



FORMULARY LIST OF COVERED DRUGS

Johns Hopkins Advantage MD (HMO)

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

HPMS Approved Formulary File Submission ID 00024149, Version 12

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 (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 (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 (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 (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 or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Johns Hopkins Advantage MD (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 10. 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 78. 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 10. 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 (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 (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 cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

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

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

If you 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 (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 (HMO) Formulary

The formulary that begins on page 10 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 78.

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.
- GC - We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.
- EX - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
- 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
- * - Non-extended day supply. Not available for an extended (long-term) supply

Johns Hopkins Advantage MD (HMO)		
Cost Sharing Tier	Standard Retail Cost-Sharing (in-network)	Standard Mail Order Cost-Sharing (in-network)
Cost-Sharing Tier 1 (Preferred Generic)	\$0 copay for a 30-day supply \$0 copay for a 60-day supply \$0 copay for a 100-day supply	\$0 copay for a 30-day supply \$0 copay for a 60-day supply \$0 copay for a 100-day supply
Cost-Sharing Tier 2 (Generic)	\$10 copay for a 30-day supply \$15 copay for a 60-day supply \$20 copay for a 90-day supply	\$10 copay for a 30-day supply \$15 copay for a 60-day supply \$20 copay for a 90-day supply
Cost-Sharing Tier 3 (Preferred Brand)	\$47 copay for a 30-day supply \$94 copay for a 60-day supply \$141 copay for a 90-day supply	\$47 copay for a 30-day supply \$70.50 copay for a 60-day supply \$94 copay for a 90-day supply
Cost-Sharing Tier 4 (Non-Preferred Drug)	\$100 copay for a 30-day supply \$200 copay for a 60-day supply \$300 copay for a 90-day supply	\$100 copay for a 30-day supply \$150 copay for a 60-day supply \$200 copay for a 90-day supply
Cost-Sharing Tier 5 (Specialty Tier)	33% coinsurance for a 30-day supply (only)	

NOTE:

- Drugs are provided in a Long-Term Care Facility up to a 31-day supply
- Drugs in Tier 5 are only available for a 30-day supply
- We provide coverage of drugs in Tier 1 at \$0 copay in the coverage gap.
- Mail order is available to conveniently order up to a 100-day supply of medications on Tier 1 and a 90-day supply of medications on Tier 2 through 4 at two times the 30-day copay saving you money and time. 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

Coverage of additional drugs

Advantage MD covers the following prescription drugs which are not normally covered in a Medicare Prescription Drug Plan. These covered excluded drugs are covered under Tier 2 and include select prescription vitamins, cough and cold medications, and erectile dysfunction medicine.

Please note: Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug total drug costs or yearly out-of-pocket expenses.

Drug Name	Drug Requirements/ Tier	Limits	Drug Name	Drug Requirements/ Tier	Limits	
Cough and Cold						
Benzonatate 150 mg Oral Capsule	2	EX	Sildenafil Tab 100mg	2	QL EX QL (6 tabs / 30 days)	
Benzonatate Cap 100mg	2	EX	Sildenafil Tab 25mg	2	QL EX QL (6 tabs / 30 days)	
Benzonatate Cap 200mg	2	EX	Sildenafil Tab 50mg	2	QL EX QL (6 tabs / 30 days)	
Brom/Pse/Dm Syp 2/30/10	2	EX	Prescription Vitamins			
Codeine Phosphate 2 mg/ml / Phenylephrine HCl 1 mg/ml / Promethazine HCl 1.25 mg/ml Oral Solution	2	EX	Folic Acid Tab 1mg	2	EX	
Prometh VC Syp 6.25-5/5	2	EX	Dodex Inj	2	EX	
Prometh/Cod Sol 6.25-10	2	EX	Nascobal Spr 500mcg	2	EX	
Promethazine Sol DM	2	EX	Vitamin B12 1 mg/ml Injectable Solution	2	EX	
			Vitamin D2 Cap 50,000IU	2	EX	

Johns Hopkins Advantage MD (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	GC
<i>colchicine</i> TABS .6mg QL (120 tabs / 30 days)	4	QL
<i>colchicine w/ probenecid tab</i> 0.5-500 mg	3	
<i>MITIGARE</i> CAPS .6mg QL (60 caps / 30 days)	3	QL
<i>probenecid</i> TABS 500mg	3	
NSAIDS - DRUGS TO TREAT PAIN AND INFLAMMATION		
<i>celecoxib</i> (generic of CELEBREX) CAPS 50mg, 100mg, 200mg QL (60 caps / 30 days)	3	QL
<i>celecoxib</i> (generic of CELEBREX) CAPS 400mg QL (30 caps / 30 days)	3	QL
<i>diclofenac potassium</i> TABS 50mg QL (120 tabs / 30 days)	3	QL
<i>diclofenac sodium</i> TB24 100mg	3	
<i>diclofenac sodium</i> TBEC 25mg, 50mg, 75mg	2	
<i>diflunisal</i> TABS 500mg	3	
<i>ec-naproxen</i> (generic of EC- NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	2	QL
<i>ec-naproxen</i> (generic of EC- NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	4	QL
<i>etodolac</i> CAPS 200mg, 300mg; TABS 500mg; TB24 400mg, 500mg, 600mg	3	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>etodolac</i> (generic of LODINE) TABS 400mg	3	
<i>flurbiprofen</i> TABS 100mg	3	
<i>ibu</i> TABS 400mg, 600mg, 800mg	1	GC
<i>ibuprofen</i> SUSP 100mg/5ml	3	
<i>ibuprofen</i> TABS 400mg, 600mg, 800mg	1	GC
<i>meloxicam</i> TABS 7.5mg, 15mg	1	GC
<i>nabumetone</i> TABS 500mg, 750mg	2	
<i>naproxen</i> TABS 250mg, 375mg	1	GC
<i>naproxen</i> (generic of NAPROSYN) TABS 500mg	1	GC
<i>naproxen</i> (generic of EC- NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	2	QL
<i>naproxen</i> (generic of EC- NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	4	QL
<i>naproxen sodium</i> TABS 275mg	3	
<i>naproxen sodium</i> (generic of ANAPROX DS) TABS 550mg	3	
<i>piroxicam</i> (generic of FELDENE) CAPS 10mg, 20mg	3	
<i>sulindac</i> TABS 150mg, 200mg	2	
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)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
hydrocodone bitartrate 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	T24A 3	QL PA
HYSINGLA ER 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	T24A 3	QL PA
methadone hcl SOLN 5mg/5ml, 10mg/5ml QL (450 mL / 30 days)	3	QL PA
methadone hcl TABS 5mg, 10mg QL (90 tabs / 30 days)	3	QL PA
methadone hydrochloride i (generic of METHADOSE) CONC 10mg/ml QL (90 mL / 30 days)	3	QL PA
morphine sulfate (generic of MS CONTIN) TBCR 15mg, 30mg, 60mg, 100mg, 200mg QL (90 tabs / 30 days)	3	QL PA
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen w/ codeine soln 120-12 mg/5ml QL (2700 mL / 30 days)	2	QL
acetaminophen w/ codeine tab 300-15 mg QL (400 tabs / 30 days)	2	QL
acetaminophen w/ codeine tab 300-30 mg QL (360 tabs / 30 days)	2	QL
acetaminophen w/ codeine tab 300-60 mg QL (180 tabs / 30 days)	2	QL
butorphanol tartrate SOLN 1mg/ml, 2mg/ml	4	
endocet tab 2.5-325mg (generic of PERCO CET) QL (360 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
endocet tab 5-325mg (generic of PERCO CET) QL (360 tabs / 30 days)	3	QL
endocet tab 7.5-325mg (generic of PERCO CET) QL (240 tabs / 30 days)	3	QL
endocet tab 10-325mg (generic of PERCO CET) QL (180 tabs / 30 days)	3	QL
fentanyl citrate LPOP 200mcg QL (120 lozenges / 30 days)	4	QL PA
fentanyl citrate LPOP 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg QL (120 lozenges / 30 days)	5	* QL PA
hydrocodone-acetaminophen soln 7.5-325 mg/15ml QL (2700 mL / 30 days)	4	QL
hydrocodone-acetaminophen tab 5-325 mg QL (240 tabs / 30 days)	3	QL
hydrocodone-acetaminophen tab 7.5-325 mg QL (180 tabs / 30 days)	3	QL
hydrocodone-acetaminophen tab 10-325 mg QL (180 tabs / 30 days)	3	QL
hydrocodone-ibuprofen tab 7.5-200 mg QL (150 tabs / 30 days)	3	QL
hydromorphone hcl (generic of DILAUDID) LIQD 1mg/ml QL (600 mL / 30 days)	4	QL
hydromorphone hcl (generic of DILAUDID) TABS 2mg, 4mg, 8mg QL (180 tabs / 30 days)	3	QL
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 50mg/ml	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml	4	B/D
morphine sulfate SOLN 10mg/5ml, 20mg/5ml QL (900 mL / 30 days)	3	QL
morphine sulfate SOLN 20mg/ml QL (180 mL / 30 days)	3	QL
morphine sulfate TABS 15mg, 30mg QL (180 tabs / 30 days)	3	QL
MORPHINE SULFATE/SODIUM C SOLN 1mg/ml	4	B/D
nalbuphine hcl SOLN 10mg/ml, 20mg/ml	4	
oxycodone hcl CAPS 5mg QL (180 caps / 30 days)	4	QL
oxycodone hcl CONC 100mg/5ml QL (180 mL / 30 days)	4	QL
oxycodone hcl SOLN 5mg/5ml QL (900 mL / 30 days)	4	QL
oxycodone hcl TABS 5mg, 10mg, 20mg QL (180 tabs / 30 days)	3	QL
oxycodone hcl (generic of ROXICODONE) TABS 15mg, 30mg QL (180 tabs / 30 days)	3	QL
oxycodone w/ acetaminophen tab 2.5-325 mg (generic of PERCO CET) QL (360 tabs / 30 days)	3	QL
oxycodone w/ acetaminophen tab 5-325 mg (generic of PERCO CET) QL (360 tabs / 30 days)	3	QL
oxycodone w/ acetaminophen tab 7.5-325 mg (generic of PERCO CET) QL (240 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
oxycodone w/ acetaminophen tab 10-325 mg (generic of PERCO CET) QL (180 tabs / 30 days)	3	QL
tramadol hcl TABS 50mg QL (240 tabs / 30 days)	2	QL
tramadol-acetaminophen tab 37.5-325 mg QL (240 tabs / 30 days)	3	QL
ANESTHETICS - DRUGS FOR NUMBING LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) (generic of XYLOCAINE-MPF) SOLN .5%, 1%, 1.5%	3	B/D
lidocaine hcl (local anesth.) (generic of XYLOCAINE) SOLN .5%, 1%, 2%	3	B/D
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTI-INFECTIVES - MISCELLANEOUS		
albendazole TABS 200mg QL (672 tabs / year)	5	* QL PA
amikacin sulfate SOLN 1gm/4ml, 500mg/2ml	4	
atovaquone (generic of MEPRON) SUSP 750mg/5ml	4	
aztreonam (generic of AZACTAM) SOLR 1gm, 2gm	4	
CAYSTON SOLR 75mg	5	* NM LA PA
clindamycin hcl (generic of CLEOCIN) CAPS 75mg, 150mg, 300mg	2	
clindamycin palmitate hydrochloride (generic of CLEOCIN PEDIATRIC GRANULE) SOLR 75mg/5ml	4	
clindamycin phosphate (generic of CLEOCIN PHOSPHATE) SOLN 600mg/4ml, 900mg/6ml, 9000mg/60ml	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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 in d5w	4	
iv soln 300 mg/50ml		
clindamycin phosphate in d5w	4	
iv soln 600 mg/50ml		
clindamycin phosphate in d5w	4	
iv soln 900 mg/50ml		
CLINDMYC/NAC INJ 300/50ML	4	
CLINDMYC/NAC INJ 600/50ML	4	
CLINDMYC/NAC INJ 900/50ML	4	
colistimethate sodium (generic of COLY-MYCIN M) SOLR 150mg	4	
dapsone TABS 25mg, 100mg	3	
DAPTOMYCIN SOLR 350mg	5	*
daptomycin (generic of DAPTOMYCIN) SOLR 350mg	5	*
daptomycin SOLR 500mg	5	*
EMVERM CHEW 100mg QL (12 tabs / year)	5	* QL
ertapenem sodium SOLR 1gm	4	
gentamicin in saline inj 0.8 mg/ml	3	
gentamicin in saline inj 1 mg/ml	3	
gentamicin in saline inj 1.2 mg/ml	3	
gentamicin in saline inj 1.6 mg/ml	3	
gentamicin in saline inj 2 mg/ml	3	
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	3	
imipenem-cilastatin intravenous for soln 250 mg	4	
imipenem-cilastatin intravenous for soln 500 mg (generic of PRIMAXIN IV)	4	

Drug Name	Drug Requirements/ Tier	Limits
ivermectin (generic of STROMECTOL) TABS 3mg QL (12 tabs / 90 days)	3	QL PA
linezolid (generic of ZYVOX) SOLN 600mg/300ml	4	
linezolid (generic of ZYVOX) SUSR 100mg/5ml QL (1800 mL / 30 days)	5	* QL
linezolid (generic of ZYVOX) TABS 600mg QL (60 tabs / 30 days)	4	QL
LINEZOLID INJ 2MG/ML	4	
meropenem SOLR 1gm, 500mg	4	
methenamine hippurate (generic of HIPREX) TABS 1gm	4	
metronidazole (generic of METRONIDAZOLE) SOLN 500mg/100ml	3	
metronidazole TABS 250mg, 500mg	1	GC
neomycin sulfate TABS 500mg	2	
nitazoxanide (generic of ALINIA) TABS 500mg QL (6 tabs / 30 days)	5	* QL
nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 50mg, 100mg	3	
nitrofurantoin monohyd macro (generic of MACROBID) CAPS 100mg	3	
pentamidine isethionate inh (generic of NEBUPENT) SOLR 300mg	4	B/D
pentamidine isethionate inj (generic of PENTAM 300) SOLR 300mg	4	
praziquantel (generic of BILTRICIDE) TABS 600mg	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
SIVEXTRO SOLR 200mg; TABS 200mg	5	*
streptomycin sulfate SOLR 1gm	5	*
sulfadiazine TABS 500mg	5	*
sulfamethoxazole- trimethoprim iv soln 400-80 mg/5ml	4	
sulfamethoxazole- trimethoprim susp 200-40 mg/5ml	3	
sulfamethoxazole- trimethoprim tab 400-80 mg (generic of BACTRIM)	1	GC
sulfamethoxazole- trimethoprim tab 800-160 mg (generic of BACTRIM DS)	1	GC
tinidazole TABS 250mg, 500mg	3	
tobramycin (generic of KITABIS PAK) NEBU 300mg/5ml	5	* NM PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	3	
trimethoprim TABS 100mg	3	
vancomycin hcl (generic of VANCOCIN) CAPS 125mg QL (80 caps / 180 days)	4	QL
vancomycin hcl (generic of VANCOCIN) CAPS 250mg QL (160 caps / 180 days)	4	QL
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	4	
VANCOMYCIN INJ 1 GM	4	
VANCOMYCIN INJ 500MG	4	
VANCOMYCIN INJ 750MG	4	
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ABELCET SUSP 5mg/ml	4	B/D
amphotericin b SOLR 50mg	4	B/D

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
amphotericin b liposome (generic of AMBISOME) SUSR 50mg	5	* B/D
caspofungin acetate (generic of CANCIDAS) SOLR 50mg, 70mg	4	
fluconazole (generic of DIFLUCAN) SUSR 10mg/ml, 40mg/ml; TABS 100mg, 200mg	3	
fluconazole TABS 50mg	3	
fluconazole (generic of DIFLUCAN) TABS 150mg	2	
fluconazole in nacl 0.9% inj 200 mg/100ml	3	
fluconazole in nacl 0.9% inj 400 mg/200ml	3	
flucytosine (generic of ANCOBON) CAPS 250mg, 500mg	5	* PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	4	
griseofulvin ultramicrosize TABS 125mg, 250mg	4	
itraconazole (generic of SPORANOX) CAPS 100mg	4	PA
ketoconazole TABS 200mg	3	PA
micafungin sodium (generic of MYCAMINE) SOLR 50mg, 100mg	5	*
nystatin TABS 500000unit	3	
posaconazole (generic of NOXAFL) SUSP 40mg/ml QL (630 mL / 30 days)	5	* QL PA
posaconazole (generic of NOXAFL) TBEC 100mg QL (93 tabs / 30 days)	5	* QL PA
terbinafine hcl TABS 250mg QL (90 tabs / year)	1	GC QL
voriconazole (generic of VFEND IV) SOLR 200mg	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
voriconazole (generic of VFEND) SUSR 40mg/ml	5	* PA
voriconazole (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	4	QL PA
voriconazole (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	4	QL PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
atovaquone-proguanil hcl tab 62.5-25 mg (generic of MALARONE)	4	
atovaquone-proguanil hcl tab 250-100 mg (generic of MALARONE)	4	
chloroquine phosphate TABS 250mg, 500mg	4	
COARTEM TAB 20-120MG	4	
mefloquine hcl TABS 250mg	3	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
primaquine phosphate (generic of PRIMAQUINE PHOSPHATE) TABS 26.3mg	3	
quinine sulfate (generic of QUALAQUIN) CAPS 324mg	4	PA
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate (generic of ZIAGEN) SOLN 20mg/ml	4	NM
abacavir sulfate TABS 300mg	3	NM
APTVUS CAPS 250mg	5	* NM
atazanavir sulfate CAPS 150mg	4	NM
atazanavir sulfate (generic of REYATAZ) CAPS 200mg, 300mg	4	NM
darunavir (generic of PREZISTA) TABS 600mg QL (60 tabs / 30 days)	5	* QL NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
darunavir (generic of PREZISTA) TABS 800mg QL (30 tabs / 30 days)	5	* QL NM
EDURANT TABS 25mg	5	* NM
efavirenz CAPS 50mg, 200mg	4	NM
efavirenz (generic of SUSTIVA) TABS 600mg	4	NM
emtricitabine (generic of EMTRIVA) CAPS 200mg	3	NM
EMTRIVA SOLN 10mg/ml	4	NM
etravirine (generic of INTELENCE) TABS 100mg, 200mg	5	* NM
fosamprenavir calcium (generic of LEXIVA) TABS 700mg	5	* NM
FUZEON SOLR 90mg	5	* NM LA
INTELENCE TABS 25mg	4	NM
ISENTRESS CHEW 25mg	4	NM
ISENTRESS CHEW 100mg; PACK 100mg; TABS 400mg	5	* NM
ISENTRESS HD TABS 600mg	5	* NM
lamivudine (generic of EPIVIR) SOLN 10mg/ml; TABS 150mg, 300mg	3	NM
LEXIVA SUSP 50mg/ml	4	NM
maraviroc (generic of SELZENTRY) TABS 150mg, 300mg	5	* NM
nevirapine SUSP 50mg/5ml; TB24 400mg	4	NM
nevirapine TABS 200mg	2	NM
NORVIR PACK 100mg	4	NM
PIFELTRO TABS 100mg	5	* NM
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	5	* QL NM
PREZISTA TABS 75mg QL (480 tabs / 30 days)	4	QL NM
PREZISTA TABS 150mg QL (240 tabs / 30 days)	5	* QL 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
REYATAZ PACK 50mg	5	* NM
ritonavir (generic of NORVIR)	3	NM
TABS 100mg		
RUKOBIA TB12 600mg	5	* NM
SELZENTRY SOLN 20mg/ml; TABS 75mg	5	* NM
SELZENTRY TABS 25mg	4	NM
SUNLENCA TBPK 300mg	5	* NM LA
<i>tenofovir disoproxil fumarate</i> (generic of VIREAD) TABS 300mg	3	NM
TIVICAY TABS 10mg	3	NM
TIVICAY TABS 25mg, 50mg	5	* NM
TIVICAY PD TBSO 5mg	5	* NM
TROGARZO SOLN 200mg/1.33ml	5	* NM LA
TYBOST TABS 150mg	3	NM
VIRACEPT TABS 250mg, 625mg	5	* NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	* NM
<i>zidovudine</i> (generic of RETROVIR) CAPS 100mg; SYRP 50mg/5ml	4	NM
<i>zidovudine</i> TABS 300mg	3	NM

**ANTIRETROVIRAL COMBINATION
AGENTS - DRUGS TO SUPPRESS
HIV/AIDS INFECTION**

abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	3	NM
BIKTARVY TAB 30-120-15 MG	5	* NM
BIKTARVY TAB 50-200-25 MG	5	* NM
CIMDUO TAB 300-300	5	* NM
COMPLERA TAB	5	* NM
DELSTRIGO TAB	5	* NM
DESCOVY TAB 120-15MG QL (30 tabs / 30 days)	5	* QL NM
DESCOVY TAB 200/25MG QL (30 tabs / 30 days)	5	* QL 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
DOVATO TAB 50-300MG	5	* NM
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i> (generic of ATRIPLA)	5	* NM
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i> (generic of SYMFI LO)	5	* NM
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i> (generic of SYMFI)	5	* NM
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i> (generic of TRUVADA)	5	* QL NM
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i> (generic of TRUVADA)	5	* QL NM
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i> (generic of TRUVADA)	5	* QL NM
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i> (generic of TRUVADA)	4	QL NM
EVOTAZ TAB 300-150	5	* NM
GENVOYA TAB	5	* NM
JULUCA TAB 50-25MG	5	* NM
<i>lamivudine-zidovudine tab 150-300 mg</i>	4	NM
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i> (generic of KALETRA)	4	NM
<i>lopinavir-ritonavir tab 100-25 mg</i> (generic of KALETRA)	4	NM
<i>lopinavir-ritonavir tab 200-50 mg</i> (generic of KALETRA)	4	NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ODEFSEY TAB	5	* NM
PREZCOBIX TAB 800-150	5	* NM
STRIBILD TAB	5	* NM
SYMTUZA TAB	5	* NM
TRIUMEQ PD TAB	5	* NM
TRIUMEQ TAB	5	* NM
TRIZIVIR TAB	5	* NM
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine CAPS 250mg	5	*
ethambutol hcl TABS 100mg	3	
ethambutol hcl (generic of MYAMBUTOL) TABS 400mg	3	
isoniazid SYRP 50mg/5ml	4	
isoniazid TABS 100mg, 300mg	1	GC
PRIFTIN TABS 150mg	4	
pyrazinamide TABS 500mg	4	
rifabutin (generic of MYCOBUTIN) CAPS 150mg	4	
rifampin CAPS 150mg, 300mg	3	
rifampin (generic of RIFADIN) SOLR 600mg	4	
SIRTURO TABS 20mg, 100mg	5	* NM LA PA
TRECATOR TABS 250mg	4	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
acyclovir CAPS 200mg; TABS 400mg, 800mg	2	
acyclovir SUSP 200mg/5ml	4	
acyclovir sodium SOLN 50mg/ml	4	B/D
adefovir dipivoxil TABS 10mg	4	NM
BARACLUDE SOLN .05mg/ml	5	* NM
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	4	NM
EPCLUSA PAK 150-37.5	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
EPCLUSA PAK 200-50MG	5	* NM PA
EPCLUSA TAB 200-50MG	5	* NM PA
EPCLUSA TAB 400-100	5	* NM PA
<i>famciclovir</i> TABS 125mg, 250mg, 500mg	3	
<i>ganciclovir sodium</i> SOLR 500mg	4	B/D
HARVONI PAK 33.75-150MG	5	* NM PA
HARVONI PAK 45-200MG	5	* NM PA
HARVONI TAB 45-200MG	5	* NM PA
HARVONI TAB 90-400MG	5	* NM PA
<i>lamivudine (hbv)</i> TABS 100mg	4	NM
MAVYRET PAK 50-20MG	5	* NM PA
MAVYRET TAB 100-40MG	5	* NM PA
<i>oseltamivir phosphate</i> (generic of TAMIFLU) CAPS 30mg	3	QL
QL (168 caps / year)		
<i>oseltamivir phosphate</i> (generic of TAMIFLU) CAPS 45mg, 75mg	3	QL
QL (84 caps / year)		
<i>oseltamivir phosphate</i> (generic of TAMIFLU) SUSR 6mg/ml	3	QL
QL (1080 mL / year)		
PAXLOVID TAB 150-100	3	QL
QL (40 tabs / 30 days)		
\$0 Cost Share		
PAXLOVID TAB 300-100	3	QL
QL (60 tabs / 30 days)		
\$0 Cost Share		
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	5	* NM PA
PREVYMIS TABS 240mg, 480mg	5	* QL PA
QL (28 tabs / 28 days)		
RELENZA DISKHALER AEPB 5mg/blister	3	QL
QL (6 inhalers / year)		

Drug Name	Drug Requirements/ Tier	Limits
ribavirin (hepatitis c) CAPS 200mg	3	NM
ribavirin (hepatitis c) TABS 200mg	4	NM
rimantadine hydrochloride TABS 100mg	4	
valacyclovir hcl (generic of VALTREX) TABS 1gm, 500mg	3	
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml	5	*
valganciclovir hcl (generic of VALCYTE) TABS 450mg	3	
VEMLIDY TABS 25mg	5	* NM
VOSEVI TAB	5	* NM PA
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
cefaclor CAPS 250mg, 500mg	3	
cefaclor SUSR 250mg/5ml	4	
CEFACLOR ER TB12 500mg	4	
cefadroxil CAPS 500mg	2	
cefadroxil SUSR 250mg/5ml, 500mg/5ml	3	
CEFAZOLIN SOLR 2gm, 3gm	4	
CEFAZOLIN INJ 1GM/50ML	4	
cefazolin sodium SOLR 1gm, 2gm, 10gm, 500mg	3	
CEFAZOLIN SOLN 2GM/100ML-4%	4	
cefdinir CAPS 300mg	2	
cefdinir SUSR 125mg/5ml, 250mg/5ml	3	
cefepime hcl SOLR 1gm, 2gm	4	
cefixime CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	4	
cefoxitin sodium SOLR 1gm, 2gm, 10gm	4	

Drug Name	Drug Requirements/ Tier	Limits
cefpodoxime proxetil SUSR 50mg/5ml, 100mg/5ml	4	
cefpodoxime proxetil TABS 100mg, 200mg	3	
cefprozil SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	3	
ceftazidime SOLR 1gm, 2gm, 6gm	4	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	4	
cefuroxime axetil TABS 250mg, 500mg	3	
cefuroxime sodium SOLR 1.5gm, 750mg	3	
cephalexin CAPS 250mg, 500mg	1	GC
cephalexin SUSR 125mg/5ml, 250mg/5ml	3	
tazicef SOLR 1gm, 2gm, 6gm	4	
TEFLARO SOLR 400mg, 600mg	5	*
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
azithromycin PACK 1gm	3	
azithromycin (generic of ZITHROMAX) SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	3	
azithromycin (generic of ZITHROMAX) TABS 250mg, 500mg	1	GC
azithromycin TABS 600mg	1	GC
clarithromycin SUSR 125mg/5ml, 250mg/5ml	4	
clarithromycin TABS 250mg, 500mg	3	
clarithromycin (generic of BIAXIN XL) TB24 500mg	4	
DIFICID SUSR 40mg/ml; TABS 200mg	5	*
e.e.s. 400 TABS 400mg	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ery-tab TBEC 250mg, 333mg, 500mg	4	
ERYTHROCIN LACTOBIONATE SOLR 500mg	4	
erythrocin stearate TABS 250mg	4	
erythromycin base CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	4	
erythromycin ethylsuccinate TABS 400mg	4	
erythromycin lactobionate (generic of ERYTHROCIN LACTOBIONATE) SOLR 500mg	4	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO SUSR 500mg/5ml	4	
ciprofloxacin 200 mg/100ml in d5w	3	
ciprofloxacin 400 mg/200ml in d5w	3	
ciprofloxacin hcl (generic of CIPRO) TABS 250mg, 500mg	1	GC
ciprofloxacin hcl TABS 750mg	1	GC
levofloxacin SOLN 25mg/ml	4	
levofloxacin TABS 250mg, 500mg, 750mg	1	GC
levofloxacin in d5w iv soln 250 mg/50ml	3	
levofloxacin in d5w iv soln 500 mg/100ml	3	
levofloxacin in d5w iv soln 750 mg/150ml	3	
moxifloxacin hcl TABS 400mg	4	
moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj	4	

Drug Name	Drug Requirements/ Tier	Limits
PENICILLINS - DRUGS TO TREAT INFECTIONS		
amoxicillin CAPS 250mg, 500mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	GC
amoxicillin CHEW 125mg, 250mg	2	
amoxicillin & k clavulanate chew tab 200-28.5 mg	4	
amoxicillin & k clavulanate chew tab 400-57 mg	4	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	3	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	4	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	3	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml (generic of AUGMENTIN ES- 600)	3	
amoxicillin & k clavulanate tab 250-125 mg	3	
amoxicillin & k clavulanate tab 500-125 mg (generic of AUGMENTIN)	2	
amoxicillin & k clavulanate tab 875-125 mg	2	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	4	
ampicillin CAPS 500mg	2	
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm (generic of UNASYN)	4	
ampicillin & sulbactam sodium for inj 3 (2-1) gm (generic of UNASYN)	4	
ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ampicillin & sulbactam sodium 4 for iv soln 3 (2-1) gm		
ampicillin & sulbactam sodium 4 for iv soln 15 (10-5) gm (generic of UNASYN BULK PACK)		
ampicillin sodium SOLR 1gm, 4 2gm, 10gm, 125mg, 250mg, 500mg		
BICILLIN L-A SUSY 4 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml		
dicloxacillin sodium CAPS 3 250mg, 500mg		
nafcillin sodium SOLR 1gm, 4 2gm		
nafcillin sodium SOLR 10gm 5 *		
oxacillin sodium SOLR 1gm, 4 2gm, 10gm		
PEN GK/DEXTR INJ 4 40000/ML		
PEN GK/DEXTR INJ 4 60000/ML		
penicillin g potassium SOLR 4 5000000unit, 20000000unit		
penicillin g sodium SOLR 4 5000000unit		
penicillin v potassium SOLR 2 125mg/5ml, 250mg/5ml		
penicillin v potassium TABS 1 GC 250mg, 500mg		
pfizerpen SOLR 5000000unit, 4 20000000unit		
piperacillin sod-tazobactam na 4 for inj 3.375 gm (3-0.375 gm)		
piperacillin sod-tazobactam 4 sod for inj 2.25 gm (2-0.25 gm)		
piperacillin sod-tazobactam 4 sod for inj 4.5 gm (4-0.5 gm)		

Drug Name	Drug Requirements/ Tier	Limits
piperacillin sod-tazobactam 4 sod for inj 13.5 gm (12-1.5 gm)		
piperacillin sod-tazobactam 4 sod for inj 40.5 gm (36-4.5 gm)		
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
doxy 100 SOLR 100mg	4	
doxycycline (monohydrate) CAPS 50mg, 100mg	2	
doxycycline (monohydrate) (generic of VIBRAMYCIN) SUSR 25mg/5ml	3	
doxycycline (monohydrate) TABS 50mg, 75mg, 100mg	3	
doxycycline hyclate CAPS 50mg; TABS 20mg, 100mg	3	
doxycycline hyclate (generic of VIBRAMYCIN) CAPS 100mg	3	
doxycycline hyclate SOLR 100mg	4	
minocycline hcl CAPS 50mg, 3 75mg, 100mg		
NUZYRA SOLR 100mg; 5 * NM LA TABS 150mg		
tetracycline hcl CAPS 250mg, 4 PA 500mg		
tigecycline (generic of TYGACIL) SOLR 50mg	5 *	
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml 5 * B/D NM LA		
carboplatin SOLN 50mg/5ml, 3 B/D 150mg/15ml, 450mg/45ml, 600mg/60ml		
cisplatin SOLN 50mg/50ml, 3 B/D 100mg/100ml, 200mg/200ml		
cyclophosphamide CAPS 3 B/D 25mg, 50mg		

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml, 500mg/ml	5	* B/D
cyclophosphamide SOLR 1gm, 500mg	4	B/D
cyclophosphamide SOLR 2gm	5	* B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	4	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	5	* B/D
GLEOSTINE CAPS 10mg, 40mg	4	NM
GLEOSTINE CAPS 100mg	5	* NM
LEUKERAN TABS 2mg	5	*
oxaliplatin SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg	4	B/D
oxaliplatin SOLR 100mg	5	* B/D
paraplatin SOLN 1000mg/100ml	3	B/D
ANTIBIOTICS		
doxorubicin hcl SOLN 2mg/ml	4	B/D
doxorubicin hcl liposomal (generic of DOXIL) INJ 2mg/ml	5	* B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	4	B/D
ANTIMETABOLITES		
azacitidine (generic of VIDAZA) SUSR 100mg	5	* B/D NM
cytarabine SOLN 20mg/ml	3	B/D
fluorouracil SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	3	B/D
gemcitabine hcl (generic of GEMCITABINE HYDROCHLORIDE) SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml	4	B/D

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
gemcitabine hcl SOLR 1gm, 2gm, 200mg	4	B/D
INQOVI TAB 35-100MG QL (5 tabs / 28 days)	5	* QL NM LA PA
LONSURF TAB 15-6.14 QL (100 tabs / 28 days)	5	* QL NM LA PA
LONSURF TAB 20-8.19 QL (80 tabs / 28 days)	5	* QL NM LA PA
mercaptopurine TABS 50mg	3	
methotrexate sodium SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	3	B/D
ONUREG TABS 200mg, 300mg	5	* QL NM LA PA
QL (14 tabs / 28 days)		
pemetrexed disodium (generic of ALIMTA) SOLR 100mg, 500mg	5	* B/D
pemetrexed disodium SOLR 750mg, 1000mg	5	* B/D
PURIXAN SUSP 2000mg/100ml	5	* NM LA
TABLOID TABS 40mg	4	
HORMONAL ANTI NEOPLASTIC AGENTS		
abiraterone acetate (generic of ZYTIGA) TABS 250mg QL (120 tabs / 30 days)	5	* QL NM PA
abiraterone acetate (generic of ZYTIGA) TABS 500mg QL (60 tabs / 30 days)	5	* QL NM PA
AKEEGA TAB 50/500MG QL (60 tabs / 30 days)	5	* QL NM LA PA
AKEEGA TAB 100/500 QL (60 tabs / 30 days)	5	* QL NM LA PA
anastrozole (generic of ARIMIDEX) TABS 1mg	2	
bicalutamide (generic of CASODEX) TABS 50mg	2	
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	4	NM PA
EMCYT CAPS 140mg	5	*

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ERLEADA TABS 60mg QL (120 tabs / 30 days)	5	* QL NM LA PA
ERLEADA TABS 240mg QL (30 tabs / 30 days)	5	* QL NM LA PA
EULEXIN CAPS 125mg	5	*
exemestane (generic of AROMASIN) TABS 25mg	4	
FIRMAGON SOLR 80mg	4	NM PA
FIRMAGON SOLR 120mg/vial	5	* NM PA
fulvestrant (generic of FASLODEX) SOSY 250mg/5ml	5	* B/D
letrozole (generic of FEMARA) TABS 2.5mg	2	
leuprolide acetate KIT 1mg/0.2ml	4	NM PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	* NM PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	* NM PA
LYSODREN TABS 500mg	5	* NM LA
megestrol acetate TABS 20mg, 40mg	3	
nilutamide (generic of NILANDRON) TABS 150mg	5	*
NUBEQA TABS 300mg QL (120 tabs / 30 days)	5	* QL NM LA PA
ORGOVYX TABS 120mg	5	* NM LA PA
ORSERDU TABS 86mg QL (90 tabs / 30 days)	5	* QL NM LA PA
ORSERDU TABS 345mg QL (30 tabs / 30 days)	5	* QL NM LA PA
SOLTAMOX SOLN 10mg/5ml	5	*
tamoxifen citrate TABS 10mg, 20mg	2	
toremifene citrate (generic of FARESTON) TABS 60mg	4	
XTANDI CAPS 40mg QL (120 caps / 30 days)	5	* QL NM LA PA
XTANDI TABS 40mg QL (120 tabs / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
XTANDI TABS 80mg QL (60 tabs / 30 days)	5	* QL NM LA PA
IMMUNOMODULATORS		
lenalidomide CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	5	* QL NM LA PA
lenalidomide CAPS 20mg, 25mg QL (21 caps / 28 days)	5	* QL NM LA PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg QL (21 caps / 28 days)	5	* QL NM LA PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	5	* QL NM LA PA
REVLIMID CAPS 20mg, 25mg QL (21 caps / 28 days)	5	* QL NM LA PA
THALOMID CAPS 50mg, 100mg QL (28 caps / 28 days)	5	* QL NM LA PA
THALOMID CAPS 150mg, 200mg QL (56 caps / 28 days)	5	* QL NM LA PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml QL (2 syringes / 28 days)	5	* QL NM LA PA
bexarotene (generic of TARGRETIN) CAPS 75mg QL (300 caps / 30 days)	5	* QL NM PA
hydroxyurea (generic of HYDREA) CAPS 500mg	2	
irinotecan hcl (generic of CAMPTOSAR) SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml	4	B/D
irinotecan hcl SOLN 500mg/25ml	4	B/D
IWLIFIN TABS 192mg QL (240 tabs / 30 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
KISQALI 200 PAK FEMARA QL (49 tabs / 28 days)	5	* QL NM PA
KISQALI 400 PAK FEMARA QL (70 tabs / 28 days)	5	* QL NM PA
KISQALI 600 PAK FEMARA QL (91 tabs / 28 days)	5	* QL NM PA
MATULANE CAPS 50mg <i>tretinoin (chemotherapy)</i>	5	* NM LA
CAPS 10mg	5	*
WELIREG TABS 40mg QL (90 tabs / 30 days)	5	* QL NM LA PA
MITOTIC INHIBITORS		
docetaxel (generic of DOCETAXEL) CONC 20mg/ml	4	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	* B/D
docetaxel (generic of DOCETAXEL) CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	* B/D
etoposide SOLN 1gm/50ml, 100mg/5ml, 500mg/25ml	3	B/D
paclitaxel CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	4	B/D
paclitaxel protein-bound particles for iv susp 100 mg	5	* B/D NM
vincristine sulfate SOLN 1mg/ml	2	B/D
vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml	4	B/D
MOLECULAR TARGET AGENTS		
ALECENSA CAPS 150mg QL (240 caps / 30 days)	5	* QL NM LA PA
ALUNBRIG TABS 30mg QL (120 tabs / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ALUNBRIG TABS 90mg, 180mg QL (30 tabs / 30 days)	5	* QL NM LA PA
ALUNBRIG PAK QL (30 tabs / 30 days)	5	* QL NM LA PA
AUGTYRO CAPS 40mg QL (240 caps / 30 days)	5	* QL NM LA PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg QL (30 tabs / 30 days)	5	* QL NM LA PA
BALVERSA TABS 3mg QL (84 tabs / 28 days)	5	* QL NM LA PA
BALVERSA TABS 4mg QL (56 tabs / 28 days)	5	* QL NM LA PA
BALVERSA TABS 5mg QL (28 tabs / 28 days)	5	* QL NM LA PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	5	* NM PA
bortezomib (generic of VELCADE) SOLR 3.5mg	5	* NM PA
BOSULIF CAPS 50mg QL (360 caps / 30 days)	5	* QL NM PA
BOSULIF CAPS 100mg QL (150 caps / 25 days)	5	* QL NM PA
BOSULIF TABS 100mg QL (180 tabs / 30 days)	5	* QL NM PA
BOSULIF TABS 400mg, 500mg QL (30 tabs / 30 days)	5	* QL NM PA
BRAFTOVI CAPS 75mg QL (180 caps / 30 days)	5	* QL NM LA PA
BRUKINSA CAPS 80mg QL (120 caps / 30 days)	5	* QL NM LA PA
CABOMETYX TABS 20mg, 40mg, 60mg QL (30 tabs / 30 days)	5	* QL NM LA PA
CALQUENCE CAPS 100mg QL (60 caps / 30 days)	5	* QL NM LA PA
CALQUENCE TABS 100mg QL (60 tabs / 30 days)	5	* QL NM LA PA
CAPRELSA TABS 100mg QL (60 tabs / 30 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
CAPRELSA TABS 300mg QL (30 tabs / 30 days)	5	* QL NM LA PA
COMETRIQ (60MG DOSE) KIT 20mg QL (84 caps / 28 days)	5	* QL NM LA PA
COMETRIQ KIT 100MG QL (56 caps / 28 days)	5	* QL NM LA PA
COMETRIQ KIT 140MG QL (112 caps / 28 days)	5	* QL NM LA PA
COPIKTRA CAPS 15mg, 25mg QL (56 caps / 28 days)	5	* QL NM LA PA
COTELLIC TABS 20mg QL (63 tabs / 28 days)	5	* QL NM LA PA
DAURISMO TABS 25mg QL (60 tabs / 30 days)	5	* QL NM LA PA
DAURISMO TABS 100mg QL (30 tabs / 30 days)	5	* QL NM LA PA
ERIVEDGE CAPS 150mg QL (30 caps / 30 days)	5	* QL NM LA PA
erlotinib hcl (generic of TARCEVA) TABS 25mg QL (90 tabs / 30 days)	5	* QL NM PA
erlotinib hcl (generic of TARCEVA) TABS 100mg, 150mg QL (30 tabs / 30 days)	5	* QL NM PA
everolimus (generic of AFINITOR) TABS 2.5mg, 5mg, 7.5mg, 10mg QL (30 tabs / 30 days)	5	* QL NM PA
everolimus (generic of AFINITOR DISPERZ) TBSO 2mg QL (150 tabs / 30 days)	5	* QL NM PA
everolimus (generic of AFINITOR DISPERZ) TBSO 3mg QL (90 tabs / 30 days)	5	* QL NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
everolimus (generic of AFINITOR DISPERZ) TBSO 5mg QL (60 tabs / 30 days)	5	* QL NM PA
EXKIVITY CAPS 40mg QL (120 caps / 30 days)	5	* QL NM LA PA
FOTIVDA CAPS .89mg, 1.34mg QL (21 caps / 28 days)	5	* QL NM LA PA
FRUZAQLA CAPS 1mg QL (84 caps / 28 days)	5	* QL NM LA PA
FRUZAQLA CAPS 5mg QL (21 caps / 28 days)	5	* QL NM LA PA
GAVRETO CAPS 100mg QL (120 caps / 30 days)	5	* QL NM LA PA
gefitinib (generic of IRESSA) TABS 250mg QL (30 tabs / 30 days)	5	* QL NM PA
GILOTRIF TABS 20mg, 30mg, 40mg QL (30 tabs / 30 days)	5	* QL NM LA PA
HERCEP HYLEC SOL 60- 10000	5	* NM LA PA
HERCEPTIN SOLR 150mg	5	* NM LA PA
HERZUMA SOLR 150mg, 420mg	5	* NM PA
IBRANCE CAPS 75mg, 100mg, 125mg QL (21 caps / 28 days)	5	* QL NM LA PA
IBRANCE TABS 75mg, 100mg, 125mg QL (21 tabs / 28 days)	5	* QL NM LA PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg QL (30 tabs / 30 days)	5	* QL NM LA PA
IDHIFA TABS 50mg, 100mg QL (30 tabs / 30 days)	5	* QL NM LA PA
imatinib mesylate (generic of GLEEVEC) TABS 100mg QL (90 tabs / 30 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>imatinib mesylate</i> (generic of GLEEVEC) TABS 400mg QL (60 tabs / 30 days)	5	* QL NM PA
IMBRUVICA CAPS 70mg QL (30 caps / 30 days)	5	* QL NM LA PA
IMBRUVICA CAPS 140mg QL (120 caps / 30 days)	5	* QL NM LA PA
IMBRUVICA SUSP 70mg/ml QL (216 mL / 27 days)	5	* QL NM LA PA
IMBRUVICA TABS 140mg, 280mg, 420mg QL (30 tabs / 30 days)	5	* QL NM LA PA
INLYTA TABS 1mg QL (180 tabs / 30 days)	5	* QL NM LA PA
INLYTA TABS 5mg QL (120 tabs / 30 days)	5	* QL NM LA PA
INREBIC CAPS 100mg QL (120 caps / 30 days)	5	* QL NM LA PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg QL (60 tabs / 30 days)	5	* QL NM LA PA
JAYPIRCA TABS 50mg QL (30 tabs / 30 days)	5	* QL NM LA PA
JAYPIRCA TABS 100mg QL (60 tabs / 30 days)	5	* QL NM LA PA
KADCYLA SOLR 100mg, 160mg	5	* B/D NM LA
KANJINTI SOLR 150mg, 420mg	5	* NM LA PA
KEYTRUDA SOLN 100mg/4ml	5	* NM LA PA
KISQALI 200 DOSE TBPK 200mg QL (21 tabs / 28 days)	5	* QL NM PA
KISQALI 400 DOSE TBPK 200mg QL (42 tabs / 28 days)	5	* QL NM PA
KISQALI 600 DOSE TBPK 200mg QL (63 tabs / 28 days)	5	* QL NM PA
KOSELUGO CAPS 10mg QL (240 caps / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
KOSELUGO CAPS 25mg QL (120 caps / 30 days)	5	* QL NM LA PA
KRAZATI TABS 200mg QL (180 tabs / 30 days)	5	* QL NM LA PA
<i>lapatinib ditosylate</i> (generic of TYKERB) TABS 250mg QL (180 tabs / 30 days)	5	* QL NM PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg QL (30 caps / 30 days)	5	* QL NM LA PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg QL (60 caps / 30 days)	5	* QL NM LA PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg QL (30 caps / 30 days)	5	* QL NM LA PA
LENVIMA 12MG DAILY DOSE CPPK 4mg QL (90 caps / 30 days)	5	* QL NM LA PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg QL (60 caps / 30 days)	5	* QL NM LA PA
LENVIMA CAP 14 MG QL (60 caps / 30 days)	5	* QL NM LA PA
LENVIMA CAP 18 MG QL (90 caps / 30 days)	5	* QL NM LA PA
LENVIMA CAP 24 MG QL (90 caps / 30 days)	5	* QL NM LA PA
LORBRENA TABS 25mg QL (90 tabs / 30 days)	5	* QL NM LA PA
LORBRENA TABS 100mg QL (30 tabs / 30 days)	5	* QL NM LA PA
LUMAKRAS TABS 120mg QL (240 tabs / 30 days)	5	* QL NM LA PA
LUMAKRAS TABS 320mg QL (90 tabs / 30 days)	5	* QL NM LA PA
LYNPARZA TABS 100mg, 150mg QL (120 tabs / 30 days)	5	* QL NM LA PA
LYTGOBI (12 MG DAILY DOSE) TBPK 4mg QL (84 tabs / 28 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
LYTGOBI (16 MG DAILY DOSE) TBPK 4mg QL (112 tabs / 28 days)	5	* QL NM LA PA
LYTGOBI (20 MG DAILY DOSE) TBPK 4mg QL (140 tabs / 28 days)	5	* QL NM LA PA
MEKINIST SOLR .05mg/ml QL (1260 mL / 30 days)	5	* QL NM LA PA
MEKINIST TABS 2mg QL (30 tabs / 30 days)	5	* QL NM LA PA
MEKINIST TABS .5mg QL (90 tabs / 30 days)	5	* QL NM LA PA
MEKTOVI TABS 15mg QL (180 tabs / 30 days)	5	* QL NM LA PA
MONJUVI SOLR 200mg	5	* NM LA PA
NERLYNX TABS 40mg QL (180 tabs / 30 days)	5	* QL NM LA PA
NEXAVAR TABS 200mg QL (120 tabs / 30 days)	5	* QL NM LA PA
NINLARO CAPS 2.3mg, 3mg, 4mg QL (3 caps / 28 days)	5	* QL NM PA
ODOMZO CAPS 200mg QL (30 caps / 30 days)	5	* QL NM LA PA
OGIVRI SOLR 150mg	5	* NM LA PA
OGIVRI INJ 420MG	5	* NM LA PA
OGSIVEO TABS 50mg QL (180 tabs / 30 days)	5	* QL NM LA PA
OJJAARA TABS 100mg, 150mg, 200mg QL (30 tabs / 30 days)	5	* QL NM LA PA
ONTRUZANT SOLR 150mg, 420mg	5	* NM LA PA
pazopanib hcl (generic of VOTRIENT) TABS 200mg QL (120 tabs / 30 days)	5	* QL NM PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg QL (28 tabs / 28 days)	5	* QL NM LA PA
PHESGO SOL	5	* NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
PIQRAY 200MG DAILY DOSE TBPK 200mg QL (28 tabs / 28 days)	5	* QL NM PA
PIQRAY 250MG TAB DOSE QL (56 tabs / 28 days)	5	* QL NM PA
PIQRAY 300MG DAILY DOSE TBPK 150mg QL (56 tabs / 28 days)	5	* QL NM PA
QINLOCK TABS 50mg QL (90 tabs / 30 days)	5	* QL NM LA PA
RETEVMO CAPS 40mg QL (180 caps / 30 days)	5	* QL NM LA PA
RETEVMO CAPS 80mg QL (120 caps / 30 days)	5	* QL NM LA PA
REZLIDHIA CAPS 150mg QL (60 caps / 30 days)	5	* QL NM LA PA
ROZLYTREK CAPS 100mg QL (150 caps / 30 days)	5	* QL NM LA PA
ROZLYTREK CAPS 200mg QL (90 caps / 30 days)	5	* QL NM LA PA
ROZLYTREK PACK 50mg QL (336 packets / 28 days)	5	* QL NM LA PA
RUBRACA TABS 200mg, 250mg, 300mg QL (120 tabs / 30 days)	5	* QL NM LA PA
RYDAPT CAPS 25mg QL (224 caps / 28 days)	5	* QL NM PA
SCEMBLIX TABS 20mg QL (60 tabs / 30 days)	5	* QL NM PA
SCEMBLIX TABS 40mg QL (300 tabs / 30 days)	5	* QL NM PA
sorafenib tosylate (generic of NEXAVAR) TABS 200mg QL (120 tabs / 30 days)	5	* QL NM PA
SPRYCEL TABS 20mg QL (90 tabs / 30 days)	5	* QL NM PA
SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg QL (30 tabs / 30 days)	5	* QL NM PA
STIVARGA TABS 40mg QL (84 tabs / 28 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
sunitinib malate (generic of SUTENT) CAPS 12.5mg, 25mg, 37.5mg, 50mg QL (30 caps / 30 days)	5	* QL NM PA
TABRECTA TABS 150mg, 200mg QL (112 tabs / 28 days)	5	* QL NM PA
TAFINLAR CAPS 50mg, 75mg QL (120 caps / 30 days)	5	* QL NM LA PA
TAFINLAR TBSO 10mg QL (900 tabs / 30 days)	5	* QL NM LA PA
TAGRISSO TABS 40mg, 80mg QL (30 tabs / 30 days)	5	* QL NM LA PA
TALZENNA CAPS .1mg, .35mg, .5mg, .75mg, 1mg QL (30 caps / 30 days)	5	* QL NM LA PA
TALZENNA CAPS .25mg QL (90 caps / 30 days)	5	* QL NM LA PA
TASIGNA CAPS 50mg QL (120 caps / 30 days)	5	* QL NM PA
TASIGNA CAPS 150mg, 200mg QL (112 caps / 28 days)	5	* QL NM PA
TAZVERIK TABS 200mg QL (240 tabs / 30 days)	5	* QL NM LA PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	* NM LA PA
TEPMETKO TABS 225mg QL (60 tabs / 30 days)	5	* QL NM LA PA
TIBSOVO TABS 250mg QL (60 tabs / 30 days)	5	* QL NM LA PA
TRAZIMERA SOLR 150mg, 420mg	5	* NM PA
TRUQAP TABS 160mg, 200mg QL (64 tabs / 28 days)	5	* QL NM LA PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	* NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
TUKYSA TABS 50mg, 150mg QL (120 tabs / 30 days)	5	* QL NM LA PA
TURALIO CAPS 125mg QL (120 caps / 30 days)	5	* QL NM LA PA
VANFLYTA TABS 17.7mg, 26.5mg QL (56 tabs / 28 days)	5	* QL NM LA PA
VENCLEXTA TABS 10mg QL (112 tabs / 28 days)	4	QL NM LA PA
VENCLEXTA TABS 50mg QL (112 tabs / 28 days)	5	* QL NM LA PA
VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	5	* QL NM LA PA
VENCLEXTA TAB START PK QL (42 tabs / 28 days)	5	* QL NM LA PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	5	* QL NM LA PA
VITRAKVI CAPS 25mg QL (180 caps / 30 days)	5	* QL NM LA PA
VITRAKVI CAPS 100mg QL (60 caps / 30 days)	5	* QL NM LA PA
VITRAKVI SOLN 20mg/ml QL (300 mL / 30 days)	5	* QL NM LA PA
VIZIMPRO TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	5	* QL NM LA PA
VONJO CAPS 100mg QL (120 caps / 30 days)	5	* QL NM LA PA
VOTRIENT TABS 200mg QL (120 tabs / 30 days)	5	* QL NM LA PA
XALKORI CAPS 200mg, 250mg; CPSP 50mg QL (120 caps / 30 days)	5	* QL NM LA PA
XALKORI CPSP 20mg QL (240 caps / 30 days)	5	* QL NM LA PA
XALKORI CPSP 150mg QL (180 caps / 30 days)	5	* QL NM LA PA
XOSPATA TABS 40mg QL (90 tabs / 30 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg QL (4 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg QL (4 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg QL (24 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg QL (32 tabs / 28 days)	5	* QL NM LA PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg QL (8 tabs / 28 days)	5	* QL NM LA PA
ZEJULA CAPS 100mg QL (90 caps / 30 days)	5	* QL NM LA PA
ZEJULA TABS 100mg, 200mg, 300mg QL (30 tabs / 30 days)	5	* QL NM LA PA
ZELBORAF TABS 240mg QL (240 tabs / 30 days)	5	* QL NM LA PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	* NM LA PA
ZOLINZA CAPS 100mg QL (120 caps / 30 days)	5	* QL NM PA
ZYDELIG TABS 100mg, 150mg QL (60 tabs / 30 days)	5	* QL NM LA PA
ZYKADIA TABS 150mg QL (84 tabs / 28 days)	5	* QL NM LA PA
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	4	B/D

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
leucovorin calcium TABS 5mg, 10mg, 15mg, 25mg	3	
MESNEX TABS 400mg	5	*
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
amlodipine besylate- benazepril hcl cap 2.5-10 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 5-10 mg (generic of LOTREL) QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 5-40 mg QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days)	1	GC QL
amlodipine besylate- benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days)	1	GC QL
benazepril & hydrochlorothiazide tab 5- 6.25mg	1	GC
benazepril & hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT)	1	GC
benazepril & hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT)	1	GC

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
benazepril & hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT)	1	GC
captopril & hydrochlorothiazide tab 25-15 mg	1	GC
captopril & hydrochlorothiazide tab 25-25 mg	1	GC
captopril & hydrochlorothiazide tab 50-15 mg	1	GC
captopril & hydrochlorothiazide tab 50-25 mg	1	GC
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	GC
enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)	1	GC
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	GC
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	1	GC
lisinopril & hydrochlorothiazide 1 tab 10-12.5 mg (generic of ZESTORETIC)	1	GC
lisinopril & hydrochlorothiazide 1 tab 20-12.5 mg (generic of ZESTORETIC)	1	GC
lisinopril & hydrochlorothiazide 1 tab 20-25 mg (generic of ZESTORETIC)	1	GC
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
benazepril hcl TABS 5mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
benazepril hcl (generic of LOTENSIN) TABS 10mg, 20mg, 40mg	1	GC
captopril TABS 12.5mg, 25mg, 50mg, 100mg	1	GC
enalapril maleate (generic of VASOTEC) TABS 2.5mg, 5mg, 10mg, 20mg	1	GC
fosinopril sodium TABS 10mg, 20mg, 40mg	1	GC
lisinopril (generic of ZESTRIL) TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	GC
moexipril hcl TABS 7.5mg, 15mg	1	GC
perindopril erbumine TABS 2mg, 4mg, 8mg	1	GC
quinapril hcl (generic of ACCUPRIL) TABS 5mg, 10mg, 20mg, 40mg	1	GC
ramipril (generic of ALTACE) CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	GC
trandolapril TABS 1mg, 2mg, 4mg	1	GC
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
eplerenone (generic of INSPRA) TABS 25mg, 50mg	3	
KERENDIA TABS 10mg, 20mg	3	QL
QL (30 tabs / 30 days)		
spironolactone (generic of ALDACTONE) TABS 25mg, 50mg, 100mg	1	GC
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
doxazosin mesylate (generic of CARDURA) TABS 1mg, 2mg, 4mg, 8mg	2	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>prazosin hcl</i> (generic of MINIPRESS) CAPS 1mg, 2mg, 5mg	3	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	1	GC
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>amlodipine besylate-</i> 1 <i>olmesartan medoxomil tab 5-</i> 20 mg (generic of AZOR) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-</i> 1 <i>olmesartan medoxomil tab 5-</i> 40 mg (generic of AZOR) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-</i> 1 <i>olmesartan medoxomil tab 10-</i> 20 mg (generic of AZOR) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-</i> 1 <i>olmesartan medoxomil tab 10-</i> 40 mg (generic of AZOR) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-valsartan</i> 1 tab 5-160 mg (generic of EXFORGE) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-valsartan</i> 1 tab 5-320 mg (generic of EXFORGE) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-valsartan</i> 1 tab 10-160 mg (generic of EXFORGE) QL (30 tabs / 30 days)	1	GC QL
<i>amlodipine besylate-valsartan</i> 1 tab 10-320 mg (generic of EXFORGE) QL (30 tabs / 30 days)	1	GC QL
ENTRESTO TAB 24-26MG QL (60 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
ENTRESTO TAB 49-51MG QL (60 tabs / 30 days)	3	QL
ENTRESTO TAB 97-103MG QL (60 tabs / 30 days)	3	QL
<i>irbesartan-hydrochlorothiazide</i> 1 tab 150-12.5 mg (generic of AVALIDE) QL (60 tabs / 30 days)	1	GC QL
<i>irbesartan-hydrochlorothiazide</i> 1 tab 300-12.5 mg (generic of AVALIDE) QL (30 tabs / 30 days)	1	GC QL
<i>losartan potassium &</i> <i>hydrochlorothiazide tab 50-</i> 12.5 mg (generic of HYZAAR)	1	GC
<i>losartan potassium &</i> <i>hydrochlorothiazide tab 100-</i> 12.5 mg (generic of HYZAAR)	1	GC
<i>losartan potassium &</i> <i>hydrochlorothiazide tab 100-</i> 25 mg (generic of HYZAAR)	1	GC
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 20-</i> 12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	GC QL
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-</i> 12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	GC QL
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-25</i> mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	1	GC QL
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 20-5-</i> 12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	GC 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	GC QL
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg (generic of TRIBENZOR) QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 80-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 160-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 160-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	GC QL
valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	GC 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	GC QL
candesartan cilexetil (generic of ATACAND) TABS 32mg QL (30 tabs / 30 days)	1	GC QL
irbesartan (generic of AVAPRO) TABS 75mg, 150mg, 300mg QL (30 tabs / 30 days)	1	GC QL
losartan potassium (generic of COZAAR) TABS 25mg, 50mg, 100mg QL (60 tabs / 30 days)	1	GC
olmesartan medoxomil (generic of BENICAR) TABS 5mg QL (60 tabs / 30 days)	1	GC QL
olmesartan medoxomil (generic of BENICAR) TABS 20mg, 40mg QL (30 tabs / 30 days)	1	GC QL
telmisartan (generic of MICARDIS) TABS 20mg, 40mg, 80mg QL (30 tabs / 30 days)	1	GC QL
valsartan (generic of DIOVAN) TABS 40mg, 80mg, 160mg QL (60 tabs / 30 days)	1	GC QL
valsartan (generic of DIOVAN) TABS 320mg QL (30 tabs / 30 days)	1	GC QL
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg QL (200mg / 30 days)	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>disopyramide phosphate</i> (generic of NORPACE) CAPS 100mg, 150mg	4	
<i>dofetilide</i> (generic of TIKOSYN) CAPS 125mcg, 250mcg, 500mcg	4	NM
<i>flecainide acetate</i> TABS 50mg, 100mg, 150mg	3	
MULTAQ TABS 400mg	4	
NORPACE CR CP12 100mg, 150mg	4	
<i>pacerone</i> TABS 100mg, 400mg	4	
<i>pacerone</i> TABS 200mg	1	GC
<i>propafenone hcl</i> CP12 225mg, 325mg, 425mg	4	
<i>propafenone hcl</i> TABS 150mg, 225mg, 300mg	3	
<i>quinidine sulfate</i> TABS 200mg, 300mg	3	
<i>sorine</i> (generic of BETAPACE) TABS 80mg, 120mg, 160mg	2	
<i>sorine</i> TABS 240mg	2	
<i>sotalol hcl</i> (generic of BETAPACE) TABS 80mg, 120mg, 160mg	2	
<i>sotalol hcl</i> TABS 240mg	2	
<i>sotalol hcl (afib/afl)</i> (generic of BETAPACE AF) TABS 80mg, 120mg, 160mg	3	
ANTILIPEMICS, FIBRATES		
<i>fenofibrate</i> (generic of TRICOR) TABS 48mg, 145mg	2	
<i>fenofibrate</i> TABS 54mg, 160mg	2	
<i>fenofibrate micronized</i> CAPS 67mg, 134mg, 200mg	3	
<i>gemfibrozil</i> (generic of LOPID) TABS 600mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>atorvastatin calcium</i> (generic of LIPITOR) TABS 10mg, 20mg, 40mg, 80mg	1	GC QL QL (30 tabs / 30 days)
<i>lovastatin</i> TABS 10mg, 20mg, 40mg	1	GC QL QL (60 tabs / 30 days)
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg	1	GC QL QL (30 tabs / 30 days)
<i>rosuvastatin calcium</i> (generic of CRESTOR) TABS 5mg, 10mg, 20mg, 40mg	1	GC QL QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 80mg	1	GC QL QL (30 tabs / 30 days)
<i>simvastatin</i> (generic of ZOCOR) TABS 10mg, 20mg, 40mg	1	GC QL QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>cholestyramine</i> (generic of QUESTRAN) PACK 4gm; POWD 4gm/dose	3	
<i>cholestyramine light</i> PACK 4gm	3	
<i>cholestyramine light</i> (generic of QUESTRAN LIGHT) POWD 4gm/dose	3	
<i>colesevelam hcl</i> (generic of WELCHOL) PACK 3.75gm; TABS 625mg	4	
<i>colestipol hcl</i> (generic of COLESTID) GRAN 5gm; PACK 5gm	4	
<i>colestipol hcl</i> (generic of COLESTID) TABS 1gm	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ezetimibe (generic of ZETIA) TABS 10mg	3	
ezetimibe-simvastatin tab 10- 10 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	GC QL
ezetimibe-simvastatin tab 10- 20 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	GC QL
ezetimibe-simvastatin tab 10- 40 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	GC QL
ezetimibe-simvastatin tab 10- 80 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	GC QL
niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg QL (60 tabs / 30 days)	3	QL
omega-3-acid ethyl esters cap 1 gm (generic of LOVAZA)	3	PA
prevalte PACK 4gm	3	
prevalte (generic of QUESTRAN LIGHT) POWD 4gm/dose	3	
REPATHA SOSY 140mg/ml	3	NM PA
REPATHA PUSHTRONEX	3	NM PA
SYSTEM SOCT 420mg/3.5ml		
REPATHA SURECLICK SOAJ 140mg/ml	3	NM PA
VASCEPA CAPS .5gm, 1gm	3	
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
atenolol & chlorthalidone tab 50-25 mg (generic of TENORETIC 50)	2	
atenolol & chlorthalidone tab 100-25 mg (generic of TENORETIC 100)	2	

Drug Name	Drug Requirements/ Tier	Limits
bisoprolol & hydrochlorothiazide tab 2.5- 6.25 mg	2	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	2	
bisoprolol & hydrochlorothiazide tab 10- 6.25 mg	2	
metoprolol & hydrochlorothiazide tab 50-25 mg	3	
metoprolol & hydrochlorothiazide tab 100- 25 mg	3	
metoprolol & hydrochlorothiazide tab 100- 50 mg	3	
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
acebutolol hcl CAPS 200mg, 400mg	3	
atenolol (generic of TENORMIN) TABS 25mg, 50mg, 100mg	1	GC
bisoprolol fumarate TABS 5mg, 10mg	2	
carvedilol (generic of COREG) TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	GC
labetalol hcl TABS 100mg, 200mg, 300mg	3	
metoprolol succinate (generic of TOPROL XL) TB24 25mg, 50mg, 100mg, 200mg	2	
metoprolol tartrate SOLN 5mg/5ml	4	
metoprolol tartrate TABS 25mg	1	GC

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>metoprolol tartrate</i> (generic of LOPRESSOR) TABS 50mg, 100mg	1	GC
<i>nadolol</i> (generic of CORGARD) TABS 20mg, 40mg	3	
<i>nadolol</i> TABS 80mg	3	
<i>nebivolol hcl</i> (generic of BYSTOLIC) TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	3	QL
<i>nebivolol hcl</i> (generic of BYSTOLIC) TABS 20mg QL (60 tabs / 30 days)	3	QL
<i>pindolol</i> TABS 5mg, 10mg	3	
<i>propranolol hcl</i> (generic of Inderal LA) CP24 60mg, 80mg, 120mg, 160mg	3	
<i>propranolol hcl</i> SOLN 20mg/5ml, 40mg/5ml	3	
<i>propranolol hcl</i> TABS 10mg, 20mg, 40mg, 60mg, 80mg	2	
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	3	
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	GC
<i>cartia xt</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	2	
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	3	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg	4	
<i>diltiazem hcl</i> SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	3	

Drug Name	Drug Requirements/ Tier	Limits
<i>diltiazem hcl</i> (generic of CARDIZEM) TABS 30mg, 60mg, 120mg	2	
<i>diltiazem hcl</i> TABS 90mg	2	
<i>diltiazem hcl coated beads</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	2	
<i>diltiazem hcl coated beads</i> (generic of CARDIZEM CD) CP24 360mg	4	
<i>diltiazem hcl extended release beads</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	2	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	4	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	3	
<i>nifedipine</i> (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	3	
<i>nimodipine</i> CAPS 30mg	4	
<i>NYMALIZE</i> SOLN 6mg/ml	5	*
<i>taztia xt</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg	2	
<i>tiadylt er</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>verapamil hcl</i> CP24 100mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml	4	
<i>verapamil hcl</i> (generic of VERELAN) CP24 120mg, 180mg, 240mg	3	
<i>verapamil hcl</i> TABS 40mg, 80mg, 120mg	1	GC
<i>verapamil hcl</i> TBCR 120mg, 180mg, 240mg	2	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
acetazolamide CP12 500mg	4	
acetazolamide TABS 125mg, 3 250mg	3	
amiloride & hydrochlorothiazide tab 5-50 mg	2	
amiloride hcl TABS 5mg	2	
bumetanide SOLN .25mg/ml; 3 TABS 1mg, 2mg	3	
bumetanide (generic of BUMEX) TABS .5mg	3	
chlorthalidone TABS 25mg, 50mg	2	
furosemide SOLN 10mg/ml, 40mg/5ml	2	
furosemide (generic of LASIX) 1 TABS 20mg, 40mg, 80mg	1	GC
furosemide inj SOLN 10mg/ml	3	
hydrochlorothiazide CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	GC
indapamide TABS 1.25mg, 2.5mg	1	GC
methazolamide TABS 25mg, 50mg	4	
metolazone TABS 2.5mg, 5mg, 10mg	3	
spironolactone & hydrochlorothiazide tab 25-25 mg	3	
torsemide TABS 5mg, 10mg, 20mg, 100mg	2	
triamterene & hydrochlorothiazide cap 37.5- 25 mg	1	GC
triamterene & hydrochlorothiazide tab 37.5- 25 mg	1	GC

Drug Name	Drug Requirements/ Tier	Limits
triamterene & hydrochlorothiazide tab 75-50 mg (generic of MAXZIDE)	1	GC
MISCELLANEOUS		
aliskiren fumarate (generic of TEKTURNA) TABS 150mg, 300mg	1	GC
clonidine (generic of CATAPRES-TTS-1) PTWK .1mg/24hr	3	
clonidine (generic of CATAPRES-TTS-2) PTWK .2mg/24hr	3	
clonidine (generic of CATAPRES-TTS-3) PTWK .3mg/24hr	3	
clonidine hcl TABS .1mg, .2mg, .3mg	1	GC
CORLANOR SOLN 5mg/5ml QL (450 mL / 30 days)	4	QL
CORLANOR TABS 5mg, 7.5mg QL (60 tabs / 30 days)	4	QL
digoxin SOLN .05mg/ml	4	
digoxin (generic of LANOXIN) SOLN .25mg/ml	4	
digoxin (generic of LANOXIN) TABS 125mcg, 250mcg QL (30 tabs / 30 days)	2	QL
droxidopa (generic of NORTHERA) CAPS 100mg QL (90 caps / 30 days)	5	* QL NM PA
droxidopa (generic of NORTHERA) CAPS 200mg, 300mg QL (180 caps / 30 days)	5	* QL NM PA
epinephrine (anaphylaxis) SOLN 1mg/ml	4	
guanfacine hcl TABS 1mg, 2mg PA if 70 years and older	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
hydralazine hcl SOLN 20mg/ml	4	
hydralazine hcl TABS 10mg, 25mg, 50mg, 100mg	2	
metyrosine (generic of DEMSER) CAPS 250mg	5	* PA
midodrine hcl TABS 2.5mg, 5mg	3	
midodrine hcl TABS 10mg	4	
minoxidil TABS 2.5mg, 10mg	2	
ranolazine TB12 500mg, 1000mg	4	
VERQUVO TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	3	QL

NITRATES - DRUGS TO TREAT HEART CONDITIONS

isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg	3	
isosorbide dinitrate TABS 10mg, 20mg, 30mg	3	
isosorbide mononitrate TABS 10mg, 20mg	2	
isosorbide mononitrate TB24 30mg, 60mg, 120mg	1	GC
NITRO-BID OINT 2%	3	
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	3	
nitroglycerin (generic of NITROSTAT) SUBL .3mg, .4mg, .6mg	3	

PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION

ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg QL (90 tabs / 30 days)	5	* QL NM LA PA
ambrisentan (generic of LETAIRIS) TABS 5mg, 10mg QL (30 tabs / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Limits
bosentan (generic of TRACLEER) TABS 62.5mg, 125mg QL (60 tabs / 30 days)	5	* QL NM LA PA
OPSUMIT TABS 10mg QL (30 tabs / 30 days)	5	* QL NM LA PA
sildenafil citrate (pulmonary hypertension) (generic of REVATIO) TABS 20mg QL (360 tabs / 30 days)	3	QL NM PA
treprostinil SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	* NM LA PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	* 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)	2	QL
buspirone hcl TABS 5mg, 10mg, 15mg	1	GC
buspirone hcl TABS 7.5mg, 30mg	3	
fluvoxamine maleate TABS 25mg, 50mg, 100mg	3	
lorazepam CONC 2mg/ml QL (150 mL / 30 days)	3	QL
lorazepam (generic of ATIVAN) SOLN 2mg/ml, 4mg/ml	2	
lorazepam (generic of ATIVAN) TABS .5mg, 1mg, 2mg QL (150 tabs / 30 days)	2	QL
lorazepam intensol CONC 2mg/ml QL (150 mL / 30 days)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride (generic of ARICEPT) TABS 5mg	2	QL QL (30 tabs / 30 days)
donepezil hydrochloride (generic of ARICEPT) TABS 10mg	2	
donepezil hydrochloride TBDP 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TBDP 10mg	2	
galantamine hydrobromide CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)	3	QL
galantamine hydrobromide SOLN 4mg/ml QL (200 mL / 30 days)	4	QL
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)	3	QL
memantine hcl CP24 7mg; SOLN 2mg/ml PA applies if 29 years and younger	4	PA
memantine hcl (generic of NAMENDA XR) CP24 14mg, 21mg, 28mg PA applies if 29 years and younger	4	PA
memantine hcl TABS 5mg, 10mg PA applies if 29 years and younger	3	PA
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	
NAMZARIC CAP PACK	4	
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
rivastigmine (generic of EXELON) PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	4	QL
rivastigmine tartrate CAPS 1.5mg, 3mg, 4.5mg, 6mg QL (60 caps / 30 days)	3	QL
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	
amoxapine TABS 25mg, 50mg, 100mg, 150mg	3	
AUVELITY TAB 45-105MG QL (60 tabs / 30 days)	4	QL PA
bupropion hcl TABS 75mg, 100mg	3	
bupropion hcl (generic of WELLBUTRIN SR) TB12 100mg, 150mg, 200mg QL (60 tabs / 30 days)	3	QL
bupropion hcl (generic of WELLBUTRIN XL) TB24 150mg QL (60 tabs / 30 days)	3	QL
bupropion hcl (generic of WELLBUTRIN XL) TB24 300mg QL (30 tabs / 30 days)	3	QL
citalopram hydrobromide SOLN 10mg/5ml	3	
citalopram hydrobromide (generic of CELEXA) TABS 10mg, 20mg, 40mg	1	GC
clomipramine hcl (generic of ANAFRANIL) CAPS 25mg, 50mg, 75mg	4	PA
desipramine hcl (generic of NORPRAMIN) TABS 10mg, 25mg	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>desipramine hcl</i> TABS 50mg, 4 75mg, 100mg, 150mg		
<i>desvenlafaxine succinate</i> 4 QL PA (generic of PRISTIQ) TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)		
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	3	
<i>duloxetine hcl</i> (generic of CYMBALTA) CPEP 20mg, 30mg, 60mg QL (60 caps / 30 days)	3	QL
<i>EMSAM</i> PT24 6mg/24hr, 9mg/24hr, 12mg/24hr QL (30 patches / 30 days)	5	* QL PA
<i>escitalopram oxalate</i> SOLN 4 5mg/5ml		
<i>escitalopram oxalate</i> (generic of LEXAPRO) TABS 5mg, 10mg, 20mg	1	GC
<i>FETZIMA</i> CP24 20mg, 40mg 4 QL PA QL (60 caps / 30 days)		
<i>FETZIMA</i> CP24 80mg, 120mg QL (30 caps / 30 days)	4	QL PA
<i>FETZIMA</i> CAP TITRATIO 4 QL PA QL (2 packs / year)		
<i>fluoxetine hcl</i> (generic of PROZAC) CAPS 10mg, 20mg	1	GC
<i>fluoxetine hcl</i> (generic of PROZAC) CAPS 40mg	2	
<i>fluoxetine hcl</i> SOLN 3 20mg/5ml		
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	2	
<i>MARPLAN</i> TABS 10mg 4 QL QL (180 tabs / 30 days)		
<i>mirtazapine</i> TABS 7.5mg	3	

Drug Name	Drug Requirements/ Tier	Limits
<i>mirtazapine</i> (generic of REMERON) TABS 15mg, 30mg	2	
<i>mirtazapine</i> TABS 45mg	2	
<i>mirtazapine</i> (generic of REMERON SOLTAB) TBDP 15mg, 30mg, 45mg	3	
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	4	
<i>nortriptyline hcl</i> (generic of PAMELOR) CAPS 10mg, 25mg, 50mg, 75mg	2	
<i>nortriptyline hcl</i> SOLN 4 10mg/5ml		
<i>paroxetine hcl</i> (generic of PAXIL) SUSP 10mg/5ml QL (900 mL / 30 days)	4	QL PA
<i>paroxetine hcl</i> (generic of PAXIL) TABS 10mg, 20mg, 30mg, 40mg	2	
<i>phenelzine sulfate</i> (generic of NARDIL) TABS 15mg	3	
<i>protriptyline hcl</i> TABS 5mg, 10mg	4	
<i>sertraline hcl</i> (generic of ZOLOFT) CONC 20mg/ml	3	
<i>sertraline hcl</i> (generic of ZOLOFT) TABS 25mg, 50mg, 100mg	1	GC
<i>tranylcypromine sulfate</i> 4 (generic of PARNATE) TABS 10mg		
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<i>trimipramine maleate</i> CAPS 4 QL 25mg, 50mg QL (120 caps / 30 days)		
<i>trimipramine maleate</i> CAPS 4 QL 100mg QL (60 caps / 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
TRINTELLIX TABS 5mg, 10mg, 20mg QL (30 tabs / 30 days)	4	QL
venlafaxine hcl (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg	2	
venlafaxine hcl TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	3	
vilazodone hcl (generic of VIIBRYD) TABS 10mg, 20mg, 40mg QL (30 tabs / 30 days)	4	QL
ZURZUVAE CAPS 20mg, 25mg QL (28 caps / 14 days)	5	* QL NM LA PA
ZURZUVAE CAPS 30mg QL (14 caps / 14 days)	5	* QL NM LA PA
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
amantadine hcl CAPS 100mg QL (120 caps / 30 days)	3	QL
amantadine hcl SOLN 50mg/5ml	3	
amantadine hcl TABS 100mg	4	
benztropine mesylate SOLN 1mg/ml	4	
benztropine mesylate TABS .5mg, 1mg, 2mg PA if 70 years and older	2	PA
bromocriptine mesylate (generic of PARLODEL) CAPS 5mg; TABS 2.5mg	4	
carb/levo orally disintegrating tab 10-100mg	4	
carb/levo orally disintegrating tab 25-100mg	4	
carb/levo orally disintegrating tab 25-250mg	4	
carbidopa & levodopa tab 10- 100 mg (generic of SINEMET)	2	
carbidopa & levodopa tab 25- 100 mg (generic of SINEMET)	2	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
carbidopa & levodopa tab 25- 250 mg	2	
carbidopa & levodopa tab er 25-100 mg	3	
carbidopa & levodopa tab er 50-200 mg	3	
carbidopa-levodopa- entacapone tabs 12.5-50-200 mg	4	
carbidopa-levodopa- entacapone tabs 18.75-75- 200 mg	4	
carbidopa-levodopa- entacapone tabs 25-100-200 mg	4	
carbidopa-levodopa- entacapone tabs 31.25-125- 200 mg	4	
carbidopa-levodopa- entacapone tabs 37.5-150- 200 mg (generic of STALEVO 150)	4	
carbidopa-levodopa- entacapone tabs 50-200-200 mg	4	
entacapone TABS 200mg	4	
INBRIJA CAPS 42mg QL (300 caps / 30 days)	5	* QL NM LA PA
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg	2	
rasagiline mesylate (generic of AZILECT) TABS .5mg, 1mg QL (30 tabs / 30 days)	4	QL
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	2	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
selegiline hcl CAPS 5mg; TABS 5mg	3	
trihexyphenidyl hcl SOLN .4mg/ml PA if 70 years and older	3	PA
trihexyphenidyl hcl TABS 2mg, 5mg PA if 70 years and older	2	PA
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
ABILIFY MAINTENA PRSY 300mg, 400mg QL (1 syringe / 28 days)	5	* QL
ABILIFY MAINTENA SRER 300mg, 400mg QL (1 injection / 28 days)	5	* QL
ariPIPRAZOLE SOLN 1mg/ml QL (900 mL / 30 days)	4	QL
ariPIPRAZOLE (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg QL (30 tabs / 30 days)	4	QL
ariPIPRAZOLE TBDP 10mg, 15mg QL (60 tabs / 30 days)	4	QL
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	5	* QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	5	* QL
ARISTADA INITIO PRSY 675mg/2.4ml	5	*
asenapine maleate (generic of SAPHRIS) SUBL 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	4	QL
CAPLYTA CAPS 10.5mg, 21mg, 42mg QL (30 caps / 30 days)	4	QL

Drug Name	Drug Requirements/ Tier	Limits
chlorpromazine hcl CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	4	
clozapine (generic of CLOZARIL) TABS 25mg, 50mg	3	
clozapine (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30 days)	4	QL
clozapine (generic of CLOZARIL) TABS 200mg QL (120 tabs / 30 days)	4	QL
clozapine TBDP 12.5mg, 25mg	4	PA
clozapine TBDP 100mg QL (270 tabs / 30 days)	4	QL PA
clozapine TBDP 150mg QL (180 tabs / 30 days)	4	QL PA
clozapine TBDP 200mg QL (120 tabs / 30 days)	5	* QL PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	4	QL PA
FANAPT PAK QL (2 packs / year)	4	QL PA
fluphenazine decanoate SOLN 25mg/ml	4	
fluphenazine hcl CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	4	
haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	3	
haloperidol decanoate (generic of HALDOL DECANOATE 50) SOLN 50mg/ml	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>haloperidol decanoate</i> (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	3		<i>olanzapine</i> (generic of ZYPREXA) TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	2	QL
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	3		<i>olanzapine</i> (generic of ZYPREXA ZYDIS) TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	4	QL
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml QL (1 injection / 180 days)	5	* QL	<i>olanzapine</i> (generic of ZYPREXA ZYDIS) TBDP 10mg QL (60 tabs / 30 days)	4	QL
INVEGA SUSTENNA SUSY 39mg/0.25ml QL (1 syringe / 28 days)	4	QL	<i>paliperidone</i> TB24 1.5mg QL (30 tabs / 30 days)	4	QL
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml QL (1 syringe / 28 days)	5	* QL	<i>paliperidone</i> (generic of INVEGA) TB24 3mg, 9mg QL (30 tabs / 30 days)	4	QL
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml QL (1 syringe / 90 days)	5	* QL	<i>paliperidone</i> (generic of INVEGA) TB24 6mg QL (60 tabs / 30 days)	4	QL
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	3		<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	3	
<i>lurasidone hcl</i> (generic of LATUDA) TABS 20mg, 40mg, 60mg, 120mg QL (30 tabs / 30 days)	4	QL	PERSERIS PRSY 90mg, 120mg QL (1 syringe / 30 days)	5	* QL
<i>lurasidone hcl</i> (generic of LATUDA) TABS 80mg QL (60 tabs / 30 days)	4	QL	<i>pimozide</i> TABS 1mg, 2mg	4	
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	4		<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 25mg QL (180 tabs / 30 days)	2	QL
NUPLAZID CAPS 34mg QL (30 caps / 30 days)	4	QL NM LA PA	<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 50mg, 100mg, 200mg QL (90 tabs / 30 days)	2	QL
NUPLAZID TABS 10mg QL (30 tabs / 30 days)	4	QL NM LA PA	<i>quetiapine fumarate</i> TABS 150mg QL (90 tabs / 30 days)	2	QL
<i>olanzapine</i> (generic of ZYPREXA) SOLR 10mg QL (3 vials / 1 day)	4	QL	<i>quetiapine fumarate</i> (generic of SEROQUEL) TABS 300mg, 400mg QL (60 tabs / 30 days)	2	QL
<i>olanzapine</i> (generic of ZYPREXA) TABS 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	2	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
quetiapine fumarate (generic of SEROQUEL XR) TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days)	4	QL PA	risperidone microspheres (generic of RISPERDAL CONSTA) SRER 37.5mg, 50mg QL (2 injections / 28 days)	5	* QL
quetiapine fumarate (generic of SEROQUEL XR) TB24 150mg, 200mg QL (30 tabs / 30 days)	4	QL PA	SECUADO PT24 3.8mg/24hr, 4 5.7mg/24hr, 7.6mg/24hr QL (30 patches / 30 days)		QL
REXULTI TABS 3mg, 4mg QL (30 tabs / 30 days)	4	QL			
REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days)	4	QL	thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	3	
RISPERDAL CONSTA SRER 12.5mg, 25mg QL (2 injections / 28 days)	4	QL	thiothixene CAPS 1mg, 2mg, 5mg, 10mg	4	
RISPERDAL CONSTA SRER 37.5mg, 50mg QL (2 injections / 28 days)	5	* QL	trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	3	
risperidone (generic of RISPERDAL) SOLN 1mg/ml QL (240 mL / 30 days)	3	QL	VERSACLOZ SUSP 50mg/ml 4 QL (600 mL / 30 days)	4	QL PA
risperidone (generic of RISPERDAL) TABS .5mg, 1mg, 2mg, 3mg, 4mg	2		VRAYLAR CAPS 1.5mg QL (60 caps / 30 days)	4	QL
risperidone TABS .25mg	2		VRAYLAR CAPS 3mg, 4.5mg, 6mg QL (30 caps / 30 days)	4	QL
risperidone TBDP 1mg, 2mg, 3mg QL (60 tabs / 30 days)	4	QL	VRAYLAR CAP 1.5-3MG QL (2 packs / year)	4	QL
risperidone TBDP 4mg QL (120 tabs / 30 days)	4	QL	ziprasidone hcl (generic of GEODON) CAPS 20mg, 40mg, 60mg, 80mg QL (60 caps / 30 days)	4	QL
risperidone TBDP .25mg, .5mg QL (90 tabs / 30 days)	4	QL	ziprasidone mesylate (generic of GEODON) SOLR 20mg QL (6 injections / 3 days)	4	QL
risperidone microspheres (generic of RISPERDAL CONSTA) SRER 12.5mg, 25mg QL (2 injections / 28 days)	4	QL	ZYPREXA RELPREVV SUSR 210mg, 300mg QL (2 vials / 28 days)	5	* QL NM PA
			ZYPREXA RELPREVV SUSR 405mg QL (1 vial / 28 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ANTISEIZURE AGENTS					
APTIOM TABS 200mg, 400mg QL (30 tabs / 30 days)	5	* QL	clonazepam TBDP .125mg,.25mg, .5mg, 1mg QL (90 tabs / 30 days)	3	QL
APTIOM TABS 600mg, 800mg QL (60 tabs / 30 days)	5	* QL	clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg QL (180 tabs / 30 days)	4	QL PA
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	5	* QL PA	DIACOMIT CAPS 250mg QL (360 caps / 30 days)	5	* QL NM LA PA
BRIVIACT SOLN 50mg/5ml	4	PA	DIACOMIT CAPS 500mg QL (180 caps / 30 days)	5	* QL NM LA PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days)	5	* QL PA	DIACOMIT PACK 250mg QL (360 packets / 30 days)	5	* QL NM LA PA
carbamazepine CHEW 100mg	3		DIACOMIT PACK 500mg QL (180 packets / 30 days)	5	* QL NM LA PA
carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg	4		diazepam SOLN 5mg/5ml QL (1200 mL / 30 days)	3	QL PA
carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml	4		PA applies if 65 years and older after a 5 day supply in a calendar year		
carbamazepine (generic of TEGRETOL) TABS 200mg	3		diazepam (generic of VALIUM) TABS 2mg, 5mg, 10mg QL (120 tabs / 30 days)	2	QL PA
carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg	4		PA applies if 65 years and older after a 5 day supply in a calendar year		
clobazam (generic of ONFI) SUSP 2.5mg/ml QL (480 mL / 30 days)	4	QL PA	diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	4	
clobazam (generic of ONFI) TABS 10mg, 20mg QL (60 tabs / 30 days)	4	QL PA	diazepam inj SOLN 5mg/ml	4	
clonazepam (generic of KLONOPI) TABS 2mg QL (300 tabs / 30 days)	2	QL	diazepam intensol CONC 5mg/ml QL (240 mL / 30 days)	3	QL PA
clonazepam (generic of KLONOPI) TABS .5mg, 1mg QL (90 tabs / 30 days)	2	QL	PA applies if 65 years and older after a 5 day supply in a calendar year		
clonazepam TBDP 2mg QL (300 tabs / 30 days)	3	QL	DILANTIN CAPS 30mg, 100mg	4	
			DILANTIN INFATABS CHEW 50mg	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
DILANTIN-125 SUSP 125mg/5ml	4	
divalproex sodium (generic of DEPAKOTE SPRINKLES)	4	
CSDR 125mg		
divalproex sodium (generic of DEPAKOTE ER) TB24 250mg, 500mg	3	
divalproex sodium (generic of DEPAKOTE) TBEC 125mg, 250mg, 500mg	2	
EPIDIOLEX SOLN 100mg/ml QL (600 mL / 30 days)	5	* QL NM LA PA
epitol (generic of TEGRETOL) TABS 200mg	3	
EPRONTIA SOLN 25mg/ml QL (480 mL / 30 days)	4	QL PA
ethosuximide (generic of ZARONTIN) CAPS 250mg	4	
ethosuximide (generic of ZARONTIN) SOLN 250mg/5ml	3	
felbamate SUSP 600mg/5ml	5	*
felbamate (generic of FELBATOL) TABS 400mg, 600mg	4	
FINTEPLA SOLN 2.2mg/ml QL (360 mL / 30 days)	5	* QL NM LA PA
FYCOMPA SUSP .5mg/ml QL (720 mL / 30 days)	5	* QL PA
FYCOMPA TABS 2mg QL (60 tabs / 30 days)	4	QL PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg QL (30 tabs / 30 days)	5	* QL PA
gabapentin (generic of NEURONTIN) CAPS 100mg, 300mg, 400mg QL (180 caps / 30 days)	2	QL

Drug Name	Drug Requirements/ Tier	Limits
gabapentin (generic of NEURONTIN) SOLN 250mg/5ml, 300mg/6ml QL (2160 mL / 30 days)	3	QL
gabapentin (generic of NEURONTIN) TABS 600mg QL (180 tabs / 30 days)	3	QL
gabapentin (generic of NEURONTIN) TABS 800mg QL (120 tabs / 30 days)	3	QL
lacosamide (generic of VIMPAT) SOLN 200mg/20ml	4	
lacosamide (generic of VIMPAT) TABS 50mg QL (120 tabs / 30 days)	4	QL
lacosamide (generic of VIMPAT) TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	4	QL
lacosamide oral (generic of VIMPAT) SOLN 10mg/ml QL (1200 mL / 30 days)	4	QL
lamotrigine (generic of LAMICTAL CHEWABLE DISPERS) CHEW 5mg, 25mg	3	
lamotrigine (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	1	GC
lamotrigine (generic of LAMICTAL XR) TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	4	
levetiracetam (generic of KEPPTRA) SOLN 100mg/ml; TABS 250mg, 500mg, 750mg, 1000mg	3	
levetiracetam (generic of KEPPTRA) SOLN 500mg/5ml	4	
levetiracetam (generic of KEPPTRA XR) TB24 500mg, 750mg	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
levetiracetam in sodium chloride iv soln 500 mg/100ml (generic of LEVETIRACETAM)	4		phenytoin sodium SOLN 50mg/ml	3	
levetiracetam in sodium chloride iv soln 1000 mg/100ml (generic of LEVETIRACETAM)	4		phenytoin sodium extended (generic of DILANTIN) CAPS 100mg	3	
levetiracetam in sodium chloride iv soln 1500 mg/100ml (generic of LEVETIRACETAM)	4		phenytoin sodium extended CAPS 200mg, 300mg	3	
methsuximide (generic of CELONTIN) CAPS 300mg	4		pregabalin (generic of LYRICA) CAPS 25mg, 50mg, 75mg, 100mg, 150mg QL (120 caps / 30 days)	3	QL PA
NAYZILAM SOLN 5mg/0.1ml	4		pregabalin (generic of LYRICA) CAPS 200mg QL (90 caps / 30 days)	3	QL PA
oxcarbazepine (generic of TRILEPTAL) SUSP 300mg/5ml	4		pregabalin (generic of LYRICA) CAPS 225mg, 300mg QL (60 caps / 30 days)	3	QL PA
oxcarbazepine (generic of TRILEPTAL) TABS 150mg, 300mg, 600mg	3		pregabalin (generic of LYRICA) SOLN 20mg/ml QL (900 mL / 30 days)	4	QL PA
phenobarbital ELIX 20mg/5ml QL (1500 mL / 30 days) PA if 70 years and older	4	QL PA	primidone (generic of MYSOLINE) TABS 50mg, 250mg	2	
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	3	QL PA	primidone TABS 125mg	2	
phenobarbital sodium SOLN 65mg/ml, 130mg/ml PA if 70 years and older	4	PA	roweepra (generic of KEPPTRA) TABS 500mg	3	
phenytek CAPS 200mg, 300mg	4		rufinamide (generic of BANZEL) SUSP 40mg/ml QL (2400 mL / 30 days)	5	* QL PA
phenytoin (generic of DILANTIN INFATABS) CHEW 50mg	3		rufinamide (generic of BANZEL) TABS 200mg QL (480 tabs / 30 days)	4	QL PA
phenytoin (generic of DILANTIN-125) SUSP 125mg/5ml	3		rufinamide (generic of BANZEL) TABS 400mg QL (240 tabs / 30 days)	5	* QL PA
			SPRITAM TB3D 250mg QL (360 tabs / 30 days)	4	QL
			SPRITAM TB3D 500mg QL (180 tabs / 30 days)	4	QL
			SPRITAM TB3D 750mg QL (120 tabs / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
SPRITAM TB3D 1000mg QL (90 tabs / 30 days)	4	QL
subvenite (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	1	GC
SYMPAZAN FILM 5mg, 10mg, 20mg QL (60 films / 30 days)	5	* QL PA
tiagabine hcl TABS 2mg, 4mg, 12mg, 16mg	4	
topiramate (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	3	
topiramate (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg	2	
valproate sodium SOLN 100mg/ml	4	
valproate sodium SOLN 250mg/5ml	3	
valproic acid CAPS 250mg	3	
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml	4	
VALTOCO 10 MG DOSE LIQD 10mg/0.1ml	4	
VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml	4	
VALTOCO 20 MG DOSE LQPK 10mg/0.1ml	4	
vigabatrin (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	5	* QL NM LA PA
vigabatrin (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	5	* QL NM LA PA
vigadron (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
vigadron (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	5	* QL NM LA PA
XCOPRI TABS 50mg, 100mg QL (30 tabs / 30 days)	5	* QL
XCOPRI TABS 150mg, 200mg QL (60 tabs / 30 days)	5	* QL
XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	4	QL
XCOPRI PAK 50-100MG QL (28 tabs / 28 days)	5	* QL
XCOPRI PAK 100-150 QL (56 tabs / 28 days)	5	* QL
XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	5	* QL
XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	5	* QL
ZONISADE SUSP 100mg/5ml QL (900 mL / 30 days)	5	* QL PA
zonisamide (generic of ZONEGRAN) CAPS 25mg, 100mg	2	
zonisamide CAPS 50mg	2	
ZTALMY SUSP 50mg/ml QL (1100 mL / 30 days)	5	* QL NM LA PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
amphetamine- dextroamphetamine cap er 24hr 5 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	QL PA
amphetamine- dextroamphetamine cap er 24hr 10 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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 15 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	QL PA	amphetamine- dextroamphetamine tab 20 mg (generic of ADDERALL) QL (90 tabs / 30 days)	3	QL PA
amphetamine- dextroamphetamine cap er 24hr 20 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	QL PA	amphetamine- dextroamphetamine tab 30 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA
amphetamine- dextroamphetamine cap er 24hr 25 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	QL PA	atomoxetine hcl (generic of STRATTERA) CAPS 10mg, 18mg, 25mg QL (120 caps / 30 days)	4	QL
amphetamine- dextroamphetamine cap er 24hr 30 mg (generic of ADDERALL XR) QL (30 caps / 30 days)	4	QL PA	atomoxetine hcl (generic of STRATTERA) CAPS 40mg QL (60 caps / 30 days)	4	QL
amphetamine- dextroamphetamine tab 5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA	atomoxetine hcl (generic of STRATTERA) CAPS 60mg, 80mg, 100mg QL (30 caps / 30 days)	4	QL
amphetamine- dextroamphetamine tab 7.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA	dexmethylphenidate hcl (generic of FOCALIN) TABS 2.5mg, 5mg QL (120 tabs / 30 days)	3	QL PA
amphetamine- dextroamphetamine tab 10 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA	dexmethylphenidate hcl (generic of FOCALIN) TABS 10mg QL (60 tabs / 30 days)	3	QL PA
amphetamine- dextroamphetamine tab 12.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA	guanfacine hcl (adhd) (generic of INTUNIV) TB24 1mg, 2mg, 4mg QL (30 tabs / 30 days) PA if 70 years and older	3	QL PA
amphetamine- dextroamphetamine tab 15 mg (generic of ADDERALL) QL (60 tabs / 30 days)	3	QL PA	guanfacine hcl (adhd) (generic of INTUNIV) TB24 3mg QL (60 tabs / 30 days) PA if 70 years and older	3	QL PA
			methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml QL (1800 mL / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>methylphenidate hcl</i> (generic of METHYLIN) SOLN 10mg/5ml QL (900 mL / 30 days)	4	QL PA
<i>methylphenidate hcl</i> (generic of RITALIN) TABS 5mg, 10mg QL (180 tabs / 30 days)	3	QL PA
<i>methylphenidate hcl</i> (generic of RITALIN) TABS 20mg QL (90 tabs / 30 days)	3	QL PA
<i>methylphenidate hcl</i> TBCR 10mg, 20mg QL (90 tabs / 30 days)	4	QL PA
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
DAYVIGO TABS 5mg, 10mg QL (30 tabs / 30 days)	3	QL
<i>doxepin hcl</i> (sleep) (generic of SILENOR) TABS 3mg, 6mg QL (30 tabs / 30 days)	3	QL
<i>tasimelteon</i> (generic of HETLIOZ) CAPS 20mg QL (30 caps / 30 days)	5	* QL NM PA
<i>temazepam</i> (generic of RESTORIL) CAPS 7.5mg, 30mg QL (30 caps / 30 days) PA if 65 years and older	4	QL PA
<i>temazepam</i> (generic of RESTORIL) CAPS 15mg QL (60 caps / 30 days) PA if 65 years and older	4	QL PA
<i>zolpidem tartrate</i> (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	2	QL PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
<i>AIMOVIG</i> SOAJ 70mg/ml, 140mg/ml QL (1 pen / 30 days)	3	QL NM PA
<i>dihydroergotamine mesylate</i> SOLN 1mg/ml <i>dihydroergotamine mesylate</i> (generic of MIGRALAN) SOLN 4mg/ml QL (8 mL / 30 days)	5	*
<i>ergotamine w/ caffeine</i> tab 1- 100 mg QL (40 tabs / 28 days)	3	QL PA
<i>naratriptan hcl</i> TABS 1mg, 2.5mg QL (12 tabs / 30 days)	3	QL
NURTEC TBDP 75mg QL (16 tabs / 30 days)	3	QL PA
<i>QUILPTA</i> TABS 10mg, 30mg, 60mg QL (30 tabs / 30 days)	3	QL PA
<i>rizatriptan benzoate</i> TABS 5mg; TBDP 5mg QL (18 tabs / 30 days)	3	QL
<i>rizatriptan benzoate</i> (generic of MAXALT) TABS 10mg QL (18 tabs / 30 days)	3	QL
<i>rizatriptan benzoate</i> (generic of MAXALT-MLT) TBDP 10mg QL (18 tabs / 30 days)	3	QL
<i>sumatriptan</i> SOLN 5mg/act QL (24 units / 30 days)	4	QL
<i>sumatriptan</i> SOLN 20mg/act QL (12 units / 30 days)	4	QL
<i>sumatriptan succinate</i> SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml QL (18 injections / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>sumatriptan succinate</i> (generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml QL (12 injections / 30 days)	4	QL
<i>sumatriptan succinate</i> (generic of IMITREX STATDOSE REFILL) SOCT 6mg/0.5ml QL (12 injections / 30 days)	4	QL
<i>sumatriptan succinate</i> SOLN 6mg/0.5ml QL (12 injections / 30 days)	4	QL
<i>sumatriptan succinate</i> (generic of IMITREX) TABS 25mg, 50mg, 100mg QL (12 tabs / 30 days)	2	QL
UBRELVY TABS 50mg, 100mg QL (16 tabs / 30 days)	3	QL PA
MISCELLANEOUS		
AUSTEDO TABS 6mg QL (60 tabs / 30 days)	5	* QL NM LA PA
AUSTEDO TABS 9mg, 12mg QL (120 tabs / 30 days)	5	* QL NM LA PA
AUSTEDO XR TB24 6mg QL (90 tabs / 30 days)	5	* QL NM PA
AUSTEDO XR TB24 12mg QL (120 tabs / 30 days)	5	* QL NM PA
AUSTEDO XR TB24 24mg QL (60 tabs / 30 days)	5	* QL NM PA
AUSTEDO XR TAB TITR KIT QL (2 packs / year)	5	* QL NM PA
LITHIUM SOLN 8meq/5ml	4	
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg	1	GC
<i>lithium carbonate</i> TABS 300mg; TBCR 450mg	2	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>lithium carbonate</i> (generic of LITHOBID) TBCR 300mg	2	
NUEDEXTA CAP 20-10MG QL (60 caps / 30 days)	4	QL PA
<i>pyridostigmine bromide</i> (generic of MESTINON) TABS 60mg	3	
<i>riluzole</i> (generic of RILUTEK) TABS 50mg	4	
<i>tetrabenazine</i> (generic of XENAZINE) TABS 12.5mg QL (90 tabs / 30 days)	5	* QL NM PA
<i>tetrabenazine</i> (generic of XENAZINE) TABS 25mg QL (120 tabs / 30 days)	5	* QL NM PA
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BAFIERTAM CPDR 95mg QL (120 caps / 30 days)	5	* QL NM LA PA
BETASERON KIT .3mg QL (14 syringes / 28 days)	5	* QL NM PA
<i>dalfampridine</i> (generic of AMPYRA) TB12 10mg QL (60 tabs / 30 days)	3	QL NM PA
<i>fingolimod hcl</i> (generic of GILENYA) CAPS .5mg QL (30 caps / 30 days)	5	* QL NM PA
<i>glatiramer acetate</i> (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	5	* QL NM PA
<i>glatiramer acetate</i> (generic of COPAXONE) SOSY 40mg/ml QL (12 syringes / 28 days)	5	* QL NM PA
<i>glatopa</i> (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
glatopa (generic of COPAXONE) SOSY 40mg/ml	5	* QL NM PA QL (12 syringes / 28 days)
KESIMPTA SOAJ 20mg/0.4ml	5	* QL NM LA PA QL (16 pens / year)
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
baclofen TABS 5mg	3	QL QL (90 tabs / 30 days)
baclofen TABS 10mg, 20mg	3	
cyclobenzaprine hcl TABS 5mg, 10mg	3	QL PA QL (90 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year
dantrolene sodium (generic of DANTRIUM) CAPS 25mg	4	
dantrolene sodium CAPS 50mg, 100mg	4	
tizanidine hcl TABS 2mg	2	
tizanidine hcl (generic of ZANAFLEX) TABS 4mg	2	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
armodafinil (generic of NUVIGIL) TABS 50mg	4	QL PA QL (60 tabs / 30 days)
armodafinil (generic of NUVIGIL) TABS 150mg, 200mg, 250mg	4	QL PA QL (30 tabs / 30 days)
modafinil (generic of PROVIGIL) TABS 100mg	3	QL PA QL (30 tabs / 30 days)
modafinil (generic of PROVIGIL) TABS 200mg	3	QL PA QL (60 tabs / 30 days)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
SODIUM OXYBATE SOLN 500mg/ml	5	* QL NM LA PA QL (540 mL / 30 days)
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium TBEC 333mg		
buprenorphine hcl SUBL 2mg, 8mg	3	QL PA QL (90 tabs / 30 days)
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE)	4	QL QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE)	4	QL QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE)	4	QL QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE)	4	QL QL (60 films / 30 days)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	2	QL QL (90 tabs / 30 days)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	2	QL QL (90 tabs / 30 days)
bupropion hcl (smoking deterrent) TB12 150mg	3	QL QL (60 tabs / 30 days)
disulfiram TABS 250mg, 500mg	3	
naloxone hcl LIQD 4mg/0.1ml	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
naloxone hcl SOCT .4mg/ml; 2 SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	2	
naltrexone hcl TABS 50mg	3	
NICOTROL INHALER INHA 10mg	4	
NICOTROL NS SOLN 10mg/ml	4	
varenicline tartrate TABS .5mg, 1mg	4	QL PA QL (56 tabs / 28 days)
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	4	QL PA QL (2 packs / year)
VIVITROL SUSR 380mg	5	* NM
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
depo-testosterone SOLN 100mg/ml, 200mg/ml	3	PA
methyltestosterone CAPS 10mg	5	* QL PA QL (600 caps / 30 days)
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm	4	QL PA QL (300 gm / 30 days)
testosterone (generic of ANDROGEL PUMP) GEL 1.62%	4	QL PA QL (150 gm / 30 days)
testosterone cypionate SOLN 100mg/ml, 200mg/ml	3	PA
testosterone enanthate SOLN 200mg/ml	3	PA
ANTIDIABETICS		
acarbose TABS 25mg, 50mg, 100mg	3	
BYDUREON BCISE AUIJ 2mg/0.85ml	3	QL PA QL (4 pens / 28 days)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml	4	QL PA QL (1 pen / 30 days)
FARXIGA TABS 5mg, 10mg	3	QL QL (30 tabs / 30 days)
glimepiride TABS 1mg, 2mg	1	GC QL QL (90 tabs / 30 days)
glimepiride TABS 4mg	1	GC QL QL (60 tabs / 30 days)
glipizide TABS 5mg	1	GC QL QL (240 tabs / 30 days)
glipizide TABS 10mg	1	GC QL QL (120 tabs / 30 days)
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg	1	GC QL QL (90 tabs / 30 days)
glipizide (generic of GLUCOTROL XL) TB24 10mg	1	GC QL QL (60 tabs / 30 days)
glipizide xl (generic of GLUCOTROL XL) TB24 2.5mg, 5mg	1	GC QL QL (90 tabs / 30 days)
glipizide xl (generic of GLUCOTROL XL) TB24 10mg	1	GC QL QL (60 tabs / 30 days)
glipizide-metformin hcl tab 2.5-250 mg	1	GC QL QL (240 tabs / 30 days)
glipizide-metformin hcl tab 2.5-500 mg	1	GC QL QL (120 tabs / 30 days)
glipizide-metformin hcl tab 5-500 mg	1	GC QL QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	3	QL QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	3	QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	3	QL
JANUMET XR TAB 50- 500MG QL (60 tabs / 30 days)	3	QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)	3	QL
JANUMET XR TAB 100-1000 QL (30 tabs / 30 days)	3	QL
JANUVIA TABS 25mg, 50mg, 3 100mg QL (30 tabs / 30 days)	3	QL
JARDIANCE TABS 10mg, 25mg QL (30 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB 2.5-1000 QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB XR 2.5- 1000MG QL (60 tabs / 30 days)	3	QL
JENTADUETO TAB XR 5- 1000MG QL (30 tabs / 30 days)	3	QL
metformin hcl TABS 500mg QL (150 tabs / 30 days)	1	GC QL
metformin hcl TABS 850mg QL (90 tabs / 30 days)	1	GC QL
metformin hcl TABS 1000mg QL (75 tabs / 30 days)	1	GC QL
metformin hcl TB24 500mg QL (120 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	GC QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
metformin hcl TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	GC 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)	3	QL PA
nateglinide TABS 60mg, 120mg QL (90 tabs / 30 days)	1	GC QL
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml QL (1 pen / 28 days)	3	QL PA
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml QL (1 pen / 28 days)	3	QL PA
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	3	QL PA
OZEMPIC (2MG/DOSE) SOPN 8mg/3ml QL (1 pen / 28 days)	3	QL PA
pioglitazone hcl (generic of ACTOS) TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1	GC QL
pioglitazone hcl-metformin hcl tab 15-500 mg QL (90 tabs / 30 days)	1	GC QL
pioglitazone hcl-metformin hcl tab 15-850 mg (generic of ACTOPLUS MET) QL (90 tabs / 30 days)	1	GC QL
repaglinide TABS 2mg QL (240 tabs / 30 days)	1	GC QL
repaglinide TABS .5mg, 1mg QL (120 tabs / 30 days)	1	GC QL
RYBELSUS TABS 3mg, 7mg, 3 14mg QL (30 tabs / 30 days)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	3	QL
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY TAB 12.5-500 QL (60 tabs / 30 days)	3	QL
SYNJARDY TAB 12.5- 1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 5- 1000MG QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 10-1000 QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 12.5- 1000 QL (60 tabs / 30 days)	3	QL
SYNJARDY XR TAB 25-1000 QL (30 tabs / 30 days)	3	QL
TRADJENTA TABS 5mg QL (30 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG QL (60 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 10-5-1000MG QL (30 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG QL (60 tabs / 30 days)	3	QL
TRIJARDY XR TAB ER 24HR 25-5-1000MG QL (30 tabs / 30 days)	3	QL
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml QL (4 pens / 28 days)	3	QL PA
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	3	QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
XIGDUO XR TAB 5-1000MG QL (60 tabs / 30 days)	3	QL
XIGDUO XR TAB 10-500MG QL (30 tabs / 30 days)	3	QL
XIGDUO XR TAB 10-1000 QL (30 tabs / 30 days)	3	QL
ANTIDIABETICS, INSULINS		
ADMELOG SOLN 100unit/ml	3	V/I
ADMELOG SOLOSTAR SOPN 100unit/ml	3	V/I
BASAGLAR KWIKPEN SOPN 100unit/ml	3	V/I
BD ALCOHOL SWABS	3	
FIASP SOLN 100unit/ml	3	V/I
FIASP FLEXTOUCH SOPN 100unit/ml	3	V/I
FIASP PENFILL SOCT 100unit/ml	3	V/I
FIASP PUMPCART SOCT 100unit/ml	3	B/D
GAUZE PADS 2" X 2"	3	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml)	5	V/I * B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	5	V/I *
INSULIN PEN NEEDLES: BD/NOVO	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGES: BD	3	
LANTUS SOLN 100unit/ml	3	V/I
LANTUS SOLOSTAR SOPN 100unit/ml	3	V/I
NOVOLIN INJ 70/30 (brand RELION not covered)	3	V/I
NOVOLIN INJ 70/30 FP (brand RELION not covered)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
NOVOLIN N SUSP 100unit/ml (brand RELION not covered)	3	V/I
NOVOLIN N FLEXPEN SUPN 100unit/ml (brand RELION not covered)	3	V/I
NOVOLIN R SOLN 100unit/ml (brand RELION not covered)	3	V/I
NOVOLIN R FLEXPEN SOPN 100unit/ml (brand RELION not covered)	3	V/I
NOVOLOG SOLN 100unit/ml (brand RELION not covered)	3	V/I
NOVOLOG FLEXPEN SOPN 100unit/ml (brand RELION not covered)	3	V/I
NOVOLOG MIX INJ 70/30 (brand RELION not covered)	3	V/I
NOVOLOG MIX INJ FLEXPEN (brand RELION not covered)	3	V/I
NOVOLOG PENFILL SOCT 100unit/ml (brand RELION not covered)	3	V/I
OMNIPOD 5 G6 KIT INTRO QL (1 kit / year)	4	QL PA
OMNIPOD 5 G6 MIS PODS QL (15 pods / 30 days)	4	QL PA
OMNIPOD 5 G7 KIT INTRO QL (1 kit / year)	4	QL PA
OMNIPOD 5 G7 MIS PODS QL (15 pods / 30 days)	4	QL PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
OMNIPOD DASH KIT INTRO QL (1 kit / year)	4	QL PA
OMNIPOD DASH MIS PODS QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 10UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 15UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 20UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 25UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 30UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 35UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD GO KIT 40UNT/DY QL (15 pods / 30 days)	4	QL PA
OMNIPOD MIS CLASSIC QL (15 pods / 30 days)	4	QL PA
SOLIQUA INJ 100/33 QL (5 pens / 25 days)	3	V/I QL
TOUJEAO MAX SOLOSTAR SOPN 300unit/ml	3	V/I
TOUJEAO SOLOSTAR SOPN 300unit/ml	3	V/I
TRESIBA SOLN 100unit/ml	3	V/I
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	3	V/I
V-GO 20 KIT QL (30 devices / 30 days)	4	QL PA
V-GO 30 KIT QL (30 devices / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
V-GO 40 KIT QL (30 devices / 30 days)	4	QL PA
XULTOPHY INJ 100/3.6 QL (5 pens / 30 days)	3	V/I QL
CALCIUM REGULATORS		
alendronate sodium TABS 10mg, 35mg	1	GC
alendronate sodium (generic of FOSAMAX) TABS 70mg	1	GC
calcitonin (salmon) spray SOLN 200unit/act	3	B/D
ibandronate sodium TABS 150mg	3	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	* LA PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml	3	B/D
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	4	QL NM
TERIPARATIDE SOPN 620mcg/2.48ml	5	* NM PA
XGEVA SOLN 120mg/1.7ml	5	* NM PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml	4	B/D NM
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	4	B/D NM
CHELATING AGENTS		
CHEMET CAPS 100mg	5	*
deferasirox (generic of JADENU SPRINKLE) PACK 90mg, 180mg, 360mg	5	* NM PA
deferasirox (generic of JADENU) TABS 90mg	3	NM PA
deferasirox (generic of JADENU) TABS 180mg, 360mg	5	* NM PA
LOKELMA PACK 5gm, 10gm	3	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	5	* NM
sodium polystyrene sulfonate powder	3	
sps SUSP 15gm/60ml	3	
trentine hcl (generic of SYPRINE) CAPS 250mg	5	* NM PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	3	
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
afirmelle	2	
altavera	3	
alyacen 1/35	3	
alyacen 7/7/7	3	
apri	2	
aranelle	3	
aubra eq	2	
aurovela 1/20	3	
aurovela fe 1.5/30	2	
aurovela fe 1/20	2	
aviane	2	
ayuna	3	
azurette	3	
balziva	3	
blisovi fe 1.5/30	2	
briellyn	3	
camila TABS .35mg	2	
chateal eq	3	
cryselle-28	3	
cyred eq	2	
dasetta 1/35	3	
dasetta 7/7/7	3	
deblitane TABS .35mg	2	
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
desogest-eth estrad & eth estradi tab 0.15-0.02/0.01 mg(21/5)	3	
desogestrel & ethinyl estradiol 2 tab 0.15 mg-30 mcg		
drospirenone-ethinyl estradiol 3 tab 3-0.02 mg (generic of YAZ)		
drospirenone-ethinyl estradiol 3 tab 3-0.03 mg (generic of YASMIN 28)		
elonest	3	
eluryng (generic of NUVARING)	4	
enilloring (generic of NUVARING)	4	
enpresse-28	2	
enskyce	2	
errin TABS .35mg	2	
estarrylla	2	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	2	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	3	
etongestrel-ethinyl estradiol 4 va ring 0.120-0.015 mg/24hr (generic of NUVARING)		
falmina	2	
hailey 1.5/30	3	
haloette (generic of NUVARING)	4	
heather TABS .35mg	2	
iclevia	3	
incassia TABS .35mg	2	
introvale	3	
isibloom	2	
jasmiel (generic of YAZ)	3	
jolessa	3	
juleber	2	
junel 1.5/30	3	

Drug Name	Drug Requirements/ Tier	Limits
junel 1/20	3	
junel fe 1.5/30	2	
junel fe 1/20	2	
kariva	3	
kelnor 1/35	2	
kelnor 1/50	3	
kurvelo	3	
larin 1.5/30	3	
larin 1/20	3	
larin fe 1.5/30	2	
larin fe 1/20	2	
leena	3	
lessina	2	
levonest	2	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15- 0.03 mg	3	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	2	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	3	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125- 30mg-mcg	2	
levora 0.15/30-28	3	
loestrin 1.5/30-21	3	
loestrin 1/20-21	3	
loestrin fe 1.5/30	2	
loestrin fe 1/20	2	
loryna (generic of YAZ)	3	
low-ogestrel	3	
lutera	2	
lyleq TABS .35mg	2	
lyza TABS .35mg	2	
marlissa	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
medroxyprogesterone acetate (contraceptive) (generic of DEPO-PROVERA CONTRACEPTIV) SUSP 150mg/ml; SUSY 150mg/ml	3	
microgestin 1.5/30	3	
microgestin 1/20	3	
microgestin fe 1.5/30	2	
microgestin fe 1/20	2	
mili	2	
mono-linyah	2	
necon 0.5/35-28	3	
nikki (generic of YAZ)	3	
nora-be TABS .35mg	2	
norelgestromin-ethynodiol td ptwk 150-35 mcg/24hr	4	
norethindrone (contraceptive) TABS .35mg	2	
norethindrone ac-ethynodiol tab 1-20/1-30/1-35 mg-mcg	3	
norethindrone ace & ethynodiol tab 1 mg-20 mcg	3	
norethindrone ace & ethynodiol tab 1.5 mg-30 mcg	3	
norethindrone ace & ethynodiol-fe tab 1 mg-20 mcg	2	
norgestimate & ethynodiol tab 0.25 mg-35 mcg	2	
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg (generic of ORTHO TRI-CYCLEN LO)	3	
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	3	
norlyroc TABS .35mg	2	
nortrel 0.5/35 (28)	3	
nortrel 1/35 (21)	3	
nortrel 1/35 (28)	3	

Drug Name	Drug Requirements/ Tier	Limits
nortrel 7/7/7	3	
nylia 1/35	3	
nylia 7/7/7	3	
nymyo	2	
ocella (generic of YASMIN 28)	3	
philith	3	
pimtrea	3	
portia-28	3	
reclipsen	2	
setlakin	3	
sharobel TABS .35mg	2	
simliya	3	
sprintec 28	2	
sronyx	2	
syeda (generic of YASMIN 28)	3	
tarina fe 1/20 eq	2	
tilia fe	3	
tri-estarrylla	3	
tri-legest fe	3	
tri-linyah	3	
tri-lo-estarrylla (generic of ORTHO TRI-CYCLEN LO)	3	
tri-lo-marzia (generic of ORTHO TRI-CYCLEN LO)	3	
tri-lo-mili (generic of ORTHO TRI-CYCLEN LO)	3	
tri-lo-sprintec (generic of ORTHO TRI-CYCLEN LO)	3	
tri-mili	3	
tri-nymyo	3	
tri-sprintec	3	
tri-vylibra	3	
tri-vylibra lo (generic of ORTHO TRI-CYCLEN LO)	3	
trivora-28	2	
turqoz	3	
velivet	3	
vestura (generic of YAZ)	3	
vienna	2	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
viorele	3	
vyfemla	3	
vylibra	2	
wera	3	
xulane	4	
zafemy	4	
zovia 1/35	2	
zumandimine (generic of YASMIN 28)	3	
ENDOMETRIOSIS		
danazol CAPS 50mg, 100mg, 4 200mg		
SYNAREL SOLN 2mg/ml	5	* PA
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
amabelz tab 0.5-0.1mg	3	
dotti (generic of VIVELLE- DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
estradiol (generic of VIVELLE- DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
estradiol (generic of CLIMARA) PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	3	
estradiol (generic of ESTRACE) TABS .5mg, 1mg, 2mg	2	
estradiol & norethindrone acetate tab 0.5-0.1 mg	3	
estradiol & norethindrone acetate tab 1-0.5 mg (generic of ACTIVELLA)	3	
estradiol vaginal (generic of ESTRACE) CREA .1mg/gm	3	
estradiol vaginal (generic of VAGIFEM) TABS 10mcg	4	

Drug Name	Drug Requirements/ Tier	Limits
estradiol valerate (generic of DELESTROGEN) OIL 10mg/ml, 20mg/ml, 40mg/ml	4	
fyavolv tab 0.5mg-2.5mcg	3	
fyavolv tab 1mg-5mcg	3	
jinteli	3	
lyllana (generic of MINIVELLE) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
mimvey (generic of ACTIVELLA)	3	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	3	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	3	
yuvafem (generic of VAGIFEM) TABS 10mcg	4	
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	3	B/D
DEXAMETHASONE INTENSOL CONC 1mg/ml	4	B/D
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	3	
fludrocortisone acetate TABS .1mg	2	
hydrocortisone (generic of CORTEF) TABS 5mg, 10mg, 20mg	3	
methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg	3	B/D
methylprednisolone TABS 32mg	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
methylprednisolone (generic of MEDROL DOSEPAK) TBPK 4mg	2	
methylprednisolone acetate (generic of DEPO-MEDROL) SUSP 40mg/ml, 80mg/ml	3	B/D
methylprednisolone sod succ SOLR 40mg, 125mg	3	B/D
methylprednisolone sod succ (generic of SOLU-MEDROL) SOLR 1000mg	3	B/D
prednisolone SOLN 15mg/5ml	2	B/D
prednisolone sodium phosphate (generic of PEDIAPRED) SOLN 5mg/5ml	4	B/D
prednisolone sodium phosphate SOLN 15mg/5ml	2	B/D
prednisolone sodium phosphate SOLN 25mg/5ml	4	B/D
prednisone SOLN 5mg/5ml	4	B/D
prednisone TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	2	B/D
prednisone TBPK 5mg, 10mg	3	
PREDNISONE INTENSOL CONC 5mg/ml	4	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	4	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
diazoxide (generic of PROGLYCEM) SUSP 50mg/ml	5	*
GVOKE HYPOPEN 2-PACK SOAJ .5mg/.1ml, 1mg/.2ml	3	
GVOKE KIT SOLN 1mg/.2ml	3	
GVOKE PFS SOSY 1mg/.2ml	3	

Drug Name	Drug Requirements/ Tier	Limits
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	5	* NM LA PA
betaine powder for oral solution (generic of CYSTADANE)	5	* NM LA
cabergoline TABS .5mg	3	
carglumic acid (generic of CARBAGLU) TBSO 200mg	5	* NM LA PA
CERDELGA CAPS 84mg	5	* NM LA PA
CEREZYME SOLR 400unit	5	* NM LA PA
cinacalcet hcl (generic of SENSIPIAR) TABS 30mg, 60mg	4	B/D QL NM QL (60 tabs / 30 days)
cinacalcet hcl (generic of SENSIPIAR) TABS 90mg	5	* B/D QL NM QL (120 tabs / 30 days)
CYSTAGON CAPS 50mg, 150mg	4	NM LA PA
desmopressin acetate (generic of DDAVP) SOLN 4mcg/ml	5	*
desmopressin acetate (generic of DDAVP) TABS .1mg, .2mg	3	
desmopressin acetate spray SOLN .01%	4	
desmopressin acetate spray refrigerated SOLN .01%	4	
FABRAZYME SOLR 5mg, 35mg	5	* NM LA PA
GENOTROPIN CART 5mg, 12mg	5	* NM PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	* NM PA
INCRELEX SOLN 40mg/4ml	5	* NM LA PA
javygtor (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
KORLYM TABS 300mg	5	* NM LA PA
levocarnitine (<i>metabolic modifiers</i>) (generic of CARNITOR) SOLN 1gm/10ml; TABS 330mg	4	B/D
LUMIZYME SOLR 50mg	5	* NM LA PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg)	5	* NM PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg)	5	* NM PA
LUPRON DEPOT-PED (6-MONTH KIT 45mg)	5	* NM PA
mifepristone (<i>hyperglycemia</i>) (generic of KORLYM) TABS 300mg	5	* NM PA
miglustat (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	5	* QL NM PA
NAGLAZYME SOLN 1mg/ml	5	* NM LA PA
nitisinone (generic of ORFADIN) CAPS 2mg, 5mg, 10mg, 20mg	5	* NM PA
octreotide acetate (generic of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml	4	NM PA
octreotide acetate SOLN 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	4	NM PA
octreotide acetate (generic of SANDOSTATIN) SOLN 500mcg/ml	5	* NM PA
octreotide acetate SOLN 1000mcg/ml; SOSY 500mcg/ml	5	* NM PA
raloxifene hcl (generic of EVISTA) TABS 60mg	3	
sapropterin dihydrochloride (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	5	* NM PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	* NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
sodium phenylbutyrate (generic of BUPHENYL) POWD 3gm/tsp; TABS 500mg	5	* NM PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	* NM LA PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	* NM LA PA
yargesa (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	5	* QL NM PA
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
calcium acetate (phosphate binder) CAPS 667mg QL (360 caps / 30 days)	3	QL
calcium acetate (phosphate binder) TABS 667mg QL (360 tabs / 30 days)	3	QL
sevelamer carbonate (generic of RENVELA) PACK 2.4gm QL (180 packets / 30 days)	4	QL
sevelamer carbonate (generic of RENVELA) PACK .8gm QL (540 packets / 30 days)	4	QL
sevelamer carbonate (generic of RENVELA) TABS 800mg QL (540 tabs / 30 days)	4	QL
VELPHORO CHEW 500mg QL (180 tabs / 30 days)	5	* QL
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
medroxyprogesterone acetate (generic of PROVERA) TABS 2.5mg, 5mg, 10mg	1	GC
megestrol acetate SUSP 40mg/ml	3	
megestrol acetate (appetite) SUSP 625mg/5ml	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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	
norethindrone acetate TABS 5mg	3	
progesterone (generic of PROMETRIUM) CAPS 100mg, 200mg	3	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
euthyrox (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
levo-t (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
levothyroxine sodium (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
levoxyl (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
liothyronine sodium (generic of CYTOMEL) TABS 5mcg, 25mcg, 50mcg	3	
methimazole TABS 5mg, 10mg	1	GC
propylthiouracil TABS 50mg SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	3 4	

Drug Name	Drug Requirements/ Tier Limits	
unithroid (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
VITAMIN D ANALOGS		
calcitriol (generic of ROCALTROL) CAPS .25mcg, .5mcg	2	B/D
calcitriol (oral) (generic of ROCALTROL) SOLN 1mcg/ml	4	B/D
paricalcitol (generic of ZEMPLAR) CAPS 1mcg, 2mcg	4	B/D
paricalcitol CAPS 4mcg RAYALDEE CPCR 30mcg	4 5	B/D *
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
aprepitant CAPS 40mg, 125mg	4	B/D
aprepitant (generic of EMEND) CAPS 80mg	4	B/D
aprepitant capsule therapy pack 80 & 125 mg	4	B/D
compro SUPP 25mg	4	
dronabinol (generic of MARINOL) CAPS 2.5mg QL (60 caps / 30 days)	4	B/D QL
dronabinol CAPS 5mg, 10mg QL (60 caps / 30 days)	4	B/D QL
gransetron hcl SOLN 1mg/ml, 4mg/4ml	4	
gransetron hcl TABS 1mg	4	B/D
meclizine hcl TABS 12.5mg, 25mg	2	
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
metoclopramide hcl (generic of REGLAN) TABS 5mg, 10mg	1	GC
ondansetron TBDP 4mg, 8mg	3	B/D
ondansetron hcl SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	3	
ondansetron hcl SOLN 4mg/5ml	4	B/D
ondansetron hcl TABS 4mg, 8mg	3	B/D
prochlorperazine SUPP 25mg	4	
prochlorperazine edisylate SOLN 10mg/2ml	4	
prochlorperazine maleate TABS 5mg, 10mg	2	
promethazine hcl (generic of PHENERGAN) SOLN 25mg/ml, 50mg/ml PA if 70 years and older	3	PA
promethazine hcl SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg PA if 70 years and older	3	PA
scopolamine (generic of TRANSDERM-SCOP) PT72 1mg/3days QL (10 patches / 30 days)	4	QL PA
PA if 70 years and older		
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS		
dicyclomine hcl CAPS 10mg; TABS 20mg	3	
dicyclomine hcl SOLN 10mg/5ml	4	
glycopyrrolate (generic of ROBINUL) TABS 1mg QL (90 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
glycopyrrolate (generic of ROBINUL FORTE) TABS 2mg	3	QL
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
famotidine SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	3	
famotidine SUSR 40mg/5ml	4	QL
QL (300 mL / 30 days)		
famotidine (generic of PEPCID) TABS 20mg QL (120 tabs / 30 days)	1	GC QL
famotidine (generic of PEPCID) TABS 40mg QL (60 tabs / 30 days)	1	GC QL
famotidine in nacl 0.9% iv soln 20 mg/50ml	3	
nizatidine CAPS 150mg, 300mg	4	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium (generic of COLAZAL) CAPS 750mg	3	
budesonide CPEP 3mg QL (90 caps / 30 days)	4	QL PA
budesonide (generic of UCERIS) TB24 9mg QL (30 tabs / 30 days)	5	* QL PA
hydrocortisone (intrarectal) (generic of CORTENEMA) ENEM 100mg/60ml	4	
mesalamine (generic of APRISO) CP24 .375gm QL (120 caps / 30 days)	4	QL
mesalamine (generic of DELZICOL) CPDR 400mg QL (180 caps / 30 days)	4	QL
mesalamine ENEM 4gm	4	
mesalamine (generic of CANASA) SUPP 1000mg	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
mesalamine (generic of LIALDA) TBEC 1.2gm QL (120 tabs / 30 days)	4	QL
mesalamine w/ cleanser (generic of ROWASA) KIT 4gm	4	
sulfasalazine (generic of AZULFIDINE) TABS 500mg	2	
sulfasalazine (generic of AZULFIDINE EN-TABS) TBEC 500mg	3	
LAXATIVES		
constulose SOLN 10gm/15ml	3	
enulose SOLN 10gm/15ml	3	
gavilyte-c	2	
gavilyte-g (generic of GOLYTELY)	2	
generlac SOLN 10gm/15ml	3	
lactulose SOLN 10gm/15ml	3	
lactulose (encephalopathy) SOLN 10gm/15ml	3	
peg 3350-kcl-na bicarb-nacl- na sulfate for soln 236 gm (generic of GOLYTELY)	2	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	2	
PLENUV SOL	4	
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml (generic of SUPREP BOWEL PREP KIT)	3	
MISCELLANEOUS		
alosetron hcl (generic of LOTRONEX) TABS .5mg, 1mg QL (60 tabs / 30 days)	5	* QL PA
cromolyn sodium (mastocytosis) (generic of GASTROCROM) CONC 100mg/5ml	4	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	4	
diphenoxylate w/ atropine tab 2.5-0.025 mg (generic of LOMOTIL)	3	
GATTEX KIT 5mg	5	* NM LA PA
LINZESS CAPS 72mcg, 145mcg, 290mcg QL (30 caps / 30 days)	4	QL
loperamide hcl CAPS 2mg	3	
misoprostol (generic of CYTOTEC) TABS 100mcg, 200mcg	3	
MOVANTIK TABS 12.5mg, 25mg QL (30 tabs / 30 days)	3	QL
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml QL (28 syringes / 28 days)	5	* QL PA
sucralfate (generic of CARAFATE) TABS 1gm	3	
ursodiol CAPS 300mg	3	
ursodiol (generic of URSO 250) TABS 250mg	4	
ursodiol (generic of URSO FORTE) TABS 500mg	4	
XERMELO TABS 250mg QL (84 tabs / 28 days)	5	* QL NM LA PA
XIFAXAN TABS 550mg	5	* PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNT	3	
CREON CAP 24000UNT	3	
CREON CAP 36000UNT	3	
ZENPEP CAP 3000UNIT	4	
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNT	4	
ZENPEP CAP 15000UNT	4	
ZENPEP CAP 20000UNT	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ZENPEP CAP 25000UNT	4	
ZENPEP CAP 40000UNT	4	
ZENPEP CAP 60000UNT	4	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
esomeprazole magnesium (generic of NEXIUM) CPDR 20mg, 40mg QL (30 caps / 30 days)	4	QL ST
lansoprazole CPDR 15mg QL (60 caps / 30 days)	3	QL
lansoprazole (generic of PREVACID) CPDR 30mg QL (60 caps / 30 days)	3	QL
omeprazole CPDR 10mg, 20mg, 40mg	1	GC
pantoprazole sodium (generic of PROTONIX) SOLR 40mg	4	
pantoprazole sodium (generic of PROTONIX) TBEC 20mg, 40mg	1	GC
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)	2	QL
dutasteride (generic of AVODART) CAPS .5mg QL (30 caps / 30 days)	3	QL
dutasteride-tamsulosin hcl cap 4 0.5-0.4 mg (generic of JALYN) QL (30 caps / 30 days)	4	QL
finasteride (generic of PROSCAR) TABS 5mg QL (30 tabs / 30 days)	1	GC QL

Drug Name	Drug Requirements/ Tier	Limits
tamsulosin hcl (generic of FLOMAX) CAPS .4mg QL (60 caps / 30 days)	2	QL
MISCELLANEOUS		
acetic acid SOLN .25%	2	
bethanechol chloride TABS 5mg, 10mg, 25mg, 50mg	3	
potassium citrate (alkalinizer) (generic of UROCIT-K 15) TBCR 15meq	4	
potassium citrate (alkalinizer) (generic of UROCIT-K 5) TBCR 540mg	4	
potassium citrate (alkalinizer) (generic of UROCIT-K 10) TBCR 1080mg	4	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
GEMTESA TABS 75mg QL (30 tabs / 30 days)	4	QL
MYRBETRIQ SRER 8mg/ml QL (300 mL / 28 days)	4	QL
MYRBETRIQ TB24 25mg, 50mg QL (30 tabs / 30 days)	4	QL
oxybutynin chloride SOLN 5mg/5ml QL (600 mL / 30 days)	3	QL
oxybutynin chloride TABS 5mg QL (120 tabs / 30 days)	3	QL
oxybutynin chloride TB24 5mg QL (30 tabs / 30 days)	3	QL
oxybutynin chloride TB24 10mg, 15mg QL (60 tabs / 30 days)	3	QL
solifenacin succinate (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>tolterodine tartrate</i> (generic of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days)	4	QL ST
<i>tolterodine tartrate</i> (generic of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days)	4	QL
<i>trospium chloride</i> TABS 20mg QL (60 tabs / 30 days)	3	QL
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal</i> (generic of CLEOCIN) CREA 2%	3	
<i>metronidazole vaginal</i> GEL .75%	3	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	3	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
<i>dabigatran etexilate mesylate</i> CAPS 75mg QL (60 caps / 30 days)	4	QL
<i>dabigatran etexilate mesylate</i> (generic of PRADAXA) CAPS 110mg QL (120 caps / 30 days)	4	QL
<i>dabigatran etexilate mesylate</i> (generic of PRADAXA) CAPS 150mg QL (60 caps / 30 days)	4	QL
<i>ELIQUIS</i> TABS 2.5mg QL (60 tabs / 30 days)	3	QL
<i>ELIQUIS</i> TABS 5mg QL (74 tabs / 30 days)	3	QL
<i>ELIQUIS</i> STARTER PACK TBPK 5mg QL (74 tabs / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<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	4	
<i>fondaparinux sodium</i> (generic of ARIXTRA) SOLN 2.5mg/0.5ml	4	
<i>fondaparinux sodium</i> (generic of ARIXTRA) SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	*
HEP SOD/D5W INJ 20000UNT	4	
HEP SOD/D5W INJ 25000UNT	4	
HEP SOD/NACL INJ 12500UNT	3	
HEP SOD/NACL INJ 25000UNT	3	
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	3	B/D
HEPARIN/NACL INJ 25000UNT	3	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
PRADAXA CAPS 110mg QL (120 caps / 30 days)	4	QL
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
XARELTO SUSR 1mg/ml QL (620 mL / 30 days)	3	QL
XARELTO TABS 2.5mg QL (60 tabs / 30 days)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
XARELTO TABS 10mg, 15mg, 20mg QL (30 tabs / 30 days)	3	QL
XARELTO STAR TAB 15/20MG QL (51 tabs / 30 days)	3	QL
HEMATOPOIETIC GROWTH FACTORS		
PROCERIT SOLN 2000unit/ml, 3 3000unit/ml, 4000unit/ml, 10000unit/ml		NM PA
PROCERIT SOLN 20000unit/ml, 40000unit/ml	5	* NM PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	* NM PA
ZIEXTENZO SOSY 6mg/0.6ml QL (2 syringes / 28 days)	5	* QL NM PA
MISCELLANEOUS		
anagrelide hcl CAPS 1mg	4	
anagrelide hcl (generic of AGRYLIN) CAPS .5mg	4	
BERINERT KIT 500unit QL (24 boxes / 30 days)	5	* QL NM LA PA
cilostazol TABS 50mg, 100mg	2	
DOPTELET TABS 20mg	5	* NM LA PA
DROXIA CAPS 200mg, 300mg, 400mg	3	
ENDARI PACK 5gm	5	* NM LA PA
HAEGARDA SOLR 2000unit QL (30 vials / 30 days)	5	* QL NM LA PA
HAEGARDA SOLR 3000unit QL (20 vials / 30 days)	5	* QL NM LA PA
icatibant acetate (generic of FIRAZYR) SOSY 30mg/3ml QL (9 syringes / 30 days)	5	* QL NM PA
pentoxifylline TBCR 400mg	2	
PROMACTA PACK 12.5mg QL (360 packets / 30 days)	5	* QL NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
PROMACTA PACK 25mg QL (180 packets / 30 days)	5	* QL NM LA PA
PROMACTA TABS 12.5mg, 25mg QL (30 tabs / 30 days)	5	* QL NM LA PA
PROMACTA TABS 50mg, 75mg QL (60 tabs / 30 days)	5	* QL NM LA PA
sajazir (generic of FIRAZYR) SOSY 30mg/3ml QL (9 syringes / 30 days)	5	* QL NM LA PA
tranexamic acid (generic of CYKLOKAPRON) SOLN 1000mg/10ml	4	
tranexamic acid TABS 650mg	3	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	4	
BRILINTA TABS 60mg, 90mg	3	
clopidogrel bisulfate (generic of PLAVIX) TABS 75mg	1	GC
dipyridamole TABS 25mg, 50mg, 75mg PA if 70 years and older	3	PA
prasugrel hcl (generic of EFFIENT) TABS 5mg, 10mg	3	
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
AUTOIMMUNE AGENTS		
ADALIMUMAB-AACF (2 PEN) AJKT 40mg/0.8ml QL (56 pens / 365 days)	5	* QL NM PA
DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	5	* NM PA
ENBREL SOLN 25mg/0.5ml QL (16 vials / 28 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
ENBREL SOSY 25mg/0.5ml QL (16 syringes / 28 days)	5	* QL NM PA
ENBREL SOSY 50mg/ml QL (8 syringes / 28 days)	5	* QL NM PA
ENBREL MINI SOCT 50mg/ml QL (8 cartridges / 28 days)	5	* QL NM PA
ENBREL SURECLICK SOAJ 50mg/ml QL (8 pens / 28 days)	5	* QL NM PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml QL (2 syringes / 28 days)	5	* QL NM PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml QL (6 syringes / 28 days)	5	* QL NM PA
HUMIRA PEDIA INJ CROHNS QL (2 syringes / 28 days)	5	* QL NM PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml QL (3 syringes / 28 days)	5	* QL NM PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml QL (6 pens / 28 days)	5	* QL NM PA
HUMIRA PEN PNKT 80mg/0.8ml QL (4 pens / 28 days)	5	* QL NM PA
HUMIRA PEN KIT PS/UV QL (3 pens / 28 days)	5	* QL NM PA
HUMIRA PEN-CD/UC/HS START PNKT 80mg/0.8ml QL (3 pens / 28 days)	5	* QL NM PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml QL (4 pens / 28 days)	5	* QL NM PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml QL (4 pens / 28 days)	5	* QL NM PA
IDACIO (2 PEN) AJKT 40mg/0.8ml QL (56 pens / 365 days)	5	* QL NM PA
IDACIO (2 SYRINGE) PSKT 40mg/0.8ml QL (56 syringes / 365 days)	5	* QL NM PA
IDACIO CROHN INJ DISEASE AJKT 40mg/0.8ml QL (2 packs / year)	5	* QL NM PA
IDACIO PLAQU INJ PSORIASIS AJKT 40mg/0.8ml QL (2 packs / year)	5	* QL NM PA
INFILIXIMAB SOLR 100mg KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml QL (2 pens / 28 days)	5	* NM LA PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml QL (2 syringes / 28 days)	5	* QL NM PA
OTEZLA TABS 30mg QL (60 tabs / 30 days)	5	* QL NM PA
OTEZLA TAB 10/20/30 QL (110 tabs / year)	5	* QL NM PA
REMICADE SOLR 100mg RENFLEXIS SOLR 100mg RINVOQ TB24 15mg, 30mg QL (30 tabs / 30 days)	5	* NM LA PA
RINVOQ TB24 45mg QL (168 tabs / year)	5	* QL NM PA
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml QL (1 cartridge / 56 days)	5	* 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
SKYRIZI SOLN 600mg/10ml QL (6 vials / year)	5	* QL NM PA
SKYRIZI SOSY 150mg/ml QL (6 syringes / 365 days)	5	* QL NM PA
SKYRIZI PEN SOAJ 150mg/ml QL (6 pens / 365 days)	5	* QL NM PA
STELARA SOLN 45mg/0.5ml QL (1 vial / 28 days)	5	* QL NM LA PA
STELARA SOLN 130mg/26ml	5	* NM LA PA
STELARA SOSY 45mg/0.5ml, 90mg/ml QL (1 syringe / 28 days)	5	* QL NM PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml QL (3 syringes / 28 days)	5	* QL NM LA PA
XELJANZ SOLN 1mg/ml QL (480 mL / 24 days)	5	* QL NM PA
XELJANZ TABS 5mg, 10mg QL (60 tabs / 30 days)	5	* QL NM PA
XELJANZ XR TB24 11mg, 22mg QL (30 tabs / 30 days)	5	* QL NM PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
hydroxychloroquine sulfate (generic of PLAQUENIL) TABS 200mg	3	
leflunomide (generic of ARAVA) TABS 10mg, 20mg QL (30 tabs / 30 days)	3	QL
methotrexate sodium TABS 2.5mg	3	
XATMEP SOLN 2.5mg/ml	4	B/D
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml, 10%	5	* NM LA PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
FLEBOGAMMA DIF SOLN 5gm/100ml, 10gm/200ml, 20gm/400ml	5	* NM PA
GAMASTAN INJ 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	4	B/D NM LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	* NM PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	* NM PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	* NM PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	* NM LA PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	* NM PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 30gm/300ml	5	* NM PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	* NM PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	* NM PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	5	* NM LA PA
ARCALYST SOLR 220mg	5	* NM LA PA
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 5mg	5	* B/D NM
ASTAGRAF XL CP24 .5mg, 1mg	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
azathioprine (generic of IMURAN) TABS 50mg	3	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml QL (8 syringes / 28 days)	5	* QL NM LA PA
BENLYSTA SOLR 120mg, 400mg	5	* NM LA PA
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg; SOLN 50mg/ml	4	B/D NM
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	4	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg, .5mg, .75mg, 1mg	5	* B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; TABS 500mg	3	B/D NM
mycophenolate mofetil (generic of CELLCEPT) SUSR 200mg/ml	5	* B/D NM
mycophenolate sodium (generic of MYFORTIC) TBEC 180mg, 360mg	4	B/D NM
NULOJIX SOLR 250mg	5	* B/D NM
PROGRAF PACK .2mg, 1mg	4	B/D NM
REZUROCK TABS 200mg	5	* NM LA PA
SANDIMMUNE SOLN 100mg/ml	4	B/D NM
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml	5	* B/D NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
sirolimus (generic of RAPAMUNE) TABS .5mg, 1mg, 2mg	4	B/D NM
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	4	B/D NM
VACCINES		
ABRYSVO SOLR 120mcg/0.5ml	1	V/I GC
ACTHIB INJ	1	V/I GC
ADACEL INJ	1	V/I GC
AREXVY SUSR 120mcg/0.5ml	1	V/I GC
BCG VACCINE SOLR 50mg	1	V/I GC
BEXSERO INJ	1	V/I GC
BOOSTRIX INJ	1	V/I GC
DAPTACEL INJ	1	GC
DENGVAXIA SUS	1	GC
DIP/TET PED INJ 25-5LFU	1	GC B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	V/I GC B/D
GARDASIL 9 INJ	1	V/I GC
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	V/I GC
HEPLISAV-B SOSY 20mcg/0.5ml	1	V/I GC B/D
HIBERIX SOLR 10mcg	1	V/I GC
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	V/I GC B/D
INFANRIX INJ	1	GC
IPOP INJ INACTIVE	1	V/I GC
IXIARO INJ	1	V/I GC
JYNNEOS SUSP .5ml	1	V/I GC B/D
KINRIX INJ	1	V/I GC
M-M-R II INJ	1	V/I GC
MENACTRA INJ	1	V/I GC
MENQUADFI INJ	1	V/I GC
MENVEO INJ	1	V/I GC
MENVEO SOL	1	V/I GC
PEDIARIX INJ 0.5ML	1	V/I GC

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	V/I GC
PENBRAYA INJ	1	V/I GC
PENTACEL INJ	1	V/I GC
PREHEVBRIOSUSP 10mcg/ml	1	V/I GC B/D
PRIORIX INJ	1	V/I GC
PROQUAD INJ	1	GC
QUADRACEL INJ	1	V/I GC
QUADRACEL INJ 0.5ML	1	V/I GC
RABAVERT INJ	1	V/I GC B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	1	V/I GC B/D
ROTARIX SUS	1	GC
ROTAQUE SOL	1	GC
SHINGRIX SUSR 50mcg/0.5ml QL (2 vials per lifetime)	1	V/I GC QL
TDVAX INJ 2-2 LF	1	V/I GC B/D
TENIVAC INJ 5-2LF	1	V/I GC B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	1	V/I GC
TRUMENBA INJ	1	V/I GC
TWINRIX INJ	1	V/I GC
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	1	V/I GC
VAQTA SUSP 25unit/0.5ml, 50unit/ml	1	V/I GC
VARIVAX INJ 1350pfu/0.5ml	1	V/I GC
YF-VAX INJ	1	V/I GC
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS ELECTROLYTES/MINERALS, INJECTABLE		
D2.5W/NACL INJ 0.45%	4	
D5W/LYTES INJ #48	4	
D10W/NACL INJ 0.2%	3	

Drug Name	Drug Requirements/ Tier	Limits
dextrose 2.5% w/ sodium chloride 0.45% (generic of DEXTROSE 2.5%/NACL 0.45%)	3	
dextrose 5% in lactated ringers	3	
dextrose 5% w/ sodium chloride 0.2%	3	
dextrose 5% w/ sodium chloride 0.3% (generic of DEXTROSE 5%/NACL 0.3%)	3	
dextrose 5% w/ sodium chloride 0.9%	3	
dextrose 5% w/ sodium chloride 0.45%	3	
dextrose 5% w/ sodium chloride 0.225% (generic of DEXTROSE/SODIUM CHLORIDE)	3	
dextrose 10% w/ sodium chloride 0.45%	3	
ISOLYTE-P INJ /D5W	4	
ISOLYTE-S INJ	4	
ISOLYTE-S INJ PH 7.4	4	
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	3	
kcl 20 meq/l (0.15%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM)	3	
kcl 20 meq/l (0.15%) in nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM)	3	
kcl 20 meq/l (0.149%) in nacl 0.45% inj	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	3	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj (generic of KCL 0.3%/D5W/NACL 0.9%)	3	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	3	
kcl 40 meq/l (0.3%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM) KCL/D5W/NACL INJ 0.3/0.9% 4	3	
lactated ringer's solution	3	
MAGNESIUM SULFATE 3 SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml		
magnesium sulfate (generic of MAGNESIUM SULFATE) SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
magnesium sulfate SOLN 50%	3	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml (generic of MAGNESIUM SULFATE IN D5W)	3	
MG SO4/D5W INJ 10MG/ML 3		
multiple electrolytes ph 5.5 (generic of PLASMA-LYTE-148)	4	
multiple electrolytes ph 7.4 (generic of PLASMA-LYTE A)	4	
PLASMA-LYTE INJ -148	4	
PLASMA-LYTE INJ -A	4	
POT CHL 20MEQ/L IN NACL 0.9% INJ	4	
POT CHL 20MEQ/L IN NACL 0.45% INJ	4	

Drug Name	Drug Requirements/ Tier	Limits
POT CHL 40MEQ/L IN NACL 0.9% INJ	4	
potassium chloride SOLN 2meq/ml	3	
POTASSIUM CHLORIDE SOLN 10meq/50ml	4	
potassium chloride (generic of POTASSIUM CHLORIDE) SOLN 10meq/100ml, 20meq/100ml, 20meq/50ml, 40meq/100ml		
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	3	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	3	
TPN ELECTROL INJ	4	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
klor-con PACK 20meq	4	
klor-con 8 TBCR 8meq	2	
klor-con 10 TBCR 10meq	2	
klor-con m10 TBCR 10meq	2	
klor-con m15 TBCR 15meq	3	
klor-con m20 TBCR 20meq	2	
M-NATAL PLUS TAB	3	
potassium chloride CPCR 8meq, 10meq	3	
potassium chloride PACK 20meq; SOLN 10%, 20%	4	
potassium chloride TBCR 8meq, 10meq	2	
potassium chloride (generic of K-TAB) TBCR 20meq	2	
potassium chloride microencapsulated crystals er TBCR 10meq, 20meq	2	
potassium chloride microencapsulated crystals er TBCR 15meq	3	
PRENATAL TAB 27-1MG	3	
PRENATAL TAB PLUS	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	2	
IV NUTRITION		
CLINIMIX INJ 4.25/D5W	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
CLINIMIX INJ 5%/D15W	4	B/D
CLINIMIX INJ 5%/D20W	4	B/D
CLINIMIX INJ 6/5	4	B/D
CLINIMIX INJ 8/10	4	B/D
CLINIMIX INJ 8/14	4	B/D
clinisol sf 15%	4	B/D
CLINOLIPID EMU 20%	4	B/D
dextrose SOLN 5%, 10%	3	
dextrose SOLN 50%, 70%	3	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
plenamine	4	B/D
PREMASOL SOL 10%	5	* B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	B/D
TROPHAMINE INJ 10%	4	B/D
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
bacitracin-polymyxin-neomycin-hc ophth oint	3	
neo-polycin hc ophth oint 1%	3	
neo-polycin hc ophth oint 1%	3	
neomycin-polymyxin-dexamethasone ophth oint 0.1% (generic of MAXITROL)	2	
neomycin-polymyxin-dexamethasone ophth susp 0.1% (generic of MAXITROL)	2	
neomycin-polymyxin-hc ophth susp	4	

Drug Name	Drug Requirements/ Tier	Limits
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	2	
TOBRADEX OIN 0.3-0.1%	3	
TOBRADEX ST SUS 0.3-0.05	3	
tobramycin-dexamethasone ophth susp 0.3-0.1%	4	
ZYLET SUS 0.5-0.3%	3	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
bacitracin (ophthalmic) OINT 500unit/gm	3	
bacitracin-polymyxin b ophth oint	2	
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
ciprofloxacin hcl (ophth) SOLN .3%	2	
erythromycin (ophth) OINT 5mg/gm	2	
gatifloxacin (ophth) SOLN .5%	3	
gentamicin sulfate (ophth) SOLN .3%	2	
moxifloxacin hcl (ophth) (generic of VIGAMOX) SOLN .5%	3	
NATACYN SUSP 5%	4	
neo-polycin 5(3.5)mg-400unt-10000unt op oin	3	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	3	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	3	
ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	2	
polycin ophth oint	2	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	GC

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
sulfacetamide sodium (ophth) OINT 10%; SOLN 10%	3	
tobramycin (ophth) SOLN .3%	1	GC
trifluridine SOLN 1%	4	
ZIRGAN GEL .15%	4	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ALREX SUSP .2%	3	
bromfenac sodium (ophth) (generic of PROLENSA) SOLN .07%	3	
bromfenac sodium (ophth) (generic of BROMSITE) SOLN .075%	4	
BROMSITE SOLN .075%	4	
dexamethasone sodium phosphate (ophth) SOLN .1%	3	
diclofenac sodium (ophth) SOLN .1%	2	
EYSUVIS SUSP .25%	4	
FLAREX SUSP .1%	4	
fluorometholone (ophth) (generic of FML LIQUIFILM) SUSP .1%	3	
flurbiprofen sodium SOLN .03%	3	
ketorolac tromethamine (ophth) (generic of ACULAR LS) SOLN .4%	3	
ketorolac tromethamine (ophth) (generic of ACULAR) SOLN .5%	2	
LOTEMAX OINT .5%	3	
prednisolone acetate (ophth) (generic of PRED FORTE) SUSP 1%	3	
PREDNISOLONE SODIUM PHOSP SOLN 1%	3	
PROLENSA SOLN .07%	3	

Drug Name	Drug Requirements/ Tier	Limits
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
azelastine hcl (ophth) SOLN .05%	3	
cromolyn sodium (ophth) SOLN 4%	2	
ZERVIADE SOLN .24%	4	
ANTIGLAUCOMA - DRUGS TO TREAT GLAUCOMA		
betaxolol hcl (ophth) SOLN .5%	3	
BETOPTIC-S SUSP .25%	4	
brimonidine tartrate SOLN .2%	1	GC
brimonidine tartrate (generic of ALPHAGAN P) SOLN .15%	4	
brinzolamide (generic of AZOPT) SUSP 1%	4	
carteolol hcl (ophth) SOLN 1%	2	
COMBIGAN SOL 0.2/0.5%	3	
dorzolamide hcl SOLN 2%	2	
dorzolamide hcl-timolol maleate ophth soln 2-0.5% (generic of COSOPT)	2	
latanoprost (generic of XALATAN) SOLN .005%	1	GC
levobunolol hcl SOLN .5%	2	
LUMIGAN SOLN .01%	3	
pilocarpine hcl SOLN 1%, 2%, 4%	3	
RHOPRESSA SOLN .02%	4	
ROCKLATAN DRO	4	
SIMBRINZA SUS 1-0.2%	4	
timolol maleate (ophth) SOLG 4 .25%, .5%	4	
timolol maleate (ophth) SOLN 1 .25%, .5%	1	GC
VYZULTA SOLN .024%	4	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	3	
atropine sulfate (ophthalmic) SOLN 1%	3	
CYSTADROPS SOLN .37%	5	* NM LA PA
CYSTARAN SOLN .44%	5	* NM LA PA
proparacaine hcl (generic of ALCALINE) SOLN .5%	3	
RESTASIS EMUL .05%	3	
RESTASIS MULTIDOSE EMUL .05%	3	
TYRVAYA SOLN .03mg/act	4	
IIDRA SOLN 5%	3	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
OTIC AGENTS		
acetic acid (otic) SOLN 2%	3	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	4	
flac (generic of DERMOTIC) OIL .01%	3	
fluocinolone acetonide (otic) (generic of DERMOTIC) OIL .01%	3	
neomycin-polymyxin-hc otic soln 1%	3	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	3	
ofloxacin (otic) SOLN .3%	4	
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPT AER 62.5-25	3	QL QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	3	QL QL (1 inhaler / 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
BREZTRI AERO AER SPHERE	3	QL QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	3	QL QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	4	QL QL (2 inhalers / 30 days)
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	3	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	3	QL QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	3	QL QL (60 blisters / 30 days)
ANTICHOLINERGICS - DRUGS TO TREAT COPD		
ATROVENT HFA AERS 17mcg/act	4	QL QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	3	QL QL (30 blisters / 30 days)
ipratropium bromide SOLN .02%	2	B/D
ipratropium bromide (nasal) SOLN .03%, .06%	3	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
azelastine hcl SOLN .1%	3	
cetirizine hcl SOLN 1mg/ml	2	QL QL (300 mL / 30 days)
ciproheptadine hcl SYRP 2mg/5ml; TABS 4mg	3	PA PA if 70 years and older
diphenhydramine hcl SOLN 50mg/ml	3	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
hydroxyzine hcl SOLN 25mg/ml, 50mg/ml PA if 70 years and older	4	PA
hydroxyzine hcl SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg PA if 70 years and older	3	PA
hydroxyzine pamoate (generic of VISTARIL) CAPS 25mg PA if 70 years and older	3	PA
hydroxyzine pamoate CAPS 50mg PA if 70 years and older	3	PA
levocetirizine dihydrochloride SOLN 2.5mg/5ml QL (300 mL / 30 days)	4	QL
levocetirizine dihydrochloride TABS 5mg QL (30 tabs / 30 days)	3	QL
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
albuterol sulfate AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proair HFA)	3	QL
albuterol sulfate AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Ventolin HFA)	3	QL
albuterol sulfate (generic of PROVENTIL HFA) AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proventil HFA)	3	QL
albuterol sulfate NEBU .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	3	B/D
albuterol sulfate NEBU .083% 2	2	B/D
albuterol sulfate SYRP 2mg/5ml	3	
albuterol sulfate TABS 2mg, 4mg	4	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
levalbuterol hcl NEBU 1.25mg/0.5ml, 1.25mg/3ml	4	B/D
levalbuterol tartrate AERO 45mcg/act QL (2 inhalers / 30 days)	3	QL ST
SEREVENT DISKUS AEPB 50mcg/dose QL (60 inhalations / 30 days)	3	QL
terbutaline sulfate TABS 2.5mg, 5mg	4	
VENTOLIN HFA AERS 108mcg/act QL (2 inhalers / 30 days)	3	QL
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act QL (6 inhalers / 30 days)	3	QL
LEUKOTRIENE MODULATORS		
montelukast sodium (generic of SINGULAIR) CHEW 4mg, 5mg	2	
montelukast sodium (generic of SINGULAIR) PACK 4mg	4	
montelukast sodium (generic of SINGULAIR) TABS 10mg	1	GC
zafirlukast (generic of ACCOLATE) TABS 10mg, 20mg	3	
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	4	B/D
ARALAST NP SOLR 500mg, 1000mg	5	* NM LA PA
BRONCHITOL CAPS 40mg QL (560 caps / 28 days)	5	* QL NM LA PA
cromolyn sodium NEBU 20mg/2ml	3	B/D
epinephrine (anaphylaxis) (generic of EPIPEN 2-PAK) SOAJ .3mg/0.3ml (generic of EpiPen)	3	

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
epinephrine (anaphylaxis) (generic of EPIPEN-JR 2-PAK) SOAJ .15mg/0.3ml (generic of EpiPen)	3	
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)	3	
FASENRA SOSY 30mg/ml	5	* NM LA PA
FASENRA PEN SOAJ 30mg/ml	5	* NM LA PA
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg QL (56 packs / 28 days)	5	* QL NM LA PA
KALYDECO TABS 150mg QL (60 tabs / 30 days)	5	* QL NM LA PA
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)	5	* QL NM LA PA
ORKAMBI GRA 75-94MG QL (56 packs / 28 days)	5	* QL NM LA PA
ORKAMBI GRA 100-125 QL (56 packs / 28 days)	5	* QL NM LA PA
ORKAMBI GRA 150-188 QL (56 packs / 28 days)	5	* QL NM LA PA
ORKAMBI TAB 100-125 QL (112 tabs / 28 days)	5	* QL NM LA PA
ORKAMBI TAB 200-125 QL (112 tabs / 28 days)	5	* QL NM LA PA
pirfenidone (generic of ESBRIET) CAPS 267mg QL (270 caps / 30 days)	5	* QL NM PA
pirfenidone (generic of ESBRIET) TABS 267mg QL (270 tabs / 30 days)	5	* QL NM PA
pirfenidone TABS 534mg QL (90 tabs / 30 days)	5	* QL NM PA
pirfenidone (generic of ESBRIET) TABS 801mg QL (90 tabs / 30 days)	5	* QL NM PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	5	* NM LA PA

Drug Name	Drug Requirements/ Tier	Limits
PULMOZYME SOLN 2.5mg/2.5ml	5	* NM PA
roflumilast (generic of DALIRESP) TABS 250mcg QL (56 tabs / year)	3	QL
roflumilast (generic of DALIRESP) TABS 500mcg QL (30 tabs / 30 days)	3	QL
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	5	* QL NM LA PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	5	* QL NM LA PA
theophylline ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 100mg, 200mg, 300mg, 450mg	4	
theophylline TB24 400mg, 600mg	3	
TRIKAFTA PAK 59.5MG QL (56 packs / 28 days)	5	* QL NM LA PA
TRIKAFTA PAK 75MG QL (56 packs / 28 days)	5	* QL NM LA PA
TRIKAFTA TAB 50-25- 37.5MG & 75MG QL (84 tabs / 28 days)	5	* QL NM LA PA
TRIKAFTA TAB 100-50-75MG & 150MG QL (84 tabs / 28 days)	5	* QL NM LA PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	5	* NM LA PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	5	* NM LA PA
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) SOLN .025%	3	QL
QL (3 bottles / 30 days)		
fluticasone propionate (nasal) SUSP 50mcg/act QL (1 bottle / 30 days)	2	QL
XHANCE EXHU 93mcg/act QL (32 mL / 30 days)	4	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA AEPB	3	QL 50mcg/act, 100mcg/act, 200mcg/act QL (30 inhalations / 30 days)
budesonide (inhalation) (generic of PULMICORT) SUSP .25mg/2ml, .5mg/2ml	4	B/D
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
ADVAIR HFA AER 45/21 QL (1 inhaler / 30 days)	3	QL
ADVAIR HFA AER 115/21 QL (1 inhaler / 30 days)	3	QL
ADVAIR HFA AER 230/21 QL (1 inhaler / 30 days)	3	QL
BREO ELLIPTA INH 50- 25MCG QL (60 blisters / 30 days)	3	QL
BREO ELLIPTA INH 100-25 QL (60 blisters / 30 days)	3	QL
BREO ELLIPTA INH 200-25 QL (60 blisters / 30 days)	3	QL
DULERA AER 50-5MCG QL (3 inhalers / 30 days)	4	QL
DULERA AER 100-5MCG QL (3 inhalers / 30 days)	4	QL
DULERA AER 200-5MCG QL (3 inhalers / 30 days)	4	QL
fluticasone-salmeterol aer powder ba 100-50 mcg/act (generic of ADVAIR DISKUS) QL (60 inhalations / 30 days) (generic PRASCO not covered)	3	QL

Drug Name	Drug Requirements/ Tier	Limits
fluticasone-salmeterol aer powder ba 250-50 mcg/act (generic of ADVAIR DISKUS) QL (60 inhalations / 30 days) (generic PRASCO not covered)	3	QL
fluticasone-salmeterol aer powder ba 500-50 mcg/act (generic of ADVAIR DISKUS) QL (60 inhalations / 30 days) (generic PRASCO not covered)	3	QL
wixela inhub (generic of ADVAIR DISKUS) QL (60 inhalations / 30 days)	3	QL
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
accutane CAPS 10mg, 20mg, 30mg, 40mg	4	PA
amnesteem CAPS 10mg, 20mg, 40mg	4	PA
benzoyl peroxide- erythromycin gel 5-3% (generic of BENZAMYCIN) QL (46.6 gm / 30 days)	4	QL
claravis CAPS 10mg, 20mg, 30mg, 40mg	4	PA
clindamycin phosphate (topical) GEL 1% QL (75 gm / 30 days)	3	QL
clindamycin phosphate (topical) (generic of CLEOCIN-T) LOTN 1% QL (60 mL / 30 days)	3	QL
clindamycin phosphate (topical) SOLN 1% QL (60 mL / 30 days)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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	
ery PADS 2% QL (60 pledges / 30 days)	3	QL
erythromycin (acne aid) (generic of ERYGEL) GEL 2% QL (60 gm / 30 days)	3	QL
erythromycin (acne aid) SOLN 2% QL (60 mL / 30 days)	3	QL
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	4	PA
sulfacetamide sodium (acne) (generic of KLARON) LOTN 10% QL (118 mL / 30 days)	4	QL
tretinoin (generic of RETIN-A) CREA .025%, .05%, .1%; GEL .01%, .025% QL (45 gm / 30 days)	4	QL PA
zenatane CAPS 10mg, 20mg, 4 30mg, 40mg	4	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) CREA .1%; OINT .1% QL (30 gm / 30 days)	3	QL
mupirocin OINT 2% QL (220 gm / 30 days)	2	QL
silver sulfadiazine (generic of SILVADENE) CREA 1%	2	
ssd (generic of SILVADENE) 2 CREA 1%		
SULFAMYLON CREA 85mg/gm QL (453.6 gm / 30 days)	4	QL
DERMATOLOGY, ANTIFUNGALS		
ciclopirox olamine CREA .77% QL (90 gm / 30 days)	3	QL
ciclopirox olamine SUSP .77% QL (60 mL / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier Limits	
clotrimazole (topical) CREA 1% QL (45 gm / 30 days)	2	QL
clotrimazole (topical) SOLN 1% QL (30 mL / 30 days)	3	QL
clotrimazole w/ betamethasone cream 1- 0.05% QL (45 gm / 30 days)	3	QL
ketoconazole (topical) CREA 2% QL (60 gm / 30 days)	3	QL
klayesta POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
nyamyc POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm QL (30 gm / 30 days)	2	QL
nystatin (topical) POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
nystop POWD 100000unit/gm QL (60 gm / 30 days)	3	QL
DERMATOLOGY, ANTISSORIATICS		
acitretin CAPS 10mg, 17.5mg, 25mg	4	PA
calcipotriene CREA .005%; OINT .005% QL (120 gm / 30 days)	4	QL PA
calcipotriene SOLN .005% QL (120 mL / 30 days)	4	QL PA
calcitrene OINT .005% QL (120 gm / 30 days)	4	QL PA
tazarotene (generic of TAZORAC) CREA .1% QL (60 gm / 30 days)	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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
TAZORAC CREA .05% QL (60 gm / 30 days)	4	QL PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) SHAM 2 2% QL (120 mL / 30 days)	2	QL
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort CREA 1% ala-cort CREA 2.5%	1 2	GC
alclometasone dipropionate CREA .05%; OINT .05% QL (60 gm / 30 days)	3	QL
betamethasone dipropionate (topical) CREA .05% QL (120 gm / 30 days)	3	QL
betamethasone dipropionate (topical) LOTN .05% QL (120 mL / 30 days)	3	QL
betamethasone dipropionate (topical) OINT .05% QL (120 gm / 30 days)	4	QL
betamethasone dipropionate augmented CREA .05% QL (120 gm / 30 days)	2	QL
betamethasone dipropionate augmented GEL .05% QL (120 gm / 30 days)	4	QL
betamethasone dipropionate augmented LOTN .05% QL (120 mL / 30 days)	4	QL
betamethasone dipropionate augmented (generic of DIPROLENE) OINT .05% QL (120 gm / 30 days)	4	QL
betamethasone valerate CREA .1%; OINT .1% QL (120 gm / 30 days)	3	QL
betamethasone valerate LOTN .1% QL (120 mL / 30 days)	3	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
clobetasol propionate CREA .05%; GEL .05%; OINT .05% QL (60 gm / 30 days)	4	QL
clobetasol propionate SOLN .05%		
QL (50 mL / 30 days)	4	QL
clobetasol propionate e CREA .05% QL (60 gm / 30 days)		
ENSTILAR AER QL (120 gm / 30 days)		
fluocinolone acetonide CREA .01% QL (60 gm / 30 days)		
fluocinolone acetonide (generic of SYNALAR) CREA .025% QL (120 gm / 30 days)		
fluocinolone acetonide (generic of DERMA-SMOOTH/FS BODY) OIL .01% QL (118.28 mL / 30 days)		
fluocinolone acetonide (generic of DERMA-SMOOTH/FS SCALP) OIL .01% QL (118.28 mL / 30 days)		
fluocinolone acetonide (generic of SYNALAR) OINT .025% QL (120 gm / 30 days)		
fluocinolone acetonide SOLN .01% QL (90 mL / 30 days)		
fluocinonide CREA .05% QL (120 gm / 30 days)		
fluocinonide GEL .05%; OINT .05% QL (60 gm / 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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>fluocinonide SOLN .05% QL (60 mL / 30 days)</i>	3	QL
<i>fluocinonide emulsified base CREA .05% QL (120 gm / 30 days)</i>	3	QL
<i>fluticasone propionate CREA .05%; OINT .005%</i>	3	
<i>halobetasol propionate CREA .05%; OINT .05% QL (50 gm / 30 days)</i>	4	QL
<i>hydrocortisone (topical) CREA 1%</i>	1	GC
<i>hydrocortisone (topical) CREA 2.5%; LOTN 2.5%; OINT 2.5%</i>	2	
<i>mometasone furoate CREA .1%; OINT .1%; SOLN .1%</i>	3	
<i>triamcinolone acetonide (topical) CREA .025%, .1%, .5% QL (454 gm / 30 days)</i>	2	QL
<i>triamcinolone acetonide (topical) LOTN .025%, .1%</i>	3	
<i>triamcinolone acetonide (topical) OINT .025%, .1%, .5%</i>	2	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo PRSY 2% QL (60 mL / 30 days)</i>	4	QL PA
<i>lidocaine OINT 5% QL (50 gm / 30 days)</i>	4	QL PA
<i>lidocaine (generic of LIDODERM) PTCH 5% QL (3 patches / 1 day)</i>	4	QL PA
<i>lidocaine hcl SOLN 4% QL (50 mL / 30 days)</i>	3	QL PA
<i>lidocaine-prilocaine cream 2.5-2.5% QL (30 gm / 30 days)</i>	3	B/D QL
<i>lidocan iii (generic of LIDODERM) PTCH 5% QL (3 patches / 1 day)</i>	4	QL PA

Drug Name	Drug Requirements/ Tier Limits	
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>bexarotene (topical) (generic of TARGRETIN) GEL 1% QL (60 gm / 30 days)</i>	5	* QL NM PA
<i>diclofenac sodium (topical) GEL 1% QL (1000 gm / 30 days)</i>	3	QL
<i>fluorouracil (topical) (generic of EFUDEX) CREA 5% QL (40 gm / 30 days)</i>	4	QL
<i>fluorouracil (topical) SOLN 2%, 5% QL (10 mL / 30 days)</i>	3	QL
<i>hydrocortisone (rectal) (generic of PROCTOCORT) CREA 1%</i>	3	
<i>hydrocortisone (rectal) (generic of ANUSOL-HC) CREA 2.5%</i>	3	
<i>imiquimod CREA 5% QL (24 packets / 30 days)</i>	3	QL
<i>lactic acid (ammonium lactate) CREA 12%</i>	2	
<i>lactic acid (ammonium lactate) LOTN 12%</i>	3	
<i>metronidazole (topical) (generic of METROCREAM) CREA .75% QL (45 gm / 30 days)</i>	4	QL
<i>metronidazole (topical) GEL .75% QL (45 gm / 30 days)</i>	3	QL
<i>metronidazole (topical) (generic of METROLOTION) LOTN .75% QL (59 mL / 30 days)</i>	4	QL
<i>PANRETIN GEL .1% QL (60 gm / 30 days)</i>	5	* QL PA
<i>podofilox SOLN .5% QL (7 mL / 28 days)</i>	3	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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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>procto-med hc</i> (generic of ANUSOL-HC) CREA 2.5%	3	
<i>proctosol hc</i> (generic of ANUSOL-HC) CREA 2.5%	3	
<i>protozone-hc</i> (generic of ANUSOL-HC) CREA 2.5%	3	
RECTIV OINT .4% QL (30 gm / 30 days)	4	QL
<i>tacrolimus (topical)</i> OINT .03%, .1% QL (100 gm / 30 days)	4	QL
VALCHLOR GEL .016% QL (60 gm / 30 days)	5	* QL NM LA PA

DERMATOLOGY, SCABICIDES AND PEDICULIDES

<i>malathion</i> LOTN .5% QL (59 mL / 30 days)	4	QL
<i>permethrin</i> CREA 5% QL (60 gm / 30 days)	3	QL
<i>DERMATOLOGY, WOUND CARE AGENTS</i>		
REGRANEX GEL .01% QL (30 gm / 30 days)	5	* QL PA
SANTYL OINT 250unit/gm QL (180 gm / 30 days)	4	QL
<i>sodium chloride (gu irrigant)</i> SOLN .9%	3	
<i>water for irrigation, sterile</i> <i>irrigation soln</i>	2	

MOUTH/THROAT/DENTAL AGENTS

<i>chlorhexidine gluconate</i> (mouth-throat) (generic of PERIDEX) SOLN .12%	1	GC
<i>clotrimazole</i> TROC 10mg QL (150 lozenges / 30 days)	3	QL
<i>kourzeq</i> PSTE .1%	3	
<i>lidocaine hcl (mouth-throat)</i> SOLN 2%	2	
<i>nystatin (mouth-throat)</i> SUSP 2 100000unit/ml	2	
<i>periogard</i> (generic of PERIDEX) SOLN .12%	1	GC

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 **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. * - Not available as extended days supply **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.....15
abacavir sulfate-lamivudine
tab 600-300 mg.....16
ABELCET14
ABILIFY
 see aripiprazole.....40
ABILITY MAINTENA.....40
abiraterone acetate.....21
ABRYSVO69
acamprosate calcium.....50
acarbose.....51
ACCOLATE
 see zafirlukast.....75
ACCUPRIL
 see quinapril hcl29
accutane77
acebutolol hcl.....33
acetaminophen w/ codeine
 soln 120-12 mg/5ml....11
acetaminophen w/ codeine
 tab 300-15 mg.....11
acetaminophen w/ codeine
 tab 300-30 mg.....11
acetaminophen w/ codeine
 tab 300-60 mg.....11
acetazolamide35
acetic acid.....64
acetic acid (otic).....74
acetylcysteine75
acitretin78
ACTHIB INJ69
ACTIMMUNE68
ACTIVELLA
 see estradiol &
 norethindrone acetate
 tab 1-0.5 mg58
 see mimvey.....58
ACTOPLUS MET
 see pioglitazone hcl-
 metformin hcl tab 15-
 850 mg52
ACTOS
 see pioglitazone hcl....52
ACULAR
 see ketorolac
 tromethamine (ophth)
 73
- ACULAR LS
 see ketorolac
 tromethamine (ophth)
 73
- acyclovir.....17
acyclovir sodium17
ADACEL INJ69
ADALIMUMAB-AACF (2
 PEN)66
- ADDERALL
 see amphetamine-
 dextroamphetamine
 tab 10 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 12.5 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 15 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 20 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 30 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 5 mg.....47
- see amphetamine-
 dextroamphetamine
 tab 7.5 mg.....47
- ADDERALL XR
 see amphetamine-
 dextroamphetamine
 cap er 24hr 10 mg ...46
- see amphetamine-
 dextroamphetamine
 cap er 24hr 15 mg ...47
- see amphetamine-
 dextroamphetamine
 cap er 24hr 20 mg ...47
- see amphetamine-
 dextroamphetamine
 cap er 24hr 25 mg ...47
- see amphetamine-
 dextroamphetamine
 cap er 24hr 30 mg ...47
- see amphetamine-
 dextroamphetamine
 cap er 24hr 5 mg46
- adefovir dipivoxil17
- ADEMPAS36
- ADMELOG53
- ADMELOG SOLOSTAR .53
- ADVAIR DISKUS
 see fluticasone-
 salmeterol aer powder
 ba 100-50 mcg/act...77
- see fluticasone-
 salmeterol aer powder
 ba 250-50 mcg/act...77
- see fluticasone-
 salmeterol aer powder
 ba 500-50 mcg/act...77
- see wixela inhub.....77
- ADVAIR HFA AER 115/21
 77
- ADVAIR HFA AER 230/21
 77
- ADVAIR HFA AER 45/21 77
- AFINITOR
 see everolimus24
- AFINITOR DISPERZ
 see everolimus24
- afirmelle55
- AGRYLIN
 see anagrelide hcl.....66
- AIMOVIG48
- AKEEGA TAB 100/500 ..21
- AKEEGA TAB 50/500MG
 21
- ala-cort.....79
- albendazole12
- albuterol sulfate75
- ALCAINE
 see proparacaine hcl...74
- alclometasone dipropionate
 79
- ALDACTONE
 see spironolactone29
- ALDURAZYME59

ALECENSA	23	amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	19
alendronate sodium	55	amoxicillin & k clavulanate tab 250-125 mg	19
alfuzosin hcl.....	64	amoxicillin & k clavulanate tab 500-125 mg	19
ALIMTA see pemetrexed disodium	21	amoxicillin & k clavulanate tab 875-125 mg	19
ALINIA see nitazoxanide	13	amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	19
aliskiren fumarate	35	amphetamine- dextroamphetamine cap er 24hr 10 mg.....	46
allopurinol	10	amphetamine- dextroamphetamine cap er 24hr 15 mg.....	47
alosetron hcl	63	amphetamine- dextroamphetamine cap er 24hr 20 mg.....	47
ALPHAGAN P see brimonidine tartrate	73	amphetamine- dextroamphetamine cap er 24hr 25 mg.....	47
alprazolam	36	amphetamine- dextroamphetamine cap er 24hr 30 mg.....	47
ALREX.....	73	amphetamine- dextroamphetamine cap er 24hr 5 mg.....	46
ALTACE see ramipril	29	amphetamine- dextroamphetamine tab 10 mg	47
altavera.....	55	amphetamine- dextroamphetamine tab 12.5 mg	47
ALUNBRIG	23	amphetamine- dextroamphetamine tab 15 mg	47
ALUNBRIG PAK	23	amphetamine- dextroamphetamine tab 20 mg	47
alyacen 1/35	55	amphetamine- dextroamphetamine tab 30 mg	47
alyacen 7/7/7	55		
amabelz tab 0.5-0.1mg	58		
amantadine hcl	39		
AMBIEN see zolpidem tartrate...48			
AMBISOME see amphotericin b liposome	14		
ambrisentan.....	36		
amikacin sulfate.....	12		
amiloride & hydrochlorothiazide tab 5-50 mg.....	35		
amiloride hcl	35		
amiodarone hcl	31		
amitriptyline hcl.....	37		
amlodipine besylate.....	34		
amlodipine besylate- benazepril hcl cap 10-20 mg	28		
amlodipine besylate- benazepril hcl cap 10-40 mg	28		
amlodipine besylate- benazepril hcl cap 2.5-10 mg	28		
amlodipine besylate- benazepril hcl cap 5-10 mg	28	amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	19
amlodipine besylate- benazepril hcl cap 5-20 mg	28	amoxicillin & k clavulanate tab 250-125 mg	19
amlodipine besylate- benazepril hcl cap 5-40 mg	28	amoxicillin & k clavulanate tab 500-125 mg	19
amlodipine besylate- olmesartan medoxomil tab 10-20 mg	30	amoxicillin & k clavulanate tab 875-125 mg	19
amlodipine besylate- olmesartan medoxomil tab 10-40 mg	30	amphetamine- dextroamphetamine cap er 24hr 10 mg.....	46
amlodipine besylate- olmesartan medoxomil tab 5-20 mg	30	amphetamine- dextroamphetamine cap er 24hr 15 mg.....	47
amlodipine besylate- olmesartan medoxomil tab 5-40 mg	30	amphetamine- dextroamphetamine cap er 24hr 20 mg.....	47
amlodipine besylate- valsartan tab 10-160 mg	30	amphetamine- dextroamphetamine cap er 24hr 25 mg.....	47
amlodipine besylate- valsartan tab 10-320 mg	30	amphetamine- dextroamphetamine cap er 24hr 30 mg.....	47
amlodipine besylate- valsartan tab 5-160 mg	30	amphetamine- dextroamphetamine cap er 24hr 5 mg.....	46
amlodipine besylate- valsartan tab 5-320 mg	30	amphetamine- dextroamphetamine tab 10 mg	47
amnesteem.....	77	amphetamine- dextroamphetamine tab 12.5 mg	47
amoxapine	37	amphetamine- dextroamphetamine tab 15 mg	47
amoxicillin	19	amphetamine- dextroamphetamine tab 20 mg	47
amoxicillin & k clavulanate chew tab 200-28.5 mg.	19	amphetamine- dextroamphetamine tab 30 mg	47
amoxicillin & k clavulanate chew tab 400-57 mg....	19	amphetamine- dextroamphetamine tab 5 mg	47
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	19		
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	19		
amoxicillin & k clavulanate for susp 400-57 mg/5ml	19		

amphetamine-	
dextroamphetamine tab	
7.5 mg.....	47
amphotericin b.....	14
amphotericin b liposome.....	14
ampicillin.....	19
ampicillin & sulbactam	
sodium for inj 1.5 (1-0.5) gm.....	19
ampicillin & sulbactam	
sodium for inj 3 (2-1) gm.....	19
ampicillin & sulbactam	
sodium for iv soln 1.5 (1-0.5) gm.....	19
ampicillin & sulbactam	
sodium for iv soln 15 (10-5) gm.....	20
ampicillin & sulbactam	
sodium for iv soln 3 (2-1) gm.....	20
ampicillin sodium	20
AMPYRA	
see <i>dalfampridine</i>	49
ANAFRANIL	
see <i>clomipramine hcl</i> ..	37
anagrelide hcl	66
ANAPROX DS	
see <i>naproxen sodium</i> ..	10
anastrozole	21
ANCOBON	
see <i>flucytosine</i>	14
ANDROGEL PUMP	
see <i>testosterone</i>	51
ANORO ELLIPT AER 62.5-25	74
ANUSOL-HC	
see <i>hydrocortisone (rectal)</i>	80
see <i>procto-med hc</i>	81
see <i>proctosol hc</i>	81
see <i>protozone-hc</i>	81
aprepitant.....	61
aprepitant capsule therapy	
pack 80 & 125 mg	61
apri.....	55
APRISO	
see <i>mesalamine</i>	62
APTIOM	43
APTIVUS	15
ARALAST NP	75
aranelle.....	55
ARAVA	
see <i>leflunomide</i>	68
ARCALYST	68
AREXVY	69
ARICEPT	
see <i>donepezil hydrochloride</i>	37
ARIMIDEX	
see <i>anastrozole</i>	21
aripiprazole	40
ARISTADA	40
ARISTADA INITIO	40
ARIIXTRA	
see <i>fondaparinux sodium</i>	65
armodafinil.....	50
ARNUITY ELLIPTA.....	77
AROMASIN	
see <i>exemestane</i>	22
asenapine maleate	40
aspirin-dipyridamole cap er	
12hr 25-200 mg.....	66
ASTAGRAF XL	68
ATACAND	
see <i>candesartan cilexetil</i>	31
atazanavir sulfate.....	15
atenolol.....	33
atenolol & chlorthalidone	
tab 100-25 mg	33
atenolol & chlorthalidone	
tab 50-25 mg	33
ATIVAN	
see <i>lorazepam</i>	36
atomoxetine hcl.....	47
atorvastatin calcium.....	32
atovaquone	12
atovaquone-proguanil hcl	
tab 250-100 mg	15
atovaquone-proguanil hcl	
tab 62.5-25 mg	15
ATRIPLA	
see <i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	16
ATROPINE SULFATE	74
atropine sulfate	
(ophthalmic)	74
ATROVENT HFA	74
aubra eq	55
AUGMENTIN	
see <i>amoxicillin & k clavulanate tab 500-125 mg</i>	19
AUGMENTIN ES-600	
see <i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	19
AUGTYRO	23
aurovela 1/20.....	55
aurovela fe 1.5/30.....	55
aurovela fe 1/20.....	55
AUSTEDO	49
AUSTEDO XR	49
AUSTEDO XR TAB TITR KIT	49
AUVELITY TAB 45-105MG	37
AVALIDE	
see <i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	30
see <i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	30
AVAPRO	
see <i>irbesartan</i>	31
aviane	55
AVODART	
see <i>dutasteride</i>	64
ayuna	55
AYVAKIT	23
azacitidine	21
AZACTAM	
see <i>aztreonam</i>	12
azathioprine	69
azelastine hcl	74
azelastine hcl (ophth).....	73
AZILECT	
see <i>rasagiline mesylate</i>	39
azithromycin.....	18
AZOPT	
see <i>brinzolamide</i>	73

AZOR

- see *amlodipine besylate-olmesartan medoxomil tab 10-20 mg* 30
see *amlodipine besylate-olmesartan medoxomil tab 10-40 mg* 30
see *amlodipine besylate-olmesartan medoxomil tab 5-20 mg* 30
see *amlodipine besylate-olmesartan medoxomil tab 5-40 mg* 30
aztreonam 12
AZULFIDINE
see *sulfasalazine* 63
AZULFIDINE EN-TABS
see *sulfasalazine* 63
azurette 55
B
bacitracin (ophthalmic) 72
bacitracin-polymyxin b ophth oint 72
bacitracin-polymyxin-neomycin-hc ophth oint 1% 72
baclofen 50
BACTRIM
see *sulfamethoxazole-trimethoprim tab 400-80 mg* 14
BACTRIM DS
see *sulfamethoxazole-trimethoprim tab 800-160 mg* 14
BAFIERTAM 49
balsalazide disodium 62
BALVERSA 23
balziva 55
BANZEL
see *rufinamide* 45
BARACLUDE 17
see *entecavir* 17
BASAGLAR KWIKPEN 53
BCG VACCINE 69
BD ALCOHOL SWABS 53
benazepril & hydrochlorothiazide tab 10-12.5 mg 28

- benazepril & hydrochlorothiazide tab 20-12.5 mg* 28
benazepril & hydrochlorothiazide tab 20-25 mg 29
benazepril & hydrochlorothiazide tab 5-6.25mg 28
benazepril hcl 29
BENDEKA 20
BENICAR
see *olmesartan medoxomil* 31
BENICAR HCT
see *olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg* 30
see *olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg* 30
see *olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg* 30
BENLYSTA 69
BENZAMYCIN
see *benzoyl peroxide-erythromycin gel 5-3%* 77
benzoyl peroxide-erythromycin gel 5-3% 77
benztropine mesylate 39
BERINERT 66
BESIVANCE 72
BESREMI 22
betaine powder for oral solution 59
betamethasone dipropionate (topical) 79
betamethasone dipropionate augmented 79
betamethasone valerate 79
BETAPACE
see *sorine* 32
see *sotalol hcl* 32

BETAPACE AF

- see *sotalol hcl (afib/afl)* 32
BETASERON 49
betaxolol hcl (ophth) 73
bethanechol chloride 64
BETOPTIC-S 73
BEVESPI AER 9-4.8MCG 74
bexarotene 22
bexarotene (topical) 80
BEXSERO INJ 69
BIAXIN XL
see *clarithromycin* 18
bicalutamide 21
BICILLIN L-A 20
BIKTARVY TAB 30-120-15 MG 16
BIKTARVY TAB 50-200-25 MG 16
BILTRICIDE
see *praziquantel* 13
bisoprolol & hydrochlorothiazide tab 10-6.25 mg 33
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg 33
bisoprolol & hydrochlorothiazide tab 5-6.25 mg 33
bisoprolol fumarate 33
BIVIGAM 68
blisovi fe 1.5/30 55
BOOSTRIX INJ 69
bortezomib 23
BORTEZOMIB 23
bosentan 36
BOSULIF 23
BRAFTOVI 23
BREO ELLIPTA INH 100-25 77
BREO ELLIPTA INH 200-25 77
BREO ELLIPTA INH 50-25MCG 77
BREZTRI AERO AER SPHERE 74
BREZTRI AERO AER SPHERE

(INSTITUTIONAL PACK)	
.....	74
briellyn	55
BRILINTA	66
brimonidine tartrate	73
brinzolamide	73
BRIVIACT	43
bromfenac sodium (ophth)	73
bromocriptine mesylate	39
BROMSITE	73
see bromfenac sodium (ophth)	73
BRONCHITOL	75
BRUKINSA	23
budesonide	62
budesonide (inhalation)	77
bumetanide	35
BUMEX	
see bumetanide	35
BUPHENYL	
see sodium phenylbutyrate	60
buprenorphine hcl	50
buprenorphine hcl-	
naloxone hcl sl film 12-3	
mg (base equiv)	50
buprenorphine hcl-	
naloxone hcl sl film 2-0.5	
mg (base equiv)	50
buprenorphine hcl-	
naloxone hcl sl film 4-1	
mg (base equiv)	50
buprenorphine hcl-	
naloxone hcl sl film 8-2	
mg (base equiv)	50
buprenorphine hcl-	
naloxone hcl sl tab 2-0.5	
mg (base equiv)	50
buprenorphine hcl-	
naloxone hcl sl tab 8-2	
mg (base equiv)	50
bupropion hcl	37
bupropion hcl (smoking deterrent)	50
buspirone hcl	36
butorphanol tartrate	11
BYDUREON BCISE	51
BYETTA	51
BYSTOLIC	
see nebivolol hcl	34
C	
cabergoline	59
CABOMETYX	23
calcipotriene	78
calcitonin (salmon) spray	55
calcitrene	78
calcitriol	61
calcitriol (oral)	61
calcium acetate (phosphate binder)	60
CALQUENCE	23
camila	55
CAMPTOSAR	
see irinotecan hcl	22
CANASA	
see mesalamine	62
CANCIDAS	
see caspofungin acetate	
.....	14
candesartan cilexetil	31
CAPLYTA	40
CAPRELSA	23, 24
captopril	29
captopril &	
hydrochlorothiazide tab 25-15 mg	29
captopril &	
hydrochlorothiazide tab 25-25 mg	29
captopril &	
hydrochlorothiazide tab 50-15 mg	29
captopril &	
hydrochlorothiazide tab 50-25 mg	29
CARAFATE	
see sucralfate	63
carb/levo orally	
disintegrating tab 10-100mg	39
carb/levo orally	
disintegrating tab 25-100mg	39
carb/levo orally	
disintegrating tab 25-250mg	39
CARBAGLU	
see carglumic acid	59
carbamazepine	43
CARBATROL	
see carbamazepine	43
carbidopa & levodopa tab 10-100 mg	39
carbidopa & levodopa tab 25-100 mg	39
carbidopa & levodopa tab 25-250 mg	39
carbidopa & levodopa tab er 25-100 mg	39
carbidopa & levodopa tab er 50-200 mg	39
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	39
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	39
carbidopa-levodopa-entacapone tabs 25-100-200 mg	39
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	39
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	39
carbidopa-levodopa-entacapone tabs 50-200-200 mg	39
carboplatin	20
CARDIZEM	
see diltiazem hcl	34
CARDIZEM CD	
see cartia xt	34
see diltiazem hcl coated beads	34
CARDURA	
see doxazosin mesylate	
.....	29
carglumic acid	59
CARNITOR	
see levocarnitine (metabolic modifiers)	
.....	60
carteolol hcl (ophth)	73
cartia xt	34

<i>carvedilol</i>	33
CASODEX	
see <i>bicalutamide</i>	21
caspofungin acetate.....	14
CATAPRES-TTS-1	
see <i>clonidine</i>	35
CATAPRES-TTS-2	
see <i>clonidine</i>	35
CATAPRES-TTS-3	
see <i>clonidine</i>	35
CAYSTON	12
cefaclor.....	18
CEFACLOR ER	18
cefadroxil.....	18
CEFAZOLIN	18
CEFAZOLIN INJ	
1GM/50ML	18
cefazolin sodium.....	18
CEFAZOLIN SOLN	
2GM/100ML-4%.....	18
cefdinir	18
cefepime hcl	18
cefixime	18
cefoxitin sodium.....	18
cefpodoxime proxetil.....	18
cefprozil	18
ceftazidime	18
ceftriaxone sodium.....	18
cefuroxime axetil.....	18
cefuroxime sodium.....	18
CELEBREX	
see <i>celecoxib</i>	10
celecoxib.....	10
CELEXA	
see <i>citalopram hydrobromide</i>	37
CELLCEPT	
see <i>mycophenolate mofetil</i>	69
CELONTIN	
see <i>methsuximide</i>	45
cephalexin	18
CERDELGA.....	59
CEREZYME.....	59
cetirizine hcl.....	74
chateal eq	55
CHEMET	55
chlorhexidine gluconate (mouth-throat)	81
chloroquine phosphate	15
chlorpromazine hcl.....	40
chlorthalidone	35
cholestyramine.....	32
cholestyramine light.....	32
ciclopirox olamine	78
cilostazol.....	66
CILOXAN	72
CIMDUO TAB 300-300	16
cinacalcet hcl	59
CIPRO	19
see <i>ciprofloxacin hcl</i>	19
ciprofloxacin 200 mg/100ml	
<i>in d5w</i>	19
ciprofloxacin 400 mg/200ml	
<i>in d5w</i>	19
ciprofloxacin hcl	19
ciprofloxacin hcl (ophth).....	72
ciprofloxacin-	
<i>dexamethasone otic susp</i> <i>0.3-0.1%</i>	74
cisplatin.....	20
citalopram hydrobromide	37
claravis	77
clarithromycin.....	18
CLEOCIN	
see <i>clindamycin hcl</i>	12
see <i>clindamycin</i> <i>phosphate vaginal</i> ...	65
CLEOCIN PEDIATRIC	
GRANULE	
see <i>clindamycin</i> <i>palmitate hydrochloride</i>	
.....	12
CLEOCIN PHOSPHATE	
see <i>clindamycin</i> <i>phosphate</i>	12
CLEOCIN-T	
see <i>clindamycin</i> <i>phosphate (topical)</i> ..	77
CLIMARA	
see <i>estradiol</i>	58
clindamycin hcl	12
clindamycin palmitate	
<i>hydrochloride</i>	12
clindamycin phosphate	12
clindamycin phosphate (topical)	77
clindamycin phosphate in	
<i>d5w iv soln 300 mg/50ml</i>	
.....	13
clindamycin phosphate in	
<i>d5w iv soln 600 mg/50ml</i>	
.....	13
clindamycin phosphate in	
<i>d5w iv soln 900 mg/50ml</i>	
.....	13
clindamycin phosphate	
<i>vaginal</i>	65
CLINDMYC/NAC INJ	
300/50ML	13
CLINDMYC/NAC INJ	
600/50ML	13
CLINDMYC/NAC INJ	
900/50ML	13
CLINIMIX INJ 4.25/D10 ..	72
CLINIMIX INJ 4.25/D5W	72
CLINIMIX INJ 5%/D15W	72
CLINIMIX INJ 5%/D20W	72
CLINIMIX INJ 6/5.....	72
CLINIMIX INJ 8/10.....	72
CLINIMIX INJ 8/14.....	72
clinisol sf 15%.....	72
CLINOLIPID EMU 20%... <td> </td>	
clobazam	43
clobetasol propionate.....	79
clobetasol propionate e...	79
clomipramine hcl.....	37
clonazepam	43
clonidine	35
clonidine hcl.....	35
clopidogrel bisulfate	66
clorazepate dipotassium	43
clotrimazole.....	81
clotrimazole (topical).....	78
clotrimazole w/ <i>betamethasone cream 1-0.05%</i>	78
clozapine	40
CLOZARIL	
see <i>clozapine</i>	40
COARTEM TAB 20-120MG	
.....	15
COLAZAL	
see <i>balsalazide disodium</i>	
.....	62
colchicine.....	10

colchicine w/ probenecid	see <i>rosuvastatin calcium</i>	13
tab 0.5-500 mg.....10	.....32	
colesevelam hcl.....32		
COLESTID		
see <i>colestipol hcl</i>.....32		
colestipol hcl.....32		
colistimethate sodium.....13		
COLY-MYCIN M		
see <i>colistimethate</i>		
<i>sodium</i>.....13		
COMBIGAN SOL 0.2/0.5%		
.....73		
COMBIVENT AER 20-100		
.....74		
COMETRIQ (60MG DOSE)		
.....24		
COMETRIQ KIT 100MG .24		
COMETRIQ KIT 140MG .24		
COMPLERA TAB.....16		
compro.....61		
constulose .....63		
COPAXONE		
see <i>glatiramer acetate</i> .49		
see <i>glatopa</i> .....49, 50		
COPIKTRA .....24		
COREG		
see <i>carvedilol</i>.....33		
CORGARD		
see <i>nadolol</i>.....34		
CORLANOR .....35		
CORTEF		
see <i>hydrocortisone</i>.....58		
CORTENEMA		
see <i>hydrocortisone</i>		
(<i>intrarectal</i>) .....62		
COSOPT		
see <i>dorzolamide hcl-</i>		
<i>timolol maleate ophth</i>		
<i>soln 2-0.5%</i>.....73		
COTELLIC .....24		
COZAAR		
see <i>losartan potassium</i>		
.....31		
CREON CAP 12000UNT 63		
CREON CAP 24000UNT 63		
CREON CAP 3000UNIT .63		
CREON CAP 36000UNT 63		
CREON CAP 6000UNIT .63		
CRESTOR		
	see <i>rosuvastatin calcium</i>	
	.....32	
cromolyn sodium.....75		
cromolyn sodium		
(<i>mastocytosis</i>).....63		
cromolyn sodium (ophth) 73		
cryselle-28 .....55		
cyclobenzaprine hcl .....50		
cyclophosphamide ....20, 21		
CYCLOPHOSPHAMIDE.21		
CYCLOPHOSPHAMIDE		
MONOHYDR .....21		
cycloserine.....17		
cyclosporine.....69		
cyclosporine modified (for		
<i>microemulsion</i>).....69		
CYKLOKAPRON		
see <i>tranexamic acid</i> ....66		
CYMBALTA		
see <i>duloxetine hcl</i> .....38		
cyproheptadine hcl.....74		
cyred eq.....55		
CYSTADANE		
see <i>betaine powder for</i>		
<i>oral solution</i> .....59		
CYSTADROPS .....74		
CYSTAGON.....59		
CYSTARAN .....74		
cytarabine .....21		
CYTOMEL		
see <i>liothyronine sodium</i>		
.....61		
CYTOTEC		
see <i>misoprostol</i>.....63		
D		
D10W/NACL INJ 0.2%....70		
D2.5W/NACL INJ 0.45%.70		
D5W/LYTES INJ #48 .....70		
dabigatran etexilate		
<i>mesylate</i>.....65		
dalfampridine .....49		
DALIRESP		
see <i>roflumilast</i>.....76		
danazol.....58		
DANTRIUM		
see <i>dantrolene sodium</i> 50		
dantrolene sodium .....50		
dapsone.....13		
DAPTACEL INJ .....69		
daptomycin	13	
DAPTOMYCIN.....13		
see <i>daptomycin</i>.....13		
darunavir.....15		
dasetta 1/35.....55		
dasetta 7/7/7 .....55		
DAURISMO .....24		
DAYVIGO .....48		
DDAVP		
see <i>desmopressin</i>		
<i>acetate</i>.....59		
deblitane .....55		
deferasirox.....55		
DELESTROGEN		
see <i>estradiol valerate</i> ..58		
DELSTRIGO TAB .....16		
DELZICOL		
see <i>mesalamine</i> .....62		
DEM SER		
see <i>metyrosine</i>.....36		
DENGVAXIA SUS .....69		
DEPAKOTE		
see <i>divalproex sodium</i> 44		
DEPAKOTE ER		
see <i>divalproex sodium</i> 44		
DEPAKOTE SPRINKLES		
see <i>divalproex sodium</i> 44		
DEPEN TITRATABS		
see <i>penicillamine</i>.....55		
DEPO-MEDROL		
see <i>methylprednisolone</i>		
<i>acetate</i>.....59		
DEPO-PROVERA		
CONTRACEPTIV		
see		
<i>medroxyprogesterone</i>		
<i>acetate (contraceptive)</i>		
.....57		
DEPO-SUBQ PROVERA		
104 .....55		
depo-testosterone.....51		
DERMA-SMOOTH/EFS		
BODY		
see <i>fluocinolone</i>		
<i>acetonide</i>.....79		
DERMA-SMOOTH/EFS		
SCALP		
see <i>fluocinolone</i>		
<i>acetonide</i>.....79		

DERMOTIC	
see <i>flac</i>	74
see <i>fluocinolone acetonide (otic)</i>	74
DESCOZY TAB 120-15MG	
.....	16
DESCOZY TAB 200/25MG	
.....	16
desipramine hcl.....	37, 38
desmopressin acetate.....	59
desmopressin acetate	
spray	59
desmopressin acetate	
spray refrigerated.....	59
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5).....	56
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	56
desvenlafaxine succinate	38
DETROL	
see <i>tolterodine tartrate</i> 65	
DETROL LA	
see <i>tolterodine tartrate</i> 65	
dexamethasone	58
DEXAMETHASONE	
INTENSOL	58
dexamethasone sodium phosphate	58
dexamethasone sodium phosphate (ophth)	73
dexmethylphenidate hcl..	47
dextrose.....	72
dextrose 10% w/ sodium chloride 0.45%	70
dextrose 2.5% w/ sodium chloride 0.45%	70
DEXTROSE 2.5%/NACL	
0.45%	
see <i>dextrose 2.5% w/ sodium chloride 0.45%</i>	70
dextrose 5% in lactated ringers	70
dextrose 5% w/ sodium chloride 0.2%	70
dextrose 5% w/ sodium chloride 0.225%	70
dextrose 5% w/ sodium chloride 0.3%	70
dextrose 5% w/ sodium chloride 0.45%	70
dextrose 5% w/ sodium chloride 0.9%	70
DEXTROSE 5%/NACL	
0.3%	
see <i>dextrose 5% w/ sodium chloride 0.3%</i>	70
DEXTROSE/SODIUM CHLORIDE	
see <i>dextrose 5% w/ sodium chloride</i>	
0.225%	70
DIACOMIT	43
diazepam	43
diazepam (anticonvulsant)	
.....	43
diazepam inj.....	43
diazepam intensol.....	43
diazoxide	59
diclofenac potassium	10
diclofenac sodium	10
diclofenac sodium (ophth)	73
diclofenac sodium (topical)	
.....	80
dicloxacillin sodium	20
dicyclomine hcl	62
DIFCID.....	18
DIFLUCAN	
see <i>fluconazole</i>	14
diflunisal.....	10
digoxin	35
dihydroergotamine mesylate.....	48
DILANTIN	43
see <i>phenytoin sodium extended</i>	45
DILANTIN INFATABS	43
see <i>phenytoin</i>	45
DILANTIN-125	44
see <i>phenytoin</i>	45
DILAUDID	
see <i>hydromorphone hcl</i>	11
diltiazem hcl	34
diltiazem hcl coated beads	34
diltiazem hcl extended release beads.....	34
dilt-xr.....	34
DIOVAN	
see <i>valsartan</i>	31
DIOVAN HCT	
see <i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	31
see <i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	31
see <i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	31
see <i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	31
see <i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	31
DIP/TET PED INJ 25-5LFU	69
diphenhydramine hcl.....	74
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml....	63
diphenoxylate w/ atropine tab 2.5-0.025 mg	63
DIPROLENE	
see <i>betamethasone dipropionate augmented</i>	79
dipyridamole	66
disopyramide phosphate	32
disulfiram	50
divalproex sodium	44
docetaxel	23
DOCETAXEL	23
see <i>docetaxel</i>	23
dofetilide	32
donepezil hydrochloride ..	37
DOPTELET	66
dorzolamide hcl	73
dorzolamide hcl-timolol maleate ophth soln 2-0.5%.....	73
dotti.....	58

DOVATO TAB 50-300MG	16	see <i>venlafaxine hcl</i>.....39	
doxazosin mesylate	29	EFFIENT	
doxepin hcl	38	<i>see prasugrel hcl</i>.....66	
doxepin hcl (sleep).....	48	EFUDEX	
DOXIL		<i>see fluorouracil (topical)</i>	
<i>see doxorubicin hcl</i>		.....80	
<i>liposomal</i>	21	ELIGARD	21
doxorubicin hcl.....	21	elinest	56
doxorubicin hcl <i>liposomal</i>	21	ELIQUIS	65
doxy 100.....	20	ELIQUIS STARTER PACK	65
doxycycline (<i>monohydrate</i>)	20	ELLENCE	21
doxycycline <i>hydiate</i>	20	eluryng.....	56
dronabinol.....	61	EMCYT	21
drospirenone-ethynodiol <i>estradiol tab 3-0.02 mg</i>.....56		EMEND	
drospirenone-ethynodiol <i>estradiol tab 3-0.03 mg</i>.....56		<i>see aprepitant</i>	61
DROXIA.....	66	EMSAM	38
droxidopa.....	35	emtricitabine	15
DULERA AER 100-5MCG	77	emtricitabine-tenofovir <i>disoproxil fumarate tab</i> <i>100-150 mg</i>	16
DULERA AER 200-5MCG	77	emtricitabine-tenofovir <i>disoproxil fumarate tab</i> <i>133-200 mg</i>	16
DULERA AER 50-5MCG 77		emtricitabine-tenofovir <i>disoproxil fumarate tab</i> <i>167-250 mg</i>	16
duloxetine hcl.....	38	emtricitabine-tenofovir <i>disoproxil fumarate tab</i> <i>200-300 mg</i>	16
DUPIXENT	66	EMTRIVA.....	15
dutasteride.....	64	<i>see emtricitabine</i>	15
dutasteride-tamsulosin hcl <i>cap 0.5-0.4 mg</i>	64	EMVERM.....	13
E		enalapril maleate	29
e.e.s. 400.....	18	enalapril maleate & <i>hydrochlorothiazide tab</i> <i>10-25 mg</i>	29
EC-NAPROSYN		enalapril maleate & <i>hydrochlorothiazide tab</i> <i>5-12.5 mg</i>	29
<i>see ec-naproxen</i>	10	ENBREL	66, 67
<i>see naproxen</i>	10	ENBREL MINI.....	67
ec-naproxen.....	10	ENBREL SURECLICK....	67
EDURANT	15	ENDARI	66
efavirenz.....	15	endocet tab 10-325mg....	11
efavirenz-emtricitabine- <i>tenofovir df tab 600-200-</i> <i>300 mg</i>	16	endocet tab 2.5-325mg...11	
efavirenz-lamivudine- <i>tenofovir df tab 400-300-</i> <i>300 mg</i>	16	endocet tab 5-325mg.....11	
efavirenz-lamivudine- <i>tenofovir df tab 600-300-</i> <i>300 mg</i>	16	endocet tab 7.5-325mg...11	
EFFEXOR XR		ENGERIX-B	69
		enilloring	56
		enoxaparin sodium	65
		empresse-28.....	56
		enskyce	56
		ENSTILAR AER.....	79
		entacapone	39
		entecavir	17
		ENTRESTO TAB 24-26MG	30
		ENTRESTO TAB 49-51MG	30
		ENTRESTO TAB 97- <i>103MG</i>	30
		enulose	63
		EPCLUSIA PAK 150-37.5.....17	
		EPCLUSIA PAK 200-50MG	17
		EPCLUSIA TAB 200-50MG	17
		EPCLUSIA TAB 400-100.....17	
		EPIDIOLEX	44
		epinephrine (<i>anaphylaxis</i>)	35, 75, 76
		EPIPEN 2-PAK	
		<i>see epinephrine</i> <i>(anaphylaxis)</i>	75
		EPIPEN-JR 2-PAK	
		<i>see epinephrine</i> <i>(anaphylaxis)</i>	76
		epitol	44
		EPIVIR	
		<i>see lamivudine</i>	15
		eplerenone	29
		EPRONTIA	44
		EPZICOM	
		<i>see abacavir sulfate-</i> <i>lamivudine tab 600-</i> <i>300 mg</i>	16
		ergotamine w/ caffeine tab <i>1-100 mg</i>	48
		ERIVEDGE	24
		ERLEADA	22
		erlotinib hcl.....	24
		errin	56
		ertapenem sodium	13
		ery.....	78
		ERYGEL	
		<i>see erythromycin (acne</i> <i>aid)</i>	78

ery-tab	19	see <i>raloxifene hcl</i>	60
ERYTHROCIN		EVOTAZ TAB 300-150	16
LACTOBIONATE	19	EXELON	
<i>see erythromycin</i>		<i>see rivastigmine</i>	37
lactobionate	19	exemestane	22
<i>erythrocin stearate</i>	19	EXFORGE	
<i>erythromycin (acne aid)</i>	78	<i>see amlodipine besylate-</i>	
<i>erythromycin (ophth)</i>	72	<i>valsartan tab 10-160</i>	
<i>erythromycin base</i>	19	<i>mg</i>	30
<i>erythromycin ethylsuccinate</i>		<i>see amlodipine besylate-</i>	
.....	19	<i>valsartan tab 10-320</i>	
<i>erythromycin lactobionate</i>		<i>mg</i>	30
.....	19	<i>see amlodipine besylate-</i>	
ESBRIET		<i>valsartan tab 5-160 mg</i>	
<i>see pirfenidone</i>	76	.....	30
escitalopram oxalate	38	<i>see amlodipine besylate-</i>	
esomeprazole magnesium		<i>valsartan tab 5-320 mg</i>	
.....	64	.....	30
estarrylla	56	EXKIVITY	24
ESTRACE		EYSUVIS	73
<i>see estradiol</i>	58	ezetimibe	33
<i>see estradiol vaginal</i>	58	ezetimibe-simvastatin tab	
estradiol	58	10-10 mg	33
estradiol & norethindrone		ezetimibe-simvastatin tab	
acetate tab 0.5-0.1 mg	58	10-20 mg	33
estradiol & norethindrone		ezetimibe-simvastatin tab	
acetate tab 1-0.5 mg	58	10-40 mg	33
estradiol vaginal	58	ezetimibe-simvastatin tab	
estradiol valerate	58	10-80 mg	33
ethambutol hcl	17	F	
ethosuximide	44	FABRAZYME	59
ethynodiol diacetate &		falmina	56
ethinyl estradiol tab 1		famciclovir	17
mg-35 mcg	56	famotidine	62
ethynodiol diacetate &		famotidine in nacl 0.9% iv	
ethinyl estradiol tab 1		soln 20 mg/50ml	62
mg-50 mcg	56	FANAPT	40
etodolac	10	FANAPT PAK	40
etonogestrel-ethinyl		FARESTON	
estradiol va ring 0.120-		<i>see toremifene citrate</i>	22
0.015 mg/24hr	56	FARXIGA	51
etoposide	23	FASENRA	76
etravirine	15	FASENRA PEN	76
EULEXIN	22	FASLODEX	
euthyrox	61	<i>see fulvestrant</i>	22
everolimus	24	felbamate	44
everolimus		FELBATOL	
(<i>immunosuppressant</i>)	69	<i>see felbamate</i>	44
EVISTA		FELDENE	
		<i>see piroxicam</i>	10
		felodipine	34
		FEMARA	
		<i>see letrozole</i>	22
		fenofibrate	32
		fenofibrate micronized	32
		fentanyl	10
		fentanyl citrate	11
		FETZIMA	38
		FETZIMA CAP TITRATIO	
		.....	38
		FIASP	53
		FIASP FLEXTOUCH	53
		FIASP PENFILL	53
		FIASP PUMPCART	53
		finasteride	64
		fingolimod hcl	49
		FINTEPLA	44
		FIRAZYR	
		<i>see icatibant acetate</i>	66
		<i>see sajazir</i>	66
		FIRMAGON	22
		flac	74
		FLAREX	73
		FLEBOGAMMA DIF	68
		flecainide acetate	32
		FLOMAX	
		<i>see tamsulosin hcl</i>	64
		fluconazole	14
		fluconazole in nacl 0.9% inj	
		200 mg/100ml	14
		fluconazole in nacl 0.9% inj	
		400 mg/200ml	14
		flucytosine	14
		fludrocortisone acetate	58
		flunisolide (nasal)	76
		fluocinolone acetonide	79
		fluocinolone acetonide	
		(otic)	74
		fluocinonide	79, 80
		fluocinonide emulsified	
		base	80
		fluorometholone (ophth)	73
		fluorouracil	21
		fluorouracil (topical)	80
		fluoxetine hcl	38
		fluphenazine decanoate	40
		fluphenazine hcl	40
		flurbiprofen	10

<i>flurbiprofen sodium</i>	73
<i>fluticasone propionate</i>	80
<i>fluticasone propionate</i>	
(<i>nasal</i>).....	76
<i>fluticasone-salmeterol aer</i>	
<i>powder ba 100-50</i>	
<i>mcg/act</i>	77
<i>fluticasone-salmeterol aer</i>	
<i>powder ba 250-50</i>	
<i>mcg/act</i>	77
<i>fluticasone-salmeterol aer</i>	
<i>powder ba 500-50</i>	
<i>mcg/act</i>	77
<i>fluvoxamine maleate</i>	36
FML LIQUIFILM	
<i>see fluorometholone</i>	
(<i>ophth</i>).....	73
FOCALIN	
<i>see dexmethylphenidate</i>	
<i>hcl</i>	47
<i>fondaparinux sodium</i>	65
FOSAMAX	
<i>see alendronate sodium</i>	
.....	55
<i>fosamprenavir calcium</i>	15
<i>fosinopril sodium</i>	29
<i>fosinopril sodium &</i>	
<i>hydrochlorothiazide tab</i>	
<i>10-12.5 mg</i>	29
<i>fosinopril sodium &</i>	
<i>hydrochlorothiazide tab</i>	
<i>20-12.5 mg</i>	29
FOTIVDA	24
FRUZAQLA	24
<i>fulvestrant</i>	22
<i>furosemide</i>	35
<i>furosemide inj</i>	35
FUZEON	15
<i>fyavolv tab 0.5mg-2.5mcg</i>	
.....	58
<i>fyavolv tab 1mg-5mcg</i>	58
FYCOMPA	44
G	
<i>gabapentin</i>	44
<i>galantamine hydrobromide</i>	
.....	37
GAMASTAN INJ	68
GAMMAGARD LIQUID ...68	
GAMMAGARD S/D IGA	
<i>LESS TH</i>	68
GAMMAKED	68
GAMMAPLEX	68
GAMUNEX-C	68
<i>ganciclovir sodium</i>	17
GARDASIL 9 INJ	69
GASTROCROM	
<i>see cromolyn sodium</i>	
(<i>mastocytosis</i>)	63
<i>gatifloxacin (ophth)</i>	72
GATTEX	63
GAUZE PADS 2	53
<i>gavilyte-c</i>	63
<i>gavilyte-g</i>	63
GAVRETO	24
<i>gefitinib</i>	24
<i>gemcitabine hcl</i>	21
GEMCITABINE	
<i>HYDROCHLORIDE</i>	
<i>see gemcitabine hcl</i> ...21	
<i>gemfibrozil</i>	32
GEMTESA	64
<i>generlac</i>	63
<i>genograf</i>	69
GENOTROPIN	59
GENOTROPIN MINIQUICK	
.....	59
<i>gentamicin in saline inj 0.8</i>	
<i>mg/ml</i>	13
<i>gentamicin in saline inj 1</i>	
<i>mg/ml</i>	13
<i>gentamicin in saline inj 1.2</i>	
<i>mg/ml</i>	13
<i>gentamicin in saline inj 1.6</i>	
<i>mg/ml</i>	13
<i>gentamicin in saline inj 2</i>	
<i>mg/ml</i>	13
<i>gentamicin sulfate</i>	13
<i>gentamicin sulfate (ophth)</i>	
.....	72
<i>gentamicin sulfate (topical)</i>	
.....	78
GENVOYA TAB	16
GEODON	
<i>see ziprasidone hcl</i> ....42	
<i>see ziprasidone mesylate</i>	
.....	42
GILENYA	
gleevec	
<i>see imatinib mesylate</i> ..24,	
25	
GLEOSTINE	21
<i>glimepiride</i>	51
<i>glipizide</i>	51
<i>glipizide xl</i>	51
<i>glipizide-metformin hcl tab</i>	
<i>2.5-250 mg</i>	51
<i>glipizide-metformin hcl tab</i>	
<i>2.5-500 mg</i>	51
<i>glipizide-metformin hcl tab</i>	
<i>5-500 mg</i>	51
GLUCOTROL XL	
<i>see glipizide</i>	51
<i>see glipizide xl</i>	51
<i>glycopyrrolate</i>	62
<i>glydo</i>	80
GLYXAMBI TAB 10-5 MG	
.....	51
GLYXAMBI TAB 25-5 MG	
.....	51
GOLYTELY	
<i>see gavilyte-g</i>	63
<i>see peg 3350-kcl-na</i>	
<i>bicarb-nacl-na sulfate</i>	
<i>for soln 236 gm</i>	63
<i>gransetron hcl</i>	61
<i>griseofulvin microsize</i>	14
<i>griseofulvin ultramicrosize</i>	
.....	14
<i>guanfacine hcl</i>	35
<i>guanfacine hcl (adhd)</i>....47	
GVOKE HYOPEN 2-	
<i>PACK</i>	59
GVOKE KIT	59
GVOKE PFS	59
H	
HAEGARDA	66
<i>hailey 1.5/30</i>	56
HALDOL DECANOATE	
<i>100</i>	
<i>see haloperidol</i>	
<i>decanoate</i>	41
HALDOL DECANOATE 50	

<i>see haloperidol</i>	
decanoate.....40	
<i>halobetasol propionate</i> ...80	
<i>haloette</i>.....56	
<i>haloperidol</i>.....40	
<i>haloperidol decanoate</i> ...40, 41	
<i>haloperidol lactate</i>.....41	
HARVONI PAK 33.75- 150MG .....17	
HARVONI PAK 45-200MG.....17	
HARVONI TAB 45-200MG.....17	
HARVONI TAB 90-400MG.....17	
HAVRIX .....69	
<i>heather</i> .....56	
HEP SOD/D5W INJ 20000UNT.....65	
HEP SOD/D5W INJ 25000UNT.....65	
HEP SOD/NACL INJ 12500UNT.....65	
HEP SOD/NACL INJ 25000UNT.....65	
<i>heparin sodium (porcine)</i> 65	
HEPARIN/NACL INJ 25000UNT.....65	
HEPLISAV-B .....69	
HERCEP HYLEC SOL 60- 10000 .....24	
HERCEPTIN .....24	
HERZUMA .....24	
HETLIOZ <i>see tasimelteon</i>.....48	
HIBERIX .....69	
HIPREX <i>see methenamine hippurate</i> .....13	
HUMIRA .....67	
HUMIRA PEDIA INJ CROHNS .....67	
HUMIRA PEDIATRIC CROHNS D .....67	
HUMIRA PEN .....67	
HUMIRA PEN KIT PS/UV.....67	
HUMIRA PEN-CD/UC/HS START .....67	
HUMIRA PEN-PEDIATRIC UC S .....67	
HUMIRA PEN-PS/UV STARTER .....67	
HUMULIN R U-500 (CONCENTR.....53	
HUMULIN R U-500 KWIKPEN.....53	
<i>hydralazine hcl</i>.....36	
HYDREA <i>see hydroxyurea</i>.....22	
<i>hydrochlorothiazide</i>.....35	
<i>hydrocodone bitartrate</i>....11	
<i>hydrocodone-</i> <i>acetaminophen soln 7.5- 325 mg/15ml</i> .....11	
<i>hydrocodone-</i> <i>acetaminophen tab 10- 325 mg</i> .....11	
<i>hydrocodone-</i> <i>acetaminophen tab 5-325 mg</i> .....11	
<i>hydrocodone-</i> <i>acetaminophen tab 7.5- 325 mg</i> .....11	
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i> .....11	
<i>hydrocortisone</i> .....58	
<i>hydrocortisone (intrarectal)</i> .....62	
<i>hydrocortisone (rectal)</i>....80	
<i>hydrocortisone (topical)</i> ..80	
<i>hydromorphone hcl</i>.....11	
<i>hydroxychloroquine sulfate</i>.....68	
<i>hydroxyurea</i>.....22	
<i>hydroxyzine hcl</i>.....75	
<i>hydroxyzine pamoate</i>....75	
HYSINGLA ER.....11	
HYZAAR <i>see losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i> .....30	
<i>see losartan potassium & hydrochlorothiazide tab 100-25 mg</i> .....30	
see <i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i> .....30	
I	
<i>ibandronate sodium</i> .....55	
IBRANCE .....24	
<i>ibu</i> .....10	
<i>ibuprofen</i> .....10	
<i>icatibant acetate</i> .....66	
<i>iclevia</i> .....56	
ICLUSIG .....24	
IDACIO (2 PEN).....67	
IDACIO (2 SYRINGE)....67	
IDACIO CROHN INJ DISEASE .....67	
IDACIO PLAQU INJ PSORIASIS .....67	
IDHIFA .....24	
<i>imatinib mesylate</i> .....24, 25	
IMBRUVICA .....25	
<i>imipenem-cilastatin intravenous for soln</i> 250 mg .....13	
<i>imipenem-cilastatin intravenous for soln</i> 500 mg .....13	
<i>imipramine hcl</i> .....38	
<i>imiquimod</i> .....80	
IMITREX <i>see sumatriptan succinate</i> .....49	
IMITREX STATDOSE REFILL <i>see sumatriptan succinate</i> .....49	
IMITREX STATDOSE SYSTEM <i>see sumatriptan succinate</i> .....49	
IMOVAX RABIES (H.D.C.V.) .....69	
IMURAN <i>see azathioprine</i> .....69	
INBRIJA .....39	
<i>incassia</i> .....56	
INCRELEX .....59	
INCRUSE ELLIPTA .....74	
<i>indapamide</i> .....35	
INDERAL LA	

see <i>propranolol hcl</i>	34	
INFANRIX INJ	69	
INFLIXIMAB.....	67	
INLYTA	25	
INQOVI TAB 35-100MG .	21	
INREBIC	25	
INSPRA		
see <i>eplerenone</i>	29	
INSULIN PEN NEEDLES:		
BD/NOVO	53	
INSULIN SAFETY		
NEEDLES	53	
INSULIN SYRINGES: BD		
.....	53	
INTELENCE	15	
see <i>etravirine</i>	15	
INTRALIPID	72	
<i>introvale</i>	56	
INTUNIV		
see <i>guanfacine hcl</i>		
(adhd).....	47	
INVEGA		
see <i>paliperidone</i>	41	
INVEGA HAFYERA	41	
INVEGA SUSTENNA.....	41	
INVEGA TRINZA	41	
IPOL INJ INACTIVE.....	69	
<i>ipratropium bromide</i>	74	
<i>ipratropium bromide (nasal)</i>		
.....	74	
<i>ipratropium-albuterol nebu</i>		
<i>soln 0.5-2.5(3) mg/3ml</i>	74	
irbesartan.....	31	
irbesartan-		
<i>hydrochlorothiazide tab</i>		
150-12.5 mg.....	30	
irbesartan-		
<i>hydrochlorothiazide tab</i>		
300-12.5 mg.....	30	
IRESSA		
see <i>gefitinib</i>	24	
irinotecan hcl	22	
ISENTRESS	15	
ISENTRESS HD	15	
<i>isibloom</i>	56	
ISOLYTE-P INJ /D5W....	70	
ISOLYTE-S INJ.....	70	
ISOLYTE-S INJ PH 7.4....	70	
<i>isoniazid</i>	17	
ISORDIL TITRADOSE		
see <i>isosorbide dinitrate</i>		
.....	36	
<i>isosorbide dinitrate</i>	36	
<i>isosorbide mononitrate</i> ..	36	
<i>isotretinoin</i>	78	
<i>itraconazole</i>	14	
<i>ivermectin</i>	13	
IWILFIN	22	
IXIARO INJ	69	
J		
JADENU		
see <i>deferasirox</i>	55	
JADENU SPRINKLE		
see <i>deferasirox</i>	55	
JAKAFI	25	
JALYN		
see <i>dutasteride-</i>		
<i>tamsulosin hcl cap 0.5-</i>		
<i>0.4 mg</i>	64	
<i>jantoven</i>	65	
JANUMET TAB 50-1000.	52	
JANUMET TAB 50-500MG		
.....	52	
JANUMET XR TAB 100-		
1000	52	
JANUMET XR TAB 50-		
1000	52	
JANUMET XR TAB 50-		
500MG	52	
JANUVIA	52	
JARDIANCE	52	
<i>jasmiel</i>	56	
<i>javygtor</i>	59	
JAYPIRCA	25	
JENTADUETO TAB 2.5-		
1000	52	
JENTADUETO TAB 2.5-		
500	52	
JENTADUETO TAB 2.5-		
850	52	
JENTADUETO TAB XR		
2.5-1000MG	52	
JENTADUETO TAB XR 5-		
1000MG	52	
<i>jinteli</i>	58	
<i>jolessa</i>	56	
<i>juleber</i>	56	
JULUCA TAB 50-25MG..	16	
junel 1.5/30	56	
junel 1/20	56	
junel fe 1.5/30	56	
junel fe 1/20	56	
JYNNEOS	69	
K		
KADCYLA	25	
KALETRA		
see <i>lopinavir-ritonavir</i>		
<i>soln 400-100 mg/5ml</i>		
<i>(80-20 mg/ml)</i>	16	
see <i>lopinavir-ritonavir tab</i>		
100-25 mg	16	
see <i>lopinavir-ritonavir tab</i>		
200-50 mg	16	
KALYDECO	76	
KANJINTI.....	25	
<i>kariva</i>	56	
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>	71	
<i>kcl 10 meq/l (0.075%) in</i>		
<i>dextrose 5% & nacl</i>		
<i>0.45% inj</i>	70	
<i>kcl 20 meq/l (0.149%) in</i>		
<i>nacl 0.45% inj</i>	70	
<i>kcl 20 meq/l (0.15%) in</i>		
<i>dextrose 5% & nacl 0.2%</i>		
<i>inj</i>	70	
<i>kcl 20 meq/l (0.15%) in</i>		
<i>dextrose 5% & nacl</i>		
<i>0.45% inj</i>	70	
<i>kcl 20 meq/l (0.15%) in</i>		
<i>dextrose 5% & nacl 0.9%</i>		
<i>inj</i>	70	
<i>kcl 20 meq/l (0.15%) in nacl</i>		
<i>0.45% inj</i>	70	
<i>kcl 20 meq/l (0.15%) in nacl</i>		
<i>0.9% inj</i>	70	
<i>kcl 30 meq/l (0.224%) in</i>		
<i>dextrose 5% & nacl</i>		
<i>0.45% inj</i>	71	
<i>kcl 40 meq/l (0.3%) in</i>		
<i>dextrose 5% & nacl</i>		
<i>0.45% inj</i>	71	

<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj</i>	71	<i>see mifepristone (hyperglycemia)</i> .....60	
<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i>	71	KOSELUGO.....25	
KCL/D5W/NACL INJ		<i>kourzeq</i>.....81	
0.3/0.9%.....	71	<i>KRAZATI</i>.....25	
<i>kelnor 1/35</i>	56	K-TAB	
<i>kelnor 1/50</i>	56	<i>see potassium chloride</i> 71	
KEPPRA		<i>kurvelo</i>.....56	
<i>see levetiracetam</i>.....44		KUVAN	
<i>see roweepra</i>	45	<i>see javygtor</i>.....59	
KEPPRA XR		<i>see sapropterin dihydrochloride</i> ..60	
<i>see levetiracetam</i>.....44		L	
KERENDIA	29	<i>labetalol hcl</i>.....33	
KESIMPTA	50	<i>lacosamide</i>	44
<i>ketoconazole</i>	14	<i>lacosamide oral</i>.....44	
<i>ketoconazole (topical)</i>....78,		<i>lactated ringer's solution</i> .71	
79		<i>lactic acid (ammonium lactate)</i>	80
<i>ketorolac tromethamine (ophth)</i>	73	<i>lactulose</i>	63
KEVZARA	67	<i>lactulose (encephalopathy)</i>	63
KEYTRUDA	25	LAMICTAL	
KINRIX INJ	69	<i>see lamotrigine</i>.....44	
KISQALI 200 DOSE.....25		<i>see subvenite</i>.....46	
KISQALI 200 PAK		LAMICTAL CHEWABLE DISPERS	
FEMARA	23	<i>see lamotrigine</i>.....44	
KISQALI 400 DOSE.....25		LAMICTAL XR	
KISQALI 400 PAK		<i>see lamotrigine</i>.....44	
FEMARA	23	<i>lamivudine</i>	15
KITABIS PAK		<i>lamivudine (hbv)</i>	17
<i>see tobramycin</i>.....14		<i>lamivudine-zidovudine tab 150-300 mg</i>.....16	
KLARON		<i>lamotrigine</i>	44
<i>see sulfacetamide sodium (acne)</i>.....78		LANOXIN	
klayesta	78	<i>see digoxin</i>.....35	
KLONOPIN		<i>lansoprazole</i>	64
<i>see clonazepam</i>.....43		LANTUS	53
klor-con	71	LANTUS SOLOSTAR	53
klor-con 10	71	<i>lapatinib ditosylate</i>	25
klor-con 8	71	<i>larin 1.5/30</i>.....56	
klor-con m10	71	<i>larin 1/20</i>.....56	
klor-con m15	71	<i>larin fe 1.5/30</i>.....56	
klor-con m20	71	<i>larin fe 1/20</i>.....56	
KORLYM	60	LASIX	
		<i>see furosemide</i>.....35	
		<i>latanoprost</i>.....73	
		LATUDA	
		<i>see lurasidone hcl</i>.....41	
		<i>leena</i>.....56	
		<i>leflunomide</i>	68
		<i>lenalidomide</i>.....22	
		LENVIMA 10 MG DAILY DOSE	25
		LENVIMA 12MG DAILY DOSE	25
		LENVIMA 20 MG DAILY DOSE	25
		LENVIMA 4 MG DAILY DOSE	25
		LENVIMA 8 MG DAILY DOSE	25
		LENVIMA CAP 14 MG....25	
		LENVIMA CAP 18 MG....25	
		LENVIMA CAP 24 MG....25	
		<i>lessina</i>	56
		LETAIRIS	
		<i>see ambrisentan</i>.....36	
		<i>letrozole</i>	22
		<i>leucovorin calcium</i>	28
		LEUKERAN	21
		<i>leuprolide acetate</i>	22
		<i>levalbuterol hcl</i>.....75	
		<i>levalbuterol tartrate</i>	75
		<i>levetiracetam</i>	44
		LEVETIRACETAM	
		<i>see levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>.....45	
		<i>see levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>.....45	
		<i>see levetiracetam in sodium chloride iv soln 500 mg/100ml</i>.....45	
		<i>levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>	45
		<i>levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>	45
		<i>levetiracetam in sodium chloride iv soln 500 mg/100ml</i>	45
		<i>levobunolol hcl</i>.....73	
		<i>levocarnitine (metabolic modifiers)</i>	60

<i>levocetirizine</i>	
<i>dihydrochloride</i>.....75	
<i>levofloxacin</i>.....19	
<i>levofloxacin in d5w iv soln</i>	
<i>250 mg/50ml</i> .....19	
<i>levofloxacin in d5w iv soln</i>	
<i>500 mg/100ml</i> .....19	
<i>levofloxacin in d5w iv soln</i>	
<i>750 mg/150ml</i> .....19	
<i>levonest</i>.....56	
<i>levonorgestrel & ethinyl</i>	
<i>estradiol (91-day) tab</i>	
<i>0.15-0.03 mg</i> .....56	
<i>levonorgestrel & ethinyl</i>	
<i>estradiol tab 0.1 mg-20</i>	
<i>mcg</i> .....56	
<i>levonorgestrel & ethinyl</i>	
<i>estradiol tab 0.15 mg-30</i>	
<i>mcg</i> .....56	
<i>levonorgestrel-eth estra tab</i>	
<i>0.05-30/0.075-40/0.125-</i>	
<i>30mg-mcg</i> .....56	
<i>levora 0.15/30-28</i>.....56	
<i>levo-t</i>.....61	
<i>levothyroxine sodium</i>.....61	
<i>levoxyl</i>.....61	
LEXAPRO	
<i>see escitalopram oxalate</i>	
.....38	
LEXIVA.....15	
<i>see fosamprenavir</i>	
<i>calcium</i> .....15	
LIALDA	
<i>see mesalamine</i> .....63	
<i>lidocaine</i> .....80	
<i>lidocaine hcl</i>.....80	
<i>lidocaine hcl (local anesth.)</i>	
.....12	
<i>lidocaine hcl (mouth-throat)</i>	
.....81	
<i>lidocaine-prilocaine cream</i>	
<i>2.5-2.5%</i>.....80	
<i>lidocan iii</i>.....80	
LIDODERM	
<i>see lidocaine</i> .....80	
<i>see lidocan iii</i>.....80	
<i>linezolid</i>.....13	
LINEZOLID INJ 2MG/ML 13	
LINZESS.....63	
<i>liothyronine sodium</i>.....61	
LIPITOR	
<i>see atorvastatin calcium</i>	
.....32	
<i>lisinopril</i>.....29	
<i>lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
<i>10-12.5 mg</i> .....29	
<i>lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
<i>20-12.5 mg</i> .....29	
<i>lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
<i>20-25 mg</i> .....29	
LITHIUM.....49	
<i>lithium carbonate</i> .....49	
LITHOBID	
<i>see lithium carbonate</i> ..49	
LODINE	
<i>see etodolac</i>.....10	
<i>loestrin 1.5/30-21</i>.....56	
<i>loestrin 1/20-21</i>.....56	
<i>loestrin fe 1.5/30</i> .....56	
<i>loestrin fe 1/20</i> .....56	
LOKELMA.....55	
LOMOTIL	
<i>see diphenoxylate w/</i>	
<i>atropine tab 2.5-0.025</i>	
<i>mg</i> .....63	
LONSURF TAB 15-6.14 .21	
LONSURF TAB 20-8.19 .21	
<i>loperamide hcl</i> .....63	
LOPID	
<i>see gemfibrozil</i>.....32	
<i>lopinavir-ritonavir soln 400-</i>	
<i>100 mg/5ml (80-20</i>	
<i>mg/ml)</i> .....16	
<i>lopinavir-ritonavir tab 100-</i>	
<i>25 mg</i> .....16	
<i>lopinavir-ritonavir tab 200-</i>	
<i>50 mg</i> .....16	
LOPRESSOR	
<i>see metoprolol tartrate</i> 34	
<i>lorazepam</i>.....36	
<i>lorazepam intensol</i>.....36	
LORBRENA.....25	
<i>loryna</i>.....56	
<i>losartan potassium</i>.....31	
<i>losartan potassium &</i>	
<i>hydrochlorothiazide tab</i>	
<i>100-12.5 mg</i> .....30	
<i>losartan potassium &</i>	
<i>hydrochlorothiazide tab</i>	
<i>100-25 mg</i> .....30	
LOTEMAX.....73	
LOTENSIN	
<i>see benazepril hcl</i> .....29	
LOTENSIN HCT	
<i>see benazepril &</i>	
<i>hydrochlorothiazide tab</i>	
<i>10-12.5 mg</i> .....28	
<i>see benazepril &</i>	
<i>hydrochlorothiazide tab</i>	
<i>20-12.5 mg</i> .....28	
LOTREL	
<i>see amlodipine besylate-</i>	
<i>benazepril hcl cap 10-</i>	
<i>20 mg</i> .....28	
<i>see amlodipine besylate-</i>	
<i>benazepril hcl cap 10-</i>	
<i>40 mg</i> .....28	
<i>see amlodipine besylate-</i>	
<i>benazepril hcl cap 5-10</i>	
<i>mg</i> .....28	
<i>see amlodipine besylate-</i>	
<i>benazepril hcl cap 5-20</i>	
<i>mg</i> .....28	
LOTRONEX	
<i>see alosetron hcl</i> .....63	
<i>lovastatin</i>.....32	
LOVAZA	
<i>see omega-3-acid ethyl</i>	
<i>esters cap 1 gm</i>.....33	
LOVENOX	
<i>see enoxaparin sodium</i>	
.....65	
<i>low-ogestrel</i> .....56	
<i>loxapine succinate</i> .....41	
LUMAKRAS .....25	
LUMIGAN .....73	
LUMIZYME .....60	

LUPRON DEPOT (1-MONTH).....	22
LUPRON DEPOT (3-MONTH).....	22
LUPRON DEPOT-PED (1-MONTH).....	60
LUPRON DEPOT-PED (3-MONTH).....	60
LUPRON DEPOT-PED (6-MONTH).....	60
<i>lurasidone hcl</i>	41
<i>lutera</i>	56
<i>lyleq</i>	56
<i>lyllana</i>	58
LYNPARZA.....	25
LYRICA	
see <i>pregabalin</i>	45
LYSODREN.....	22
LYTGOBI (12 MG DAILY DOSE).....	25
LYTGOBI (16 MG DAILY DOSE).....	26
LYTGOBI (20 MG DAILY DOSE).....	26
<i>lyza</i>	56
M	
MACROBID	
see <i>nitrofurantoin monohyd macro</i>	13
MACRODANTIN	
see <i>nitrofurantoin macrocrystal</i>	13
<i>magnesium sulfate</i>	71
MAGNESIUM SULFATE 71	
see <i>magnesium sulfate</i>	71
MAGNESIUM SULFATE IN D5W	
see <i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>	71
<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>	71
MALARONE	
see <i>atovaquone-proguanil hcl tab 250-100 mg</i>	15
see <i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	15
<i>malathion</i>	81
<i>maraviroc</i>	15
MARINOL	
see <i>dronabinol</i>	61
<i>marlissa</i>	56
MARPLAN	38
MATULANE	23
MAVYRET PAK 50-20MG	17
MAVYRET TAB 100-40MG	17
MAXALT	
see <i>rizatriptan benzoate</i>	48
MAXALT-MLT	
see <i>rizatriptan benzoate</i>	48
MAXITROL	
see <i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	72
see <i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	72
MAXZIDE	
see <i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	35
<i>meclizine hcl</i>	61
MEDROL	
see <i>methylprednisolone</i>	58
MEDROL DOSEPAK	
see <i>methylprednisolone</i>	59
<i>medroxyprogesterone acetate</i>	60
<i>medroxyprogesterone acetate (contraceptive)</i>	57
<i>mefloquine hcl</i>	15
<i>megestrol acetate</i>	22, 60
<i>megestrol acetate (appetite)</i>	60
MEKINIST.....	26
MEKTOVI	26
<i>meloxicam</i>	10
<i>memantine hcl</i>	37
MENACTRA INJ	69
MENQUADFI INJ	69
MENVEO INJ.....	69
MENVEO SOL	69
MEPRON	
see <i>atovaquone</i>	12
<i>mercaptopurine</i>	21
<i>meropenem</i>	13
<i>mesalamine</i>	62, 63
<i>mesalamine w/ cleanser</i>	63
MESNEX.....	28
MESTINON	
see <i>pyridostigmine bromide</i>	49
metformin hcl	52
<i>methadone hcl</i>	11
<i>methadone hydrochloride i</i>	11
METHADOSE	
see <i>methadone</i>	
<i>hydrochloride i</i>	11
<i>methazolamide</i>	35
<i>methenamine hippurate</i>	13
<i>methimazole</i>	61
<i>methotrexate sodium</i>	21, 68
<i>methsuximide</i>	45
METHYLIN	
see <i>methylphenidate hcl</i>	47, 48
<i>methylphenidate hcl</i>	47, 48
<i>methylprednisolone</i>	58, 59
<i>methylprednisolone acetate</i>	59
<i>methylprednisolone sod succ</i>	59
<i>methyltestosterone</i>	51
<i>metoclopramide hcl</i>	61, 62
<i>metolazone</i>	35
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	33
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	33
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	33
<i>metoprolol succinate</i>	33

<i>metoprolol tartrate</i>.....33, 34	<i>morphine sulfate</i> .....11, 12	NAMZARIC CAP 7-10MG
METROCREAM <i>see metronidazole (topical)</i>.....80	MORPHINE SULFATE ...11	.....37
METROLOTION <i>see metronidazole (topical)</i>.....80	MORPHINE SULFATE/SODIUM C .12	NAMZARIC CAP PACK ..37
metronidazole .....13	MOUNJARO .....52	NAPROSYN
METRONIDAZOLE <i>see metronidazole</i>.....13	MOVANTIK .....63	<i>see naproxen</i> .....10
metronidazole (topical) ...80	<i>moxifloxacin hcl</i> .....19	naproxen.....10
metronidazole vaginal.....65	<i>moxifloxacin hcl (ophth)</i> ..72	naproxen sodium .....10
metyrosine .....36	<i>moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj</i>.....19	<i>naratriptan hcl</i>.....48
MG SO4/D5W INJ 10MG/ML .....71	MS CONTIN	NARDIL
<i>micafungin sodium</i>.....14	<i>see morphine sulfate</i> ...11	<i>see phenelzine sulfate</i> 38
MICARDIS <i>see telmisartan</i>.....31	MULTAQ .....32	NATACYN.....72
microgestin 1.5/30 .....57	<i>multiple electrolytes ph 5.5</i>.....71	<i>nateglinide</i> .....52
microgestin 1/20 .....57	<i>multiple electrolytes ph 7.4</i>.....71	NATPARA.....55
microgestin fe 1.5/30 .....57	<i>mupirocin</i> .....78	NAYZILAM.....45
microgestin fe 1/20 .....57	MYAMBUTOL	<i>nebivolol hcl</i>.....34
midodrine hcl .....36	<i>see ethambutol hcl</i>.....17	NEBUPENT
mifepristone (<i>hyperglycemia</i>).....60	MYCAMINE	<i>see pentamidine isethionate inh</i> .....13
miglustat .....60	<i>see micafungin sodium</i> 14	necon 0.5/35-28.....57
MIGRALAN <i>see dihydroergotamine mesylate</i> .....48	MYCOBUTIN	nefazodone hcl .....38
mili .....57	<i>see rifabutin</i>.....17	neomycin sulfate .....13
mimvey .....58	mycophenolate mofetil....69	neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-1000unt op oin
MINIPRESS <i>see prazosin hcl</i> .....30	mycophenolate sodium...69	.....72
MINIVELLE <i>see lyllana</i> .....58	MYRBETRIQ .....64	neomycin-polomyx-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml....72
minocycline hcl .....20	mysoline	neomycin-polymyxin-dexamethasone ophth oint 0.1% .....72
minoxidil.....36	<i>see primidone</i>.....45	neomycin-polymyxin-dexamethasone ophth susp 0.1% .....72
mirtazapine .....38	N	neomycin-polymyxin-hc ophth susp.....72
misoprostol .....63	<i>nabumetone</i>.....10	neomycin-polymyxin-hc otic soln 1% .....74
MITIGARE .....10	<i>nadolol</i> .....34	neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1% .....74
M-M-R II INJ .....69	<i>nafcillin sodium</i> .....20	neo-polycin 5(3.5)mg-400unt-1000unt op oin
M-NATAL PLUS TAB.....71	NAGLAZYME.....60	.....72
modafinil .....50	<i>nalbuphine hcl</i>.....12	neo-polycin hc ophth oint 1%.....72
moexipril hcl.....29	<i>naloxone hcl</i> .....50, 51	NEORAL
molindone hcl .....41	<i>naltrexone hcl</i> .....51	
mometasone furoate.....80	NAMENDA XR	
MONJUVI .....26	<i>see memantine hcl</i>.....37	
mono-linyah.....57	NAMZARIC CAP 14-10MG	
montelukast sodium.....75	.....37	
	NAMZARIC CAP 21-10MG	
	.....37	
	NAMZARIC CAP 28-10MG	
	.....37	

see cyclosporine	
modified (for	
microemulsion)	69
see gengraf	69
NERLYNX.....	26
NEUPRO	39
NEURONTIN	
see gabapentin.....	44
nevirapine	15
NEXAVAR	26
see sorafenib tosylate .26	
NEXIUM	
see esomeprazole	
magnesium.....	64
niacin (antihyperlipidemic)	
.....	33
nicardipine hcl.....	34
NICOTROL INHALER....	51
NICOTROL NS	51
nifedipine	34
nikki	57
NILANDRON	
see nilutamide.....	22
nilutamide	22
nimodipine	34
NINLARO.....	26
nitazoxanide	13
nitisinone	60
NITRO-BID	36
nitrofurantoin macrocrystal	
.....	13
nitrofurantoin monohyd	
macro	13
nitroglycerin	36
NITROSTAT	
see nitroglycerin.....	36
nizatidine	62
nora-be	57
norelgestromin-ethinyl	
estradiol td ptwk 150-35	
mcg/24hr.....	57
norethindrone	
(contraceptive)	57
norethindrone ace & ethinyl	
estradiol tab 1 mg-20	
mcg	57
norethindrone ace & ethinyl	
estradiol tab 1.5 mg-30	
mcg	57
norethindrone ace & ethinyl	
estradiol-fe tab 1 mg-20	
mcg	57
norethindrone acetate.....	61
norethindrone acetate-	
ethinyl estradiol tab 0.5	
mg-2.5 mcg	58
norethindrone acetate-	
ethinyl estradiol tab 1	
mg-5 mcg	58
norethindrone ac-ethinyl	
estradiol tab 1-20/1-30/1-	
35 mg-mcg	57
norgestimate & ethinyl	
estradiol tab 0.25 mg-35	
mcg	57
norgestimate-eth estrad tab	
0.18-25/0.215-25/0.25-25	
mg-mcg	57
norgestimate-eth estrad tab	
0.18-35/0.215-35/0.25-35	
mg-mcg	57
norlyroc.....	57
NORPACE	
see disopyramide	
phosphate.....	32
NORPACE CR.....	32
NORPRAMIN	
see desipramine hcl ....37	
NORTHERA	
see droxidopa.....	35
nortrel 0.5/35 (28)	57
nortrel 1/35 (21)	57
nortrel 1/35 (28)	57
nortrel 7/7/7	57
nortriptyline hcl.....	38
NORVASC	
see amlodipine besylate	
.....	34
NORVIR.....	15
see ritonavir.....	16
NOVOLIN INJ 70/30	53
NOVOLIN INJ 70/30 FP..	53
NOVOLIN N	54
NOVOLIN N FLEXPEN...54	
NOVOLIN R	54
NOVOLIN R FLEXPEN...54	
NOVOLOG	54
NOVOLOG FLEXPEN ...54	
NOVOLOG MIX INJ 70/30	
.....	54
NOVOLOG MIX INJ	
FEXPEN.....	54
NOVOLOG PENFILL	54
NOXAFILE	
see posaconazole	14
NUBEQA.....	22
NUEDEXTA CAP 20-10MG	
.....	49
NULOJIX.....	69
NUPLAZID	41
NURTEC	48
NUTRILIPID	72
NUVARING	
see eluryng.....	56
see enilloring.....	56
see etonogestrel-ethinyl	
estradiol va ring 0.120-	
0.015 mg/24hr	56
see haloette.....	56
NUVIGIL	
see armodafinil.....	50
NUZYRA.....	20
nyamyc	78
nylia 1/35	57
nylia 7/7/7	57
NYMALIZE	34
nymyo	57
nystatin	14
nystatin (mouth-throat)....81	
nystatin (topical).....	78
nystop.....	78
O	
ocella	57
OCTAGAM.....	68
octreotide acetate	60
OCUFLOX	
see ofloxacin (ophth)...72	
ODEFSEY TAB.....	17
ODOMZO.....	26
OFEV	76
ofloxacin (ophth)	72
ofloxacin (otic).....	74
OGIVRI	26
OGIVRI INJ 420MG	26
OGSIVEO	26
OJJAARA.....	26
olanzapine	41

<i>olmesartan medoxomil</i>....31	
<i>olmesartan medoxomil-</i>	
<i>hydrochlorothiazide tab</i>	
20-12.5 mg.....30	
<i>olmesartan medoxomil-</i>	
<i>hydrochlorothiazide tab</i>	
40-12.5 mg.....30	
<i>olmesartan medoxomil-</i>	
<i>hydrochlorothiazide tab</i>	
40-25 mg.....30	
<i>olmesartan-amlodipine-</i>	
<i>hydrochlorothiazide tab</i>	
20-5-12.5 mg.....30	
<i>olmesartan-amlodipine-</i>	
<i>hydrochlorothiazide tab</i>	
40-10-12.5 mg.....31	
<i>olmesartan-amlodipine-</i>	
<i>hydrochlorothiazide tab</i>	
40-10-25 mg.....31	
<i>olmesartan-amlodipine-</i>	
<i>hydrochlorothiazide tab</i>	
40-5-12.5 mg.....31	
<i>olmesartan-amlodipine-</i>	
<i>hydrochlorothiazide tab</i>	
40-5-25 mg.....31	
<i>omega-3-acid ethyl esters</i>	
<i>cap 1 gm</i>.....33	
<i>omeprazole</i>.....64	
OMNIPOD 5 G6 KIT	
INTRO.....54	
OMNIPOD 5 G6 MIS PODS	
.....54	
OMNIPOD 5 G7 KIT	
INTRO.....54	
OMNIPOD 5 G7 MIS PODS	
.....54	
OMNIPOD DASH KIT	
INTRO.....54	
OMNIPOD DASH MIS	
PODS.....54	
OMNIPOD GO KIT	
10UNT/DY.....54	
OMNIPOD GO KIT	
15UNT/DY.....54	
OMNIPOD GO KIT	
20UNT/DY.....54	
OMNIPOD GO KIT	
25UNT/DY.....54	
OMNIPOD GO KIT	
30UNT/DY.....54	
OMNIPOD GO KIT	
35UNT/DY.....54	
OMNIPOD GO KIT	
40UNT/DY.....54	
OMNIPOD MIS CLASSIC	
.....54	
<i>ondansetron</i>.....62	
<i>ondansetron hcl</i>.....62	
ONFI	
see <i>clobazam</i>.....43	
ONTRUZANT.....26	
ONUREG.....21	
OPSUMIT.....36	
ORFADIN	
see <i>nitisinone</i>.....60	
ORGOVYX.....22	
ORKAMBI GRA 100-125 76	
ORKAMBI GRA 150-188 76	
ORKAMBI GRA 75-94MG	
.....76	
ORKAMBI TAB 100-125 76	
ORKAMBI TAB 200-125 76	
ORSERDU.....22	
ORTHO TRI-CYCLEN LO	
see <i>norgestimate-eth</i>	
<i>estrad tab 0.18-</i>	
<i>25/0.215-25/0.25-25</i>	
<i>mg-mcg</i>.....57	
see <i>tri-lo-estarrylla</i>.....57	
see <i>tri-lo-marzia</i>.....57	
see <i>tri-lo-mili</i>.....57	
see <i>tri-lo-sprintec</i>.....57	
see <i>tri-vylibra lo</i>.....57	
<i>oseltamivir phosphate</i>....17	
OTEZLA.....67	
OTEZLA TAB 10/20/30 ...67	
<i>oxacillin sodium</i>.....20	
<i>oxaliplatin</i>.....21	
<i>oxcarbazepine</i>.....45	
<i>oxybutynin chloride</i>.....64	
<i>oxycodone hcl</i>.....12	
<i>oxycodone w/</i>	
<i>acetaminophen tab 10-</i>	
<i>325 mg</i>.....12	
<i>oxycodone w/</i>	
<i>acetaminophen tab 2.5-</i>	
<i>325 mg</i>.....12	
<i>oxycodone w/</i>	
<i>acetaminophen tab 5-325</i>	
<i>mg</i>.....12	
<i>oxycodone w/</i>	
<i>acetaminophen tab 7.5-</i>	
<i>325 mg</i>.....12	
OZEMPIC (0.25 OR 0.5	
MG/DOSE).....52	
OZEMPIC (0.25 OR	
0.5MG/DOSE).....52	
OZEMPIC (1MG/DOSE).....52	
OZEMPIC (2MG/DOSE).....52	
P	
pacerone.....32	
paclitaxel.....23	
paclitaxel protein-bound	
particles for iv susp 100	
mg.....23	
paliperidone.....41	
PAMELOR	
see <i>nortriptyline hcl</i> ....38	
pamidronate disodium ....55	
PAMIDRONATE	
DISODIUM.....55	
PANRETIN.....80	
pantoprazole sodium ....64	
PANZYGA.....68	
paraplatin.....21	
paricalcitol.....61	
PARLODEL	
see <i>bromocriptine</i>	
<i>mesylate</i> .....39	
PARNATE	
see <i>tranylcypromine</i>	
<i>sulfate</i> .....38	
paroxetine hcl .....38	
PAXIL	
see <i>paroxetine hcl</i>.....38	
PAXLOVID TAB 150-10017	
PAXLOVID TAB 300-10017	
pazopanib hcl.....26	
PEDIAPRED	
see <i>prednisolone sodium</i>	
<i>phosphate</i>.....59	
PEDIARIX INJ 0.5ML.....69	
PEDVAX HIB .....70	
peg 3350-kcl-na bicarb-	
<i>nacl-na sulfate for soln</i>	
<i>236 gm</i>.....63	

peg 3350-kcl-sod bicarb-	
nacl for soln 420 gm.....	63
PEGASYS	17
PEMAZYRE	26
pemetrexed disodium	21
PEN GK/DEXTR INJ	
40000/ML	20
PEN GK/DEXTR INJ	
60000/ML	20
PENBRAYA INJ.....	70
penicillamine.....	55
penicillin g potassium.....	20
penicillin g sodium	20
penicillin v potassium.....	20
PENTACEL INJ	70
PENTAM 300	
see pentamidine	
isethionate inj.....	13
pentamidine isethionate inh	
.....	13
pentamidine isethionate inj	
.....	13
pentoxifylline.....	66
PEPCID	
see famotidine.....	62
PERCOCET	
see endocet tab 10-	
325mg	11
see endocet tab 2.5-	
325mg	11
see endocet tab 5-325mg	
.....	11
see endocet tab 7.5-	
325mg	11
see oxycodone w/	
acetaminophen tab 10-	
325 mg	12
see oxycodone w/	
acetaminophen tab	
2.5-325 mg	12
see oxycodone w/	
acetaminophen tab 5-	
325 mg	12
see oxycodone w/	
acetaminophen tab	
7.5-325 mg	12
PERIDEX	
see chlorhexidine	
gluconate (mouth-	
throat).....	81
see periogard	81
perindopril erbumine.....	29
periogard	81
permethrin	81
perphenazine.....	41
PERSERIS	41
pfizerpen.....	20
phenelzine sulfate.....	38
PHENERGAN	
see promethazine hcl..	62
phenobarbital.....	45
phenobarbital sodium	45
phenytek.....	45
phenytoin.....	45
phenytoin sodium.....	45
phenytoin sodium extended	
.....	45
PHESGO SOL	26
philith	57
PIFELTRO	15
pilocarpine hcl.....	73
pilocarpine hcl (oral)	81
pimozide	41
pimtrea.....	57
pindolol	34
pioglitazone hcl.....	52
pioglitazone hcl-metformin	
hcl tab 15-500 mg	52
pioglitazone hcl-metformin	
hcl tab 15-850 mg	52
piperacillin sod-tazobactam	
na for inj 3.375 gm (3-	
0.375 gm).....	20
piperacillin sod-tazobactam	
sod for inj 13.5 gm (12-	
1.5 gm).....	20
piperacillin sod-tazobactam	
sod for inj 2.25 gm (2-	
0.25 gm).....	20
piperacillin sod-tazobactam	
sod for inj 4.5 gm (4-0.5	
gm).....	20
piperacillin sod-tazobactam	
sod for inj 40.5 gm (36-	
4.5 gm).....	20
PIQRAY 200MG DAILY	
DOSE.....	26
PIQRAY 250MG TAB	
DOSE	26
PIQRAY 300MG DAILY	
DOSE	26
pirfenidone.....	76
piroxicam	10
PLAQUENIL	
see hydroxychloroquine	
sulfate	68
PLASMA-LYTE A	
see multiple electrolytes	
ph 7.4.....	71
PLASMA-LYTE INJ -148	71
PLASMA-LYTE INJ -A	71
PLASMA-LYTE-148	
see multiple electrolytes	
ph 5.5.....	71
PLAVIX	
see clopidogrel bisulfate	
.....	66
plenamine	72
PLENUV SOL	63
podofilox	80
polycin ophth oint.....	72
polymyxin b-trimethoprim	
ophth soln 10000 unit/ml-	
0.1%.....	72
POMALYST	22
portia-28	57
posaconazole.....	14
POT CHL 20MEQ/L IN	
NACL 0.45% INJ	71
POT CHL 20MEQ/L IN	
NACL 0.9% INJ	71
POT CHL 40MEQ/L IN	
NACL 0.9% INJ	71
potassium chloride.....	71
POTASSIUM CHLORIDE	
.....	71
see potassium chloride	71
potassium chloride 20	
meq/l (0.15%) in	
dextrose 5% inj.....	71
potassium chloride	
microencapsulated	
crystals er.....	71

POTASSIUM	
CHLORIDE/SODIUM	
see <i>kcl</i> 20 meq/l (0.15%)	
<i>in nacl</i> 0.45% <i>inj</i> .....70	
see <i>kcl</i> 20 meq/l (0.15%)	
<i>in nacl</i> 0.9% <i>inj</i> .....70	
see <i>kcl</i> 40 meq/l (0.3%)	
<i>in nacl</i> 0.9% <i>inj</i> .....71	
potassium citrate	
(<i>alkalinizer</i>).....64	
PRADAXA	65
see <i>dabigatran etexilate</i>	
<i>mesylate</i> .....65	
pramipexole	
<i>dihydrochloride</i>.....39	
prasugrel <i>hcl</i>.....66	
pravastatin sodium.....32	
praziquantel.....13	
prazosin <i>hcl</i> .....30	
PRED FORTE	
see <i>prednisolone acetate</i>	
(<i>ophth</i>) .....73	
prednisolone	59
<i>prednisolone acetate</i>	
(<i>ophth</i>) .....73	
PREDNISOLONE SODIUM	
PHOSP .....73	
<i>prednisolone sodium</i>	
<i>phosphate</i> .....59	
<i>prednisone</i>.....59	
PREDNISONE INTENSOL	
.....59	
pregabalin.....45	
PREHEVBARIO	70
PREMASOL SOL 10% ...72	
PRENATAL TAB 27-1MG	
.....71	
PRENATAL TAB PLUS ..71	
PREVACID	
see <i>lansoprazole</i>.....64	
prevalite	33
PREVYMIS	17
PREZCOBIX TAB 800-150	
.....17	
PREZISTA	15
see <i>darunavir</i> .....15	
PRIFTIN.....17	
primaquine phosphate ....15	
PRIMAQUINE	
PHOSPHATE .....15	
<i>see primaquine</i>	
<i>phosphate</i>.....15	
PRIMAXIN IV	
<i>see imipenem-cilastatin</i>	
<i>intravenous for soln</i>	
<i>500 mg</i> .....13	
primidone	45
PRIORIX INJ.....70	
PRISTIQ	
<i>see desvenlafaxine</i>	
<i>succinate</i> .....38	
PRIVIGEN	68
probenecid.....10	
PROCARDIA XL	
<i>see nifedipine</i> .....34	
prochlorperazine	62
<i>prochlorperazine edisylate</i>	
.....62	
<i>prochlorperazine maleate</i>	
.....62	
PROCRIPT	66
PROCTOCORT	
<i>see hydrocortisone</i>	
(<i>rectal</i>) .....80	
procto-med <i>hc</i>.....81	
proctosol <i>hc</i> .....81	
proctozone- <i>hc</i>.....81	
progesterone.....61	
PROGLYCEM	
<i>see diazoxide</i> .....59	
PROGRAF	69
<i>see tacrolimus</i> .....69	
PROLASTIN-C.....76	
PROLENSA	73
<i>see bromfenac sodium</i>	
(<i>ophth</i>) .....73	
PROLIA	55
PROMACTA	66
<i>promethazine hcl</i> .....62	
PROMETRIUM	
<i>see progesterone</i> .....61	
propafenone <i>hcl</i>.....32	
proparacaine <i>hcl</i> .....74	
propranolol <i>hcl</i> .....34	
propylthiouracil.....61	
PROQUAD INJ	70
PROSCAR	
<i>see finasteride</i> .....64	
PROSOL INJ 20%	72
PROTONIX	
<i>see pantoprazole sodium</i>	
.....64	
protriptyline <i>hcl</i>.....38	
PROVENTIL HFA	
<i>see albuterol sulfate</i> ....75	
PROVERA	
<i>see</i>	
<i>medroxyprogesterone</i>	
<i>acetate</i> .....60	
PROVIGIL	
<i>see modafinil</i> .....50	
PROZAC	
<i>see fluoxetine hcl</i> .....38	
PULMICORT	
<i>see budesonide</i>	
(<i>inhalation</i>) .....77	
PULMOZYME	76
PURIXAN.....21	
pyrazinamide	17
pyridostigmine bromide...49	
Q	
QINLOCK.....26	
QUADRACEL INJ	70
QUADRACEL INJ 0.5ML 70	
QUALAQUIN	
<i>see quinine sulfate</i> .....15	
QUESTRAN	
<i>see cholestyramine</i> ....32	
QUESTRAN LIGHT	
<i>see cholestyramine light</i>	
.....32	
<i>see prevalite</i>.....33	
quetiapine fumarate..41, 42	
quinapril <i>hcl</i>.....29	
quinidine sulfate.....32	
quinine sulfate.....15	
QULIPTA	48
R	
RABAVERT INJ	70
raloxifene <i>hcl</i>.....60	
ramipril.....29	
ranolazine	36
RAPAMUNE	
<i>see sirolimus</i> .....69	
rasagiline mesylate	39
RAYALDEE.....61	

RECLAST	
see <i>zoledronic acid</i>	55
RECLIPSEN	57
RECOMBIVAX HB	70
RECTIV	81
REGLAN	
see <i>metoclopramide hcl</i>	
	62
REGRANEX	81
RELENZA DISKHALER	17
RELISTOR	63
REMERON	
see <i>mirtazapine</i>	38
REMERON SOLTAB	
see <i>mirtazapine</i>	38
REMICADE	67
RENFLEXIS	67
RENVELA	
see <i>sevelamer carbonate</i>	
	60
repaglinide	52
REPATHA	33
REPATHA PUSHTRONEX SYSTEM	33
REPATHA SURECLICK	33
RESTASIS	74
RESTASIS MULTIDOSE	74
RESTORIL	
see <i>temazepam</i>	48
RETEVMO	26
RETIN-A	
see <i>tretinoin</i>	78
RETROVIR	
see <i>zidovudine</i>	16
REVATIO	
see <i>sildenafil citrate (pulmonary hypertension)</i>	36
REVLIMID	22
REXULTI	42
REYATAZ	16
see <i>atazanavir sulfate</i>	15
REZLIDHIA	26
REZUROCK	69
RHOPRESSA	73
ribavirin (<i>hepatitis c</i>)	18
rifabutin	17
RIFADIN	
see <i>rifampin</i>	17
rifampin	17
RILUTEK	
see <i>riluzole</i>	49
riluzole	49
rimantadine hydrochloride	
	18
RINVOQ	67
RISPERDAL	
see <i>risperidone</i>	42
RISPERDAL CONSTA	42
see <i>risperidone</i>	
<i>microspheres</i>	42
risperidone	42
risperidone microspheres	42
RITALIN	
see <i>methylphenidate hcl</i>	
	48
ritonavir	16
rivastigmine	37
rivastigmine tartrate	37
rizatriptan benzoate	48
ROBINUL	
see <i>glycopyrrolate</i>	62
ROBINUL FORTE	
see <i>glycopyrrolate</i>	62
ROCALTROL	
see <i>calcitriol</i>	61
see <i>calcitriol (oral)</i>	61
ROCKLATAN DRO	73
roflumilast	76
ropinirole hydrochloride	39
rosuvastatin calcium	32
ROTARIX SUS	70
ROTATEQ SOL	70
ROWASA	
see <i>mesalamine w/ cleanser</i>	
	63
roweepra	45
ROXICODONE	
see <i>oxycodone hcl</i>	12
ROZLYTREK	26
RUBRACA	26
rufinamide	45
RUKOBIA	16
RYBELSUS	52
RYDAPT	26
S	
SABRIL	
see <i>vigabatrin</i>	46
see <i>vigadrone</i>	46
sajazir	66
SALAGEN	
see <i>pilocarpine hcl (oral)</i>	
	81
SANDIMMUNE	69
see <i>cyclosporine</i>	69
SANDOSTATIN	
see <i>octreotide acetate</i>	60
SANTYL	81
SAPHRIS	
see <i>asenapine maleate</i>	
	40
sapropterin dihydrochloride	
	60
SCEMBLIX	26
scopolamine	62
SECUADO	42
selegiline hcl	40
selenium sulfide	79
SELZENTRY	16
see <i>maraviroc</i>	15
SENSIPAR	
see <i>cinacalcet hcl</i>	59
SEREVENT DISKUS	75
SEROQUEL	
see <i>quetiapine fumarate</i>	
	41
SEROQUEL XR	
see <i>quetiapine fumarate</i>	
	42
sertraline hcl	38
setlakin	57
sevelamer carbonate	60
sharobel	57
SHINGRIX	70
SIGNIFOR	60
sildenafil citrate (<i>pulmonary hypertension</i>)	36
SILENOR	
see <i>doxepin hcl (sleep)</i>	
	48
SILVADENE	
see <i>silver sulfadiazine</i>	78
see <i>ssd</i>	78
silver sulfadiazine	78
SIMBRINZA SUS 1-0.2%	73
simliya	57
simvastatin	32

SINEMET		
see <i>carbidopa & levodopa tab</i> 10-100		
<i>mg</i> .....39		
see <i>carbidopa & levodopa tab</i> 25-100		
<i>mg</i> .....39		
SINGULAR		
<i>see montelukast sodium</i>		
.....75		
sirolimus	.....69
SIRTURO	.....17
SIVEXTRO	.....14
SKYRIZI	.....67, 68
SKYRIZI PEN	.....68
sod sulfate-pot sulf-mg sulf		
<i>oral sol</i> 17.5-3.13-1.6		
<i>gm/177ml</i> .....63		
sodium chloride	.....71
sodium chloride (<i>gu irrigant</i>)	.....81
sodium fluoride chew; tab;		
1.1 (0.5 f) mg/ml soln ..72		
SODIUM OXYBATE	.....50
sodium phenylbutyrate	....60
sodium polystyrene		
<i>sulfonate powder</i>.....55		
solifenacin succinate	.....64
SOLIQUA INJ 100/33	....54
SOLTAMOX	.....22
SOLU-CORTEF	.....59
SOLU-MEDROL		
<i>see methylprednisolone</i>		
<i>sod succ</i> .....59		
SOMATULINE DEPOT	...60	
SOMAVERT	.....60
sorafenib tosylate	.....26
sorine	.....32
sotalol hcl	.....32
sotalol hcl (afib/afl)	.....32
spironolactone	.....29
spironolactone &		
<i>hydrochlorothiazide tab</i>		
<i>25-25 mg</i> .....35		
SPORANOX		
<i>see itraconazole</i>.....14		
sprintec 28	.....57
SPRITAM	.....45, 46
SPRYCEL	.....26
sps	.....55
sronyx	.....57
ssd	.....78
STALEVO 150		
<i>see carbidopa-levodopa-entacapone tabs</i> 37.5-150-200 mg	39	
STELARA	.....68
STIVARGA	.....26
STRATTERA		
<i>see atomoxetine hcl</i> ....47		
streptomycin sulfate	.....14
STRIBILD TAB	.....17
STROMECTOL		
<i>see ivermectin</i>.....13		
SUBOXONE		
<i>see buprenorphine hcl-naloxone hcl sl film</i> 12-3 mg (base equiv)....50		
<i>see buprenorphine hcl-naloxone hcl sl film</i> 2-0.5 mg (base equiv).50		
<i>see buprenorphine hcl-naloxone hcl sl film</i> 4-1 mg (base equiv).....50		
<i>see buprenorphine hcl-naloxone hcl sl film</i> 8-2 mg (base equiv).....50		
subvenite	.....46
sucralfate	.....63
sulfacetamide sodium		
<i>(acne)</i>.....78		
sulfacetamide sodium		
<i>(ophth)</i>.....73		
sulfacetamide sodium-prednisolone ophth soln		
10-0.23(0.25)% .....72		
sulfadiazine	.....14
sulfamethoxazole-trimethoprim iv soln		
400-80 mg/5ml .....14		
sulfamethoxazole-trimethoprim susp		
200-40 mg/5ml .....14		
sulfamethoxazole-trimethoprim tab		
400-80 mg .....14		
SYNAREL	.....58
SYNJARDY TAB	12.5-1000MG	53
SYNJARDY TAB	12.5-500	53
SYNJARDY TAB	5-1000MG	53
SYNJARDY TAB 5-500MG53	
SYNJARDY XR TAB	10-1000	53

SYNJARDY XR TAB 12.5-1000	53
SYNJARDY XR TAB 25-1000	53
SYNJARDY XR TAB 5-1000MG	53
SYNTHROID	61
<i>see euthyrox</i>	61
<i>see levo-t</i>	61
<i>see levothyroxine sodium</i>	61
<i>see levoxyl</i>	61
<i>see unithroid</i>	61
SYPRINE	
<i>see trientine hcl</i>	55
T	
TABLOID	21
TABRECTA	27
tacrolimus	69
<i>tacrolimus (topical)</i>	81
TAFINLAR	27
TAGRISSO	27
TALTZ	68
TALZENNA	27
TAMIFLU	
<i>see oseltamivir phosphate</i>	17
tamoxifen citrate	22
tamsulosin hcl	64
TARCEVA	
<i>see erlotinib hcl</i>	24
TARGETIN	
<i>see bexarotene</i>	22
<i>see bexarotene (topical)</i>	80
tarina fe 1/20 eq	57
TASIGNA	27
tasimelteon	48
tazarotene	78
tazicef	18
TAZORAC	79
<i>see tazarotene</i>	78
taztia xt	34
TAZVERIK	27
TDVAX INJ 2-2 LF	70
TECENTRIQ	27
TEFLARO	18
TEGRETOL	
<i>see carbamazepine</i>	43
<i>see epitol</i>	44
TEGRETOL-XR	
<i>see carbamazepine</i>	43
TEKTURNA	
<i>see aliskiren fumarate</i>	35
telmisartan	31
temazepam	48
TENIVAC INJ 5-2LF	70
tenofovir disoproxil fumarate	16
TENORETIC 100	
<i>see atenolol & chlorthalidone tab 100-25 mg</i>	33
TENORETIC 50	
<i>see atenolol & chlorthalidone tab 50-25 mg</i>	33
TENORMIN	
<i>see atenolol</i>	33
TEPMETKO	27
terazosin hcl	30
terbinafine hcl	14
terbutaline sulfate	75
terconazole vaginal	65
TERIPARATIDE	55
testosterone	51
<i>testosterone cypionate</i>	51
<i>testosterone enanthate</i>	51
tetrabenazine	49
tetracycline hcl	20
THALOMID	22
theophylline	76
thioridazine hcl	42
thiothixene	42
tiadylt er	34
tiagabine hcl	46
TIAZAC	
<i>see diltiazem hcl extended release beads</i>	34
<i>see taztia xt</i>	34
<i>see tiadylt er</i>	34
TIBSOVO	27
TICOVAC	70
tigecycline	20
TIKOSYN	
<i>see dofetilide</i>	32
tilia fe	57
timolol maleate	34
<i>timolol maleate (ophth)</i>	73
tinidazole	14
TIVICAY	16
TIVICAY PD	16
tizanidine hcl	50
TOBRADEX OIN 0.3-0.1%	
<i>.....</i>	72
TOBRADEX ST SUS 0.3-0.05	72
tobramycin	14
<i>tobramycin (ophth)</i>	73
tobramycin sulfate	14
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	72
tolterodine tartrate	65
TOPAMAX	
<i>see topiramate</i>	46
TOPAMAX SPRINKLE	
<i>see topiramate</i>	46
topiramate	46
TOPROL XL	
<i>see metoprolol succinate</i>	33
toremifene citrate	22
torsemide	35
TOUJEON MAX SOLOSTAR	
<i>.....</i>	54
TOUJEON SOLOSTAR	54
TPN ELECTROL INJ	71
TRACLEER	
<i>see bosentan</i>	36
TRADJENTA	
<i>.....</i>	53
tramadol hcl	12
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	12
trandolapril	29
tranexamic acid	66
TRANSDERM-SCOP	
<i>see scopolamine</i>	62
tranylcypromine sulfate	38
TRAVASOL INJ 10%	72
TRAZIMERA	
<i>.....</i>	27
trazodone hcl	38
TRECATOR	
<i>.....</i>	17
TRELEGY AER ELLIPTA 100-62.5-25 MCG	74
TRELEGY AER ELLIPTA 200-62.5-25 MCG	74

<i>treprostinil</i>	36
TRESIBA	54
TRESIBA FLEXTOUCH..	54
<i>tretinoin</i>	78
<i>tretinoin (chemotherapy)</i> ..	23
triamicinolone acetonide (mouth).....	81
triamicinolone acetonide (topical)	80
triamterene & hydrochlorothiazide cap 37.5-25 mg.....	35
triamterene & hydrochlorothiazide tab 37.5-25 mg.....	35
triamterene & hydrochlorothiazide tab 75-50 mg.....	35
TRIBENZOR	
see <i>olmesartan-</i> <i>amlodipine-</i> <i>hydrochlorothiazide tab</i> 20-5-12.5 mg	30
see <i>olmesartan-</i> <i>amlodipine-</i> <i>hydrochlorothiazide tab</i> 40-10-12.5 mg	31
see <i>olmesartan-</i> <i>amlodipine-</i> <i>hydrochlorothiazide tab</i> 40-10-25 mg	31
see <i>olmesartan-</i> <i>amlodipine-</i> <i>hydrochlorothiazide tab</i> 40-5-12.5 mg	31
see <i>olmesartan-</i> <i>amlodipine-</i> <i>hydrochlorothiazide tab</i> 40-5-25 mg	31
TRICOR	
see <i>fenofibrate</i>	32
trientine hcl	55
tri-estarrylla	57
trifluoperazine hcl.....	42
trifluridine	73
trihexyphenidyl hcl.....	40
TRIJARDY XR TAB ER	
24HR 10-5-1000MG....	53
TRIJARDY XR TAB ER	
24HR 12.5-2.5-1000MG	
.....	53
TRIJARDY XR TAB ER	
24HR 25-5-1000MG....	53
TRIKAFTA PAK	
59.5MG 76	
TRIKAFTA PAK	
75MG ...76	
TRIKAFTA TAB	
100-50-	
75MG & 150MG	76
TRIKAFTA TAB	
50-25-	
37.5MG & 75MG	76
<i>tri-legest fe</i>	57
TRILEPTAL	
see <i>oxcarbazepine</i>	45
<i>tri-linyah</i>	57
<i>tri-lo-estarrylla</i>	57
<i>tri-lo-marzia</i>	57
<i>tri-lo-mili</i>	57
<i>tri-lo-sprintec</i>	57
<i>trimethoprim</i>	14
<i>tri-mili</i>	57
<i>trimipramine maleate</i>	38
TRINTELLIX	39
<i>tri-nymyo</i>	57
<i>tri-sprintec</i>	57
TRIUMEQ PD TAB	17
TRIUMEQ TAB	17
<i>trivora-28</i>	57
<i>tri-vylibra</i>	57
<i>tri-vylibra lo</i>	57
TRIZIVIR TAB.....	17
TROGARZO	16
TROPHAMINE INJ 10% .	72
<i>trospium chloride</i>	65
TRULICITY	53
TRUMENBA INJ	70
TRUQAP	27
TRUVADA	
see <i>emtricitabine-</i> <i>tenofovir disoproxil</i> <i>fumarate tab 100-150</i>	
<i>mg</i>	16
see <i>emtricitabine-</i> <i>tenofovir disoproxil</i> <i>fumarate tab 133-200</i>	
<i>mg</i>	16
see <i>emtricitabine-</i> <i>tenofovir disoproxil</i> <i>fumarate tab 167-250</i>	
<i>mg</i>	16
see <i>emtricitabine-</i> <i>tenofovir disoproxil</i> <i>fumarate tab 200-300</i>	
<i>mg</i>	16
TRUXIMA.....	27
TUKYSA	27
TURALIO	27
<i>turqoz</i>	57
TWINRIX INJ	70
TYBOST	16
TYGACIL	
see <i>tigecycline</i>	20
TYKERB	
see <i>lapatinib ditosylate</i> 25	
TYPHIM VI.....	70
TYRVAYA	74
U	
UBRELVY	49
UCERIS	
see <i>budesonide</i>	62
UNASYN	
see <i>ampicillin &</i> <i>sulbactam sodium for</i> <i>inj 1.5 (1-0.5) gm</i>	19
see <i>ampicillin &</i> <i>sulbactam sodium for</i> <i>inj 3 (2-1) gm</i>	19
UNASYN BULK PACK	
see <i>ampicillin &</i> <i>sulbactam sodium for</i> <i>iv soln 15 (10-5) gm</i> 20	
unithroid.....	61
UROCIT-K 10	
see <i>potassium citrate</i> <i>(alkalinizer)</i>	64
UROCIT-K 15	
see <i>potassium citrate</i> <i>(alkalinizer)</i>	64
UROCIT-K 5	
see <i>potassium citrate</i> <i>(alkalinizer)</i>	64
UROXATRAL	
see <i>alfuzosin hcl</i>	64
URSO 250	
see <i>ursodiol</i>	63

URSO FORTE	
see <i>ursodiol</i>	63
<i>ursodiol</i>	63
V	
VAGIFEM	
see <i>estradiol vaginal</i> ...	58
see <i>yuvafem</i>	58
<i>valacyclovir hcl</i>	18
VALCHLOR	81
VALCYTE	
see <i>valganciclovir hcl</i> ..	18
<i>valganciclovir hcl</i>	18
VALIUM	
see <i>diazepam</i>	43
<i>valproate sodium</i>	46
<i>valproic acid</i>	46
<i>valsartan</i>	31
<i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>160-12.5 mg</i>	31
<i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>160-25 mg</i>	31
<i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>320-12.5 mg</i>	31
<i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>320-25 mg</i>	31
<i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>80-12.5 mg</i>	31
VALTOCO 10 MG DOSE	46
VALTOCO 15 MG DOSE	46
VALTOCO 20 MG DOSE	46
VALTOCO 5 MG DOSE..	46
VALTREX	
see <i>valacyclovir hcl</i>	18
VANCOCIN	
see <i>vancomycin hcl</i>	14
<i>vancomycin hcl</i>	14
VANCOMYCIN INJ 1 GM	14
VANCOMYCIN INJ 500MG	
.....	14
VANCOMYCIN INJ 750MG	
.....	14
VANFLYTA	27
VAQTA	70
<i>varenicline tartrate</i>	51
varenicline tartrate tab	11 x
<i>0.5 mg & 42 x 1 mg start</i>	
<i>pack</i>	51
VARIVAX	70
VASCEPA.....	33
VASERETIC	
see <i>enalapril maleate &</i>	
<i>hydrochlorothiazide tab</i>	
<i>10-25 mg</i>	29
VASOTEC	
see <i>enalapril maleate</i> ..	29
VELCADE	
see <i>bortezomib</i>	23
velivet	57
VELPHORO.....	60
VELTASSA	55
VEMLIDY	18
VENCLEXTA	27
VENCLEXTA TAB START	
PK	27
venlafaxine hcl.....	39
VENTAVIS.....	36
VENTOLIN HFA.....	75
VENTOLIN HFA	
(<i>INSTITUTIONAL PACK</i>)	
.....	75
verapamil hcl.....	34
VERELAN	
see <i>verapamil hcl</i>	34
VERQUVO.....	36
VERSACLOZ	42
VERZENIO	27
VESICARE	
see <i>solifenacin succinate</i>	
.....	64
vestura.....	57
VFEND	
see <i>voriconazole</i>	15
VFEND IV	
see <i>voriconazole</i>	14
V-GO 20 KIT	54
V-GO 30 KIT	54
V-GO 40 KIT	55
VIBRAMYCIN	
see <i>doxycycline</i>	
(<i>monohydrate</i>)	20
see <i>doxycycline hyclate</i>	
.....	20
VIDAZA	
see <i>azacitidine</i>	21
vienna	57
vigabatrin	46
vigadronе	46
VIGAMOX	
see <i>moxifloxacin hcl</i>	
(<i>ophth</i>)	72
VIIBRYD	
see <i>vilazodone hcl</i>	39
<i>vilazodone hcl</i>	39
VIMPAT	
see <i>lacosamide</i>	44
see <i>lacosamide oral</i> ...	44
vincristine sulfate	23
vinorelbine tartrate	23
viorele	58
VIRACEPT	16
VIREAD	16
see <i>tenofovir disoproxil</i>	
<i>fumarate</i>	16
VISTARIL	
see <i>hydroxyzine</i>	
<i>pamoate</i>	75
VITRAKVI	27
VIVELLE-DOT	
see <i>dotti</i>	58
see <i>estradiol</i>	58
VIVITROL	51
VIZIMPRO	27
VONJO	27
voriconazole.....	14, 15
VOSEVI TAB	18
VOTRIENT	27
see <i>pazopanib hcl</i>	26
VRAYLAR	42
VRAYLAR CAP 1.5-3MG	42
vyfemla	58
vylibra	58
VYTORIN	
see <i>ezetimibe-</i>	
<i>simvastatin tab 10-10</i>	
<i>mg</i>	33
see <i>ezetimibe-</i>	
<i>simvastatin tab 10-20</i>	
<i>mg</i>	33
see <i>ezetimibe-</i>	
<i>simvastatin tab 10-40</i>	
<i>mg</i>	33

see <i>ezetimibe-</i>	
<i>simvastatin tab</i> 10-80	53
<i>mg</i>	33
VYZULTA	73
W	
<i>warfarin sodium</i>	65
<i>water for irrigation, sterile</i>	
<i>irrigation soln.</i>	81
WELCHOL	
<i>see colesevelam hcl</i>	32
WELIREG	23
WELLBUTRIN SR	
<i>see bupropion hcl</i>	37
WELLBUTRIN XL	
<i>see bupropion hcl</i>	37
wera.....	58
wixela <i>inhub</i>	77
X	
XALATAN	
<i>see latanoprost</i>	73
XALKORI	27
XANAX	
<i>see alprazolam</i>	36
XARELTO	65, 66
XARELTO STAR TAB	
15/20MG	66
XATMEP	68
XCOPRI	46
XCOPRI PAK 100-150....	46
XCOPRI PAK 12.5-25....	46
XCOPRI PAK 150-200MG (MAINTENANCE).....	46
XCOPRI PAK 150-200MG (TITRATION).....	46
XCOPRI PAK 50-100MG	46
XELJANZ	68
XELJANZ XR	68
XENAZINE	
<i>see tetrabenazine</i>	49
XERMELO	63
XGEVA	55
XHANCE	76
XIFAXAN	63
XIGDUO XR TAB 10-1000	
.....	53
XIGDUO XR TAB 10- 500MG	53
XIGDUO XR TAB 2.5-1000	
.....	53
XIGDUO XR TAB 5-	
1000MG	53
XIGDUO XR TAB 5-500MG	
.....	53
XIIDRA.....	74
XOLAIR	76
XOSPATA.....	27
XPOVIO 100 MG ONCE WEEKLY	28
XPOVIO 40 MG ONCE WEEKLY	28
XPOVIO 40 MG TWICE WEEKLY	28
XPOVIO 60 MG ONCE WEEKLY	28
XPOVIO 60 MG TWICE WEEKLY	28
XPOVIO 80 MG ONCE WEEKLY	28
XPOVIO 80 MG TWICE WEEKLY	28
XTANDI	22
xulane	58
XULTOPHY INJ 100/3.6.55	
XYLOCAINE	
<i>see lidocaine hcl (local</i>	
<i>anesth.)</i>	12
XYLOCAINE-MPF	
<i>see lidocaine hcl (local</i>	
<i>anesth.)</i>	12
Y	
yargesa.....	60
YASMIN 28	
<i>see drospirenone-ethinyl</i>	
<i>estradiol tab 3-0.03 mg</i>	
.....	56
<i>see ocella</i>	57
<i>see syeda</i>	57
<i>see zumandimine</i>	58
YAZ	
<i>see drospirenone-ethinyl</i>	
<i>estradiol tab 3-0.02 mg</i>	
.....	56
<i>see jasmiel</i>	56
<i>see loryna</i>	56
<i>see nikki</i>	57
<i>see vestura</i>	57
YF-VAX INJ	70
yuvaferm	58
Z	
<i>zafemy</i>	58
<i>zafirlukast</i>	75
ZANAFLEX	
<i>see tizanidine hcl</i>	50
ZARONTIN	
<i>see ethosuximide</i>	44
ZARXIO	66
ZAVESCA	
<i>see miglustat</i>	60
<i>see yargesa</i>	60
ZEJULA	28
ZELBORAF	28
ZEMAIRA.....	76
ZEMPLAR	
<i>see paricalcitol</i>	61
zenatane.....	78
ZENPEP CAP 1000UNT	
.....	63
ZENPEP CAP 1500UNT	
.....	63
ZENPEP CAP 2000UNT	
.....	63
ZENPEP CAP 2500UNT	
.....	64
ZENPEP CAP 3000UNIT	63
ZENPEP CAP 4000UNT	
.....	64
ZENPEP CAP 5000UNIT	63
ZENPEP CAP 6000UNT	
.....	64
ZERVIATE	73
ZESTORETIC	
<i>see lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
10-12.5 mg	29
<i>see lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
20-12.5 mg	29
<i>see lisinopril &</i>	
<i>hydrochlorothiazide tab</i>	
20-25 mg	29
ZESTRIL	
<i>see lisinopril</i>	29
ZETIA	
<i>see ezetimibe</i>	33
ZIAGEN	
<i>see abacavir sulfate</i> ...	15
zidovudine.....	16

ZIEXTENZO	66	<i>zolpidem tartrate</i>	48	ZYDELIG	28
ziprasidone hcl.....	42	ZONEGRAN		ZYKADIA	28
ziprasidone mesylate.....	42	see <i>zonisamide</i>	46	ZYLET SUS 0.5-0.3%....	72
ZIRABEV	28	ZONISADE	46	ZYPREXA	
ZIRGAN	73	<i>zonisamide</i>	46	see <i>olanzapine</i>	41
ZITHROMAX		ZORTRESS		ZYPREXA RELPREVV ..	42
see <i>azithromycin</i>	18	see <i>everolimus</i>		ZYPREXA ZYDIS	
ZOCOR		(<i>immunosuppressant</i>)		see <i>olanzapine</i>	41
see <i>simvastatin</i>	32	.....	69	ZYTIGA	
zoledronic acid.....	55	zovia 1/35	58	see <i>abiraterone acetate</i>	
ZOLINZA	28	ZTALMY	46	.....	21
ZOLOFT		zumandimine	58	ZYVOX	
see <i>sertraline hcl</i>	38	ZURZUVAE	39	see <i>linezolid</i>	13

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 4/01/2024. 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.