANOX		sulfamethoxazole-		.....	49
<i>see itraconazole</i>	13	<i>trimethoprim tab 400-80</i>		SYNJARDY XR TAB 10-	
sprintec 28.....	54	<i>mg</i>	12	1000	49
SPRITAM.....	42	SULFAMYLYON	74	SYNJARDY XR TAB 12.5-	
SPRYCEL.....	24	sulfasalazine.....	59	1000	50
sps.....	52	sulindac	9	SYNJARDY XR TAB 25-	
sronyx.....	54	sumatriptan.....	45	1000	50
ssd.....	74	sumatriptan succinate....	45,	SYNJARDY XR TAB 5-	
STALEVO 150		46		1000MG	49
<i>see carbidopa-levodopa-</i>		sunitinib malate.....	24	SYNTHROID.....	58
<i>entacapone tabs 37.5-</i>		SUNLENCA	14	<i>see euthyrox</i>	58
<i>150-200 mg</i>	37	SUPREP BOWEL PREP		<i>see levo-t</i>	58
STELARA	64	KIT		<i>see levothyroxine sodium</i>	
STIVARGA	24	<i>see sod sulfate-pot sulf-</i>		.....	58
STRATTERA		<i>mg sulf oral sol 17.5-</i>		<i>see levoxyl</i>	58
<i>see atomoxetine hcl</i>	44	<i>3.13-1.6 gm/177ml</i> ..	60	<i>see unithroid</i>	58
streptomycin sulfate.....	12	SUSTIVA		SYPRINE	
STRIBILD TAB.....	15	<i>see efavirenz</i>	14	<i>see trientine hcl</i>	52
STROMECTOL		SUTENT		T	
<i>see ivermectin</i>	12	<i>see sunitinib malate</i>	24	TABLOID	19
SUBOXONE		syeda.....	54	TABRECTA.....	24
<i>see buprenorphine hcl-</i>		SYMDEKO TAB 100-15072		tacrolimus	66
<i>naloxone hcl sl film 12-</i>		SYMDEKO TAB 50-75MG		<i>tacrolimus (topical)</i>	76
<i>3 mg (base equiv)</i>	47	.....		TAFINLAR	24
<i>see buprenorphine hcl-</i>		TAGRISSO		TAGLISSO	24
<i>naloxone hcl sl film 2-</i>		TALTZ.....		TALZENNA	24
<i>0.5 mg (base equiv)</i> .47		SYMFU		TAMIFLU	
<i>see buprenorphine hcl-</i>		<i>see efavirenz</i> -		<i>see oseltamivir</i>	
<i>naloxone hcl sl film 4-1</i>		<i>lamivudine-tenofovir df</i>		<i>phosphate</i>	16
<i>mg (base equiv)</i>	47	<i>tab 600-300-300 mg</i> 15		tamoxifen citrate	20
<i>see buprenorphine hcl-</i>		SYMFU LO		tamsulosin hcl.....	61
<i>naloxone hcl sl film 8-2</i>		<i>see efavirenz</i> -		TARCEVA	
<i>mg (base equiv)</i>	47	<i>lamivudine-tenofovir df</i>		<i>see erlotinib hcl</i>	22
subvenite	42	<i>tab 400-300-300 mg</i> 15		TARGETIN	
sucralfate	60	SYMPAZAN	42	<i>see bexarotene</i>	20
sulfacetamide sodium		SYMTUZA TAB.....	15	<i>see bexarotene (topical)</i>	
<i>(acne)</i>	74	SYNALAR		.....	76
sulfacetamide sodium		<i>see fluocinolone</i>		tarina 24 fe.....	54
<i>(ophth)</i>	69	<i>acetonide</i>	75	tarina fe 1/20 eq.....	54
sulfacetamide sodium-		SYNAREL.....	55	TASIGNA.....	25
<i>prednisolone ophth soln</i>				tasimelteon	45
<i>10-0.23(0.25)%</i>	68				

tazarotene.....	75
tazicef	17
TAZORAC	75
see <i>tazarotene</i>	75
taztia xt.....	32
TAZVERIK	25
TDVAX INJ 2-2 LF	66
TECENTRIQ.....	25
TEFLARO	17
TEGRETOL	
<i>see carbamazepine</i>	40
<i>see epitol</i>	41
TEGRETOL-XR	
<i>see carbamazepine</i>	40
TEKTURNA	
<i>see aliskiren fumarate</i> ..	33
telmisartan.....	29
telmisartan-amlodipine tab	
40-10 mg.....	29
telmisartan-amlodipine tab	
40-5 mg.....	28
telmisartan-amlodipine tab	
80-10 mg.....	29
telmisartan-amlodipine tab	
80-5 mg.....	29
telmisartan-	
<i>hydrochlorothiazide tab</i>	
40-12.5 mg.....	29
telmisartan-	
<i>hydrochlorothiazide tab</i>	
80-12.5 mg.....	29
telmisartan-	
<i>hydrochlorothiazide tab</i>	
80-25 mg.....	29
temazepam.....	45
TENIVAC INJ 5-2LF	66
tenofovir disoproxil	
<i>fumarate</i>	14
TENORETIC 100	
<i>see atenolol &</i>	
<i>chlorthalidone tab 100-</i>	
<i>25 mg</i>	31
TENORETIC 50	
<i>see atenolol &</i>	
<i>chlorthalidone tab 50-</i>	
<i>25 mg</i>	31
TENORMIN	
<i>see atenolol</i>	31
TEPMETKO.....	25
terazosin hcl.....	27
terbinafine hcl	13
terbutaline sulfate	71
terconazole vaginal.....	62
TERIPARATIDE.....	52
testosterone.....	48
testosterone cypionate....	48
testosterone enanthate	48
tetrabenazine	46
tetracycline hcl.....	19
THALOMID	20
THEO-24	72
theophylline	72
thioridazine hcl.....	39
thiothixene	39
tiadylt er.....	32
tiagabine hcl	43
TIAZAC	
<i>see diltiazem hcl</i>	
<i>extended release</i>	
<i>beads</i>	32
<i>see taztia xt</i>	32
<i>see tiadylt er</i>	32
TIBSOVO.....	25
TICOVAC.....	66
tigecycline.....	19
TIKOSYN	
<i>see dofetilide</i>	30
tilia fe	54
timolol maleate.....	32
timolol maleate (ophth) ...	70
tinidazole	12
TIVICAY.....	14
TIVICAY PD.....	14
tizanidine hcl.....	47
TOBRADEX OIN 0.3-0.1%	
.....	68
TOBRADEX ST SUS 0.3-	
0.05	68
tobramycin	13
tobramycin (ophth).....	69
tobramycin sulfate.....	13
tobramycin-dexamethasone	
<i>ophth susp 0.3-0.1%</i>	68
tolterodine tartrate.....	61
TOPAMAX	
<i>see topiramate</i>	43
TOPAMAX SPRINKLE	
<i>see topiramate</i>	43
topiramate.....	43
TOPROL XL	
<i>see metoprolol succinate</i>	
.....	31
toremifene citrate	20
torsemide	33
TOUJEO MAX SOLOSTAR	
.....	51
TOUJEO SOLOSTAR....	51
TOVIAZ	
<i>see fesoterodine</i>	
<i>fumarate</i>	61
TPN ELECTROL INJ	68
TRACLEER	
<i>see bosentan</i>	34
TRADJENTA.....	50
tramadol hcl	11
tramadol-acetaminophen	
<i>tab 37.5-325 mg</i>	11
trandolapril.....	27
tranexamic acid.....	63
TRANSDERM-SCOP	
<i>see scopolamine</i>	59
tranylcyromine sulfate... 36	
TRAVASOL INJ 10%	68
TRAZIMERA	25
trazodone hcl	36
TRECATOR	15
TRELEGY AER ELLIPTA	
100-62.5-25 MCG	70
TRELEGY AER ELLIPTA	
200-62.5-25 MCG	70
treprostинil	34
TRESIBA	51
TRESIBA FLEXTOUCH.. 51	
tretinoин	74
tretinoин (chemotherapy)	21
triамcinolone acetonide	
(i mouth).....	77
triамcinolone acetonide	
(topical)	76
triамterene &	
<i>hydrochlorothiazide cap</i>	
<i>37.5-25 mg</i>	33
triамterene &	
<i>hydrochlorothiazide tab</i>	
<i>37.5-25 mg</i>	33

triamterene & hydrochlorothiazide tab 75-50 mg.....	33
TRIBENZOR	
see olmesartan- amlodipine- hydrochlorothiazide tab 20-5-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-10-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-10-25 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-5-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-5-25 mg	28
TRICOR	
see fenofibrate	30
trientine hcl	52
tri-estarrylla	54
trifluoperazine hcl.....	39
trifluridine	69
trihexyphenidyl hcl	37
TRIJARDY XR TAB ER 24HR 10-5-1000MG....	50
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	50
TRIJARDY XR TAB ER 24HR 25-5-1000MG....	50
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG... <td>50</td>	50
TRIKAFTA PAK 59.5MG 72	
TRIKAFTA PAK 75MG ...72	
TRIKAFTA TAB 100-50- 75MG & 150MG	72
TRIKAFTA TAB 50-25- 37.5MG & 75MG	72
tri-legest fe.....	54
TRILEPTAL	
see oxcarbazepine.....	42
tri-linyah	54
tri-lo-estarrylla	54
tri-lo-marzia.....	54
tri-lo-mili	54
tri-lo-sprintec.....	55
trimethoprim.....	13
tri-mili.....	55
trimipramine maleate	36
TRINTELLIX	36
tri-nymyo.....	55
tri-sprintec.....	55
TRIUMEQ PD TAB	15
TRIUMEQ TAB	15
trivora-28	55
tri-vylibra	55
tri-vylibra lo	55
TRIZIVIR TAB.....	15
TROGARZO	14
TROPHAMINE INJ 10% .68	
trospium chloride	61
TRULICITY	50
TRUMENBA INJ	66
TRUQAP	25
TRUVADA	
see emtricitabine- tenofovir disoproxil fumarate tab 100-150 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 133-200 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 167-250 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 200-300 mg	15
TRUXIMA	25
TUKYSA	25
TURALIO	25
turqoz.....	55
TWINRIX INJ	66
TYBOST	14
tydemy	55
TYGACIL	
see tigecycline.....	19
TYKERB	
see lapatinib ditosylate	23
TYPHIM VI.....	66
TYRVAYA	70
U	
UBRELVY	46
UCERIS	
see budesonide.....	59
UNASYN	
see ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm	18
see ampicillin & sulbactam sodium for inj 3 (2-1) gm	18
UNASYN BULK PACK	
see ampicillin & sulbactam sodium for iv soln 15 (10-5) gm.18	
unithroid.....	58
UROCIT-K 10	
see potassium citrate (alkalinizer)	61
UROCIT-K 15	
see potassium citrate (alkalinizer)	61
UROCIT-K 5	
see potassium citrate (alkalinizer)	61
UROXATRAL	
see alfuzosin hcl.....	61
URSO 250	
see ursodiol.....	60
URSO FORTE	
see ursodiol.....	60
ursodiol.....	60
V	
VAGIFEM	
see estradiol vaginal ..55	
see yuvafem.....	55
valacyclovir hcl.....	16
VALCHLOR	76
VALCYTE	
see valganciclovir hcl..16	
valganciclovir hcl.....	16
VALIUM	
see diazepam.....	40
valproate sodium	43
valproic acid.....	43

valsartan	29
valsartan-	
hydrochlorothiazide tab 160-12.5 mg.....	29
valsartan-	
hydrochlorothiazide tab 160-25 mg.....	29
valsartan-	
hydrochlorothiazide tab 320-12.5 mg.....	29
valsartan-	
hydrochlorothiazide tab 320-25 mg.....	29
VALTOCO 10 MG DOSE	43
VALTOCO 15 MG DOSE	43
VALTOCO 20 MG DOSE	43
VALTOCO 5 MG DOSE..	43
VALTREX	
see <i>valacyclovir hcl</i>	16
VANCOCIN	
see <i>vancomycin hcl</i>	13
vancomycin hcl	13
VANCOMYCIN INJ 1 GM	13
VANCOMYCIN INJ 500MG	
.....	13
VANCOMYCIN INJ 750MG	
.....	13
VANFLYTA	25
VAQTA	66
varenicline tartrate	48
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	48
VARIVAX	66
VASCEPA.....	31
VASERETIC	
see <i>enalapril maleate &</i> <i>hydrochlorothiazide tab</i> <i>10-25 mg</i>	26
VASOTEC	
see <i>enalapril maleate</i> ..	27
VELCADE	
see <i>bortezomib</i>	21
velivet	55
VELPHORO.....	57
VELTASSA	52
.....	
VEMLIDY	16
VENCLEXTA	25
VENCLEXTA TAB START	
PK	25
venlafaxine hcl.....	36
VENTAVIS.....	34
VENTOLIN HFA.....	71
VENTOLIN HFA	
(INSTITUTIONAL PACK)	
.....	71
verapamil hcl.....	32
VERELAN	
see <i>verapamil hcl</i>	32
VERQUVO.....	33
VERSACLOZ.....	39
VERZENIO	25
VESICARE	
see <i>solifenacin succinate</i>	
.....	61
vestura.....	55
VFEND	
see <i>voriconazole</i>	13
VFEND IV	
see <i>voriconazole</i>	13
V-GO 20 KIT	51
V-GO 30 KIT	51
V-GO 40 KIT	51
VIBRAMYCIN	
see <i>doxycycline</i>	
(<i>monohydrate</i>)	18
see <i>doxycycline hyclate</i>	
.....	19
VIDAZA	
see <i>azacitidine</i>	19
vienna	55
vigabatrin	43
vigadroner	43
VIGAMOX	
see <i>moxifloxacin hcl</i>	
(<i>ophth</i>)	69
VIIBRYD	
see <i>vilazodone hcl</i>	36
vilazodone hcl.....	36
VIMPAT	
see <i>lacosamide</i>	41
see <i>lacosamide oral</i>	41
vincristine sulfate	21
vinorelbine tartrate	21
viorele	55
.....	
VIRACEPT	14
VIREAD	14
see <i>tenofovir disoproxil</i> <i>fumarate</i>	14
VISTARIL	
see <i>hydroxyzine</i> <i>pamoate</i>	71
VITRAKVI	25
VIVELLE-DOT	
see <i>dotti</i>	55
see <i>estradiol</i>	55
VIVITROL	48
VIZIMPRO	25
VONJO	25
voriconazole.....	13
VOSEVI TAB	16
VOTRIENT.....	25
see <i>pazopanib hcl</i>	24
VRAYLAR	39
VRAYLAR CAP 1.5-3MG	39
vyfemla	55
vylibra	55
VYTORIN	
see <i>ezetimibe-</i> <i>simvastatin tab 10-10</i> <i>mg</i>	30
see <i>ezetimibe-</i> <i>simvastatin tab 10-20</i> <i>mg</i>	30
see <i>ezetimibe-</i> <i>simvastatin tab 10-40</i> <i>mg</i>	30
see <i>ezetimibe-</i> <i>simvastatin tab 10-80</i> <i>mg</i>	31
VYZULTA.....	70
W	
warfarin sodium	62
water for irrigation, sterile <i>irrigation soln</i>	77
WELCHOL	
see <i>colesevelam hcl</i> ...30	
WELIREG	21
WELLBUTRIN SR	
see <i>bupropion hcl</i>	35
WELLBUTRIN XL	
see <i>bupropion hcl</i>	35
wera.....	55
wixela inhub	73

wymzya fe.....	55
X	
XALATAN	
see <i>latanoprost</i>	70
XALKORI	25
XANAX	
see <i>alprazolam</i>	34
XARELTO	62
XARELTO STAR TAB	
15/20MG	62
XATMEP	65
XCOPRI	43
XCOPRI PAK 100-150....	43
XCOPRI PAK 12.5-25....	43
XCOPRI PAK 150-200MG (MAINTENANCE).....	43
XCOPRI PAK 150-200MG (TITRATION).....	43
XCOPRI PAK 50-100MG	43
XELJANZ.....	64
XELJANZ XR	64
XENAZINE	
see <i>tetrabenazine</i>	46
XERMELO	60
XGEVA	52
XHANCE.....	73
XIFAXAN	60
XIGDUO XR TAB 10-1000	
.....	50
XIGDUO XR TAB 10- 500MG	50
XIGDUO XR TAB 2.5-1000	
.....	50
XIGDUO XR TAB 5- 1000MG	50
XIGDUO XR TAB 5-500MG	
.....	50
XXIIDRA.....	70
XOFLUZA	16
XOLAIR	72
XOSPATA.....	25
XPOVIO 100 MG ONCE WEEKLY	25
XPOVIO 40 MG ONCE WEEKLY	25
XPOVIO 40 MG TWICE WEEKLY	25
XPOVIO 60 MG ONCE WEEKLY	25
XPOVIO 60 MG TWICE	
WEEKLY	25
XPOVIO 80 MG ONCE	
WEEKLY	25
XPOVIO 80 MG TWICE	
WEEKLY	25
XTANDI	20
xulane.....	55
XULTOPHY INJ 100/3.6	51
XYLOCAINE	
see <i>lidocaine hcl (local anest.)</i>	11
XYLOCAINE-MPF	
see <i>lidocaine hcl (local anest.)</i>	11
Y	
yargesa.....	57
YASMIN 28	
see <i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	
.....	52
see <i>ocella</i>	54
see <i>syeda</i>	54
see <i>zumandimine</i>	55
YAZ	
see <i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	
.....	52
see <i>jasmiel</i>	53
see <i>loryna</i>	53
see <i>nikki</i>	54
see <i>vestura</i>	55
YF-VAX INJ	66
yuvalfem	55
Z	
zafemy.....	55
zaflirlukast	71
zaleplon	45
ZANAFLEX	
see <i>tizanidine hcl</i>	47
ZARONTIN	
see <i>ethosuximide</i>	41
ZARXIO	62
ZAVESCA	
see <i>miglustat</i>	57
see <i>yargesa</i>	57
ZEJULA	25
ZELBORAF.....	25
ZEMAIRA.....	72
ZEMPLAR	
see <i>paricalcitol</i>	58
zenatane.....	74
ZENPEP CAP 10000UNT	
.....	60
ZENPEP CAP 15000UNT	
.....	60
ZENPEP CAP 20000UNT	
.....	60
ZENPEP CAP 25000UNT	
.....	60
ZENPEP CAP 3000UNIT	60
ZENPEP CAP 40000UNT	
.....	60
ZENPEP CAP 5000UNIT	60
ZENPEP CAP 60000UNT	
.....	60
ZERVIASTE	69
ZESTORETIC	
see <i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	26
see <i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	26
see <i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	27
ZESTRIL	
see <i>lisinopril</i>	27
ZETIA	
see <i>ezetimibe</i>	30
ZIAGEN	
see <i>abacavir sulfate</i> ...	14
zidovudine.....	14
ZIEXTENZO	
.....	62
ziprasidone hcl.....	39
ziprasidone mesylate	40
ZIRABEV	26
ZIRGAN	69
ZITHROMAX	
see <i>azithromycin</i>	17
ZOCOR	
see <i>simvastatin</i>	30
zoledronic acid.....	52
ZOLINZA.....	26
ZOLOFT	
see <i>sertraline hcl</i>	36
zolpidem tartrate.....	45

ZONEGRAN	ZTALMY	43
see <i>zonisamide</i>	<i>zonandimine</i>	55
ZONISADE	ZURZUVAE	36
<i>zonisamide</i>	ZYDELIG	26
ZORTRESS	ZYKADIA	26
see <i>everolimus</i>	ZYLET SUS 0.5-0.3%....	68
(<i>immunosuppressant</i>)	ZYPREXA	
.....	see <i>olanzapine</i>	38
zovia 1/35	ZYPREXA RELPREVV ...	40
	ZYTIGA	
	see <i>abiraterone acetate</i>	
	.....	19
	ZYVOX	
	see <i>linezolid</i>	12

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-293-5325 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-293-5325 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-293-5325 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-293-5325 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-293-5325 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-293-5325 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin

gọi 1-877-293-5325 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-293-5325 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-293-5325 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-293-5325 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-293-5325 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-293-5325 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-293-5325 (TTY: 711). Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-293-5325 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis

rele nou nan 1-877-293-5325 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w.
Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-293-5325 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため
に、無料の通訳サービスがありますございます。通訳をご用命になるには、
1-877-293-5325 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは
無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)

Y0124_MAMultiLanguageInsert0223_C

Johns Hopkins Advantage MD is a Medicare Advantage plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD depends on contract renewal.

Notice of Nondiscrimination



Johns Hopkins Advantage MD (HMO) and Johns Hopkins Advantage MD (PPO) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Johns Hopkins Advantage MD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Johns Hopkins Advantage MD:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, please contact our Customer Service Department at 1-877-293-5325 (TTY: 711).

If you believe Johns Hopkins Advantage MD has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Johns Hopkins Grievance Compliance Coordinator at 7231 Parkway Dr., Suite 100, Hanover, MD 21076, phone: 1-844-422-6957 (TTY: 711) Monday – Friday 8 a.m. to 5 p.m. or 1-844-SPEAK2US (1-844-773-2528, available 24/7), fax: 1-410-762-1527 or by email: compliance@jhhp.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Johns Hopkins Advantage MD Compliance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

This formulary was updated on 04/01/2024. For more recent information or other questions, please contact Johns Hopkins Advantage MD (HMO) Customer Service at 1-877-293-4998 or, for TTY users, 711, 24 hours a day, 7 days a week, or visit www.hopkinsmedicare.com.