



FORMULARY LIST OF COVERED DRUGS

Johns Hopkins Advantage MD D-SNP (HMO)

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

HPMS Approved Formulary File Submission ID 00024151, Version 10

This formulary was updated on 03/01/2024 For more recent information or other questions, please contact Johns Hopkins Advantage MD D-SNP (HMO) Customer Service at 1-877-293-4998 (TTY users should call 711), 24 hours a day, 7 days a week, or visit www.hopkinsmedicare.com.

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

When this drug list (formulary) refers to “we,” “us”, or “our,” it means Johns Hopkins Advantage MD. When it refers to “plan” or “our plan,” it means Johns Hopkins Advantage MD D-SNP (HMO).

This document includes the list of the drugs (formulary) for our plan which is current as of 03/01/2024. For updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

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

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Johns Hopkins Advantage MD D-SNP (HMO) Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 03/01/2024. To get updated information about the drugs covered by our plan please contact us. Our contact information appears on the front and back cover pages. In the event of any mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS”. If you know what your drug is used for, look for the category name in the list that begins page 10. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 74. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

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

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

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

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

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

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

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

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

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

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

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

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

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

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

If you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary (or if your ability to get your drugs is limited), we will cover a onetime temporary supply for up to 30-days (or 31-days if you are a long-term care resident) from a network pharmacy. During this period you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For more information

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

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

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

Johns Hopkins Advantage MD D-SNP (HMO) Formulary

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

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

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

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

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

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

NOTE:

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

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

Johns Hopkins Advantage MD D-SNP (HMO)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12

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

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

Drug Name	Drug Requirements/ Tier	Limits
<i>griseofulvin microsize</i> SUSP 125mg/5ml; TABS 500mg	1	
<i>griseofulvin ultramicrosize</i> TABS 125mg, 250mg	1	
<i>itraconazole</i> (generic of SPORANOX) CAPS 100mg	1	PA
<i>ketoconazole</i> TABS 200mg	1	PA
<i>micafungin sodium</i> (generic of MYCAMINE) SOLR 50mg, 100mg	1	
<i>nystatin</i> TABS 500000unit	1	
<i>posaconazole</i> (generic of NOXAFL) SUSP 40mg/ml QL (630 mL / 30 days)	1	QL PA
<i>posaconazole</i> (generic of NOXAFL) TBEC 100mg QL (93 tabs / 30 days)	1	QL PA
<i>terbinafine hcl</i> TABS 250mg QL (90 tabs / year)	1	QL
<i>voriconazole</i> (generic of VFEND IV) SOLR 200mg	1	PA
<i>voriconazole</i> (generic of VFEND) SUSR 40mg/ml	1	PA
<i>voriconazole</i> (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	1	QL PA
<i>voriconazole</i> (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	1	QL PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
<i>atovaquone-proguanil hcl tab</i> 62.5-25 mg (generic of MALARONE)	1	
<i>atovaquone-proguanil hcl tab</i> 250-100 mg (generic of MALARONE)	1	
<i>chloroquine phosphate</i> TABS 250mg, 500mg COARTEM TAB 20-120MG	1	
<i>mefloquine hcl</i> TABS 250mg	1	
<i>PRIMAQUINE PHOSPHATE</i> TABS 26.3mg	1	

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

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

Drug Name	Drug Requirements/ Tier	Limits
<i>primaquine phosphate</i> (generic of PRIMAQUINE PHOSPHATE) TABS 26.3mg	1	
<i>quinine sulfate</i> (generic of QUALAQUIN) CAPS 324mg	1	PA
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
<i>abacavir sulfate</i> (generic of ZIAGEN) SOLN 20mg/ml	1	NM
<i>abacavir sulfate</i> TABS 300mg	1	NM
APTVUS CAPS 250mg	1	NM
<i>atazanavir sulfate</i> CAPS 150mg	1	NM
<i>atazanavir sulfate</i> (generic of REYATAZ) CAPS 200mg, 300mg	1	NM
<i>darunavir</i> (generic of PREZISTA) TABS 600mg QL (60 tabs / 30 days)	1	QL NM
<i>darunavir</i> (generic of PREZISTA) TABS 800mg QL (30 tabs / 30 days)	1	QL NM
EDURANT TABS 25mg	1	NM
efavirenz CAPS 50mg, 200mg	1	NM
efavirenz (generic of SUSTIVA) TABS 600mg	1	NM
<i>emtricitabine</i> (generic of EMTRIVA) CAPS 200mg	1	NM
EMTRIVA SOLN 10mg/ml	1	NM
<i>etravirine</i> (generic of INTELENCE) TABS 100mg, 200mg	1	NM
<i>fosamprenavir calcium</i> (generic of LEXIVA) TABS 700mg	1	NM
FUZEON SOLR 90mg	1	NM LA
INTELENCE TABS 25mg	1	NM
ISENTRESS CHEW 25mg, 100mg; PACK 100mg; TABS 400mg	1	NM
ISENTRESS HD TABS 600mg	1	NM

Drug Name	Drug Requirements/ Tier	Limits
<i>lamivudine</i> (generic of EPIVIR) SOLN 10mg/ml; TABS 150mg, 300mg	1	NM
LEXIVA SUSP 50mg/ml	1	NM
<i>maraviroc</i> (generic of SELZENTRY) TABS 150mg, 300mg	1	NM
<i>nevirapine</i> SUSP 50mg/5ml; TABS 200mg; TB24 400mg	1	NM
NORVIR PACK 100mg	1	NM
PIFELTRO TABS 100mg	1	NM
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	1	QL NM
PREZISTA TABS 75mg QL (480 tabs / 30 days)	1	QL NM
PREZISTA TABS 150mg QL (240 tabs / 30 days)	1	QL NM
REYATAZ PACK 50mg	1	NM
<i>ritonavir</i> (generic of NORVIR) TABS 100mg	1	NM
RUKOBIA TB12 600mg	1	NM
SELZENTRY SOLN 20mg/ml; TABS 25mg, 75mg	1	NM
SUNLENCA TBPK 300mg	1	NM LA
<i>tenofovir disoproxil fumarate</i> (generic of VIREAD) TABS 300mg	1	NM
TIVICAY TABS 10mg, 25mg, 50mg	1	NM
TIVICAY PD TBSO 5mg	1	NM
TROGARZO SOLN 200mg/1.33ml	1	NM LA
TYBOST TABS 150mg	1	NM
VIRACEPT TABS 250mg, 625mg	1	NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	1	NM
<i>zidovudine</i> (generic of RETROVIR) CAPS 100mg; SYRP 50mg/5ml	1	NM
<i>zidovudine</i> TABS 300mg	1	NM

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	1	NM
BIKTARVY TAB 30-120-15 MG	1	NM
BIKTARVY TAB 50-200-25 MG	1	NM
CIMDUO TAB 300-300	1	NM
COMPLERA TAB	1	NM
DELSTRIGO TAB	1	NM
DESCOVY TAB 120-15MG QL (30 tabs / 30 days)	1	QL NM
DESCOVY TAB 200/25MG QL (30 tabs / 30 days)	1	QL NM
DOVATO TAB 50-300MG	1	NM
efavirenz-emtricitabine- tenofovir df tab 600-200-300 mg (generic of ATRIPLA)	1	NM
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (generic of SYMFI LO)	1	NM
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (generic of SYMFI)	1	NM
emtricitabine-tenofovir disoproxil fumarate tab 100- 150 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 133- 200 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
emtricitabine-tenofovir disoproxil fumarate tab 200- 300 mg (generic of TRUVADA) QL (30 tabs / 30 days)	1	QL NM
EVOTAZ TAB 300-150	1	NM
GENVOYA TAB	1	NM
JULUCA TAB 50-25MG	1	NM
lamivudine-zidovudine tab 150-300 mg	1	NM
lopinavir-ritonavir soln 400- 100 mg/5ml (80-20 mg/ml) (generic of KALETRA)	1	NM
lopinavir-ritonavir tab 100-25 mg (generic of KALETRA)	1	NM
lopinavir-ritonavir tab 200-50 mg (generic of KALETRA)	1	NM
ODEFSEY TAB	1	NM
PREZCOBIX TAB 800-150	1	NM
STRIBILD TAB	1	NM
SYMTUZA TAB	1	NM
TRIUMEQ PD TAB	1	NM
TRIUMEQ TAB	1	NM
TRIZIVIR TAB	1	NM
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
cycloserine CAPS 250mg	1	
ethambutol hcl TABS 100mg	1	
ethambutol hcl (generic of MYAMBUTOL) TABS 400mg	1	
isoniazid SYRP 50mg/5ml; TABS 100mg, 300mg	1	
PRIFTIN TABS 150mg	1	
pyrazinamide TABS 500mg	1	
rifabutin (generic of MYCOBUTIN) CAPS 150mg	1	
rifampin CAPS 150mg, 300mg	1	
rifampin (generic of RIFADIN) SOLR 600mg	1	
SIRTURO TABS 20mg, 100mg	1	NM LA PA
TRECATOR TABS 250mg	1	

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

15

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			
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS								
acyclovir CAPS 200mg; SUSP 200mg/5ml; TABS 400mg, 800mg	1		PREVYMIS TABS 240mg, 480mg	1	QL PA			
acyclovir sodium SOLN 50mg/ml	1	B/D	QL (28 tabs / 28 days)					
adefovir dipivoxil TABS 10mg	1	NM	RELENZA DISKHALER	1	QL			
BARACLUDE SOLN .05mg/ml	1	NM	AEPB 5mg/blister					
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	1	NM	QL (6 inhalers / year)					
EPCLUSA PAK 150-37.5	1	NM PA	ribavirin (hepatitis c) CAPS 200mg; TABS 200mg	1	NM			
EPCLUSA PAK 200-50MG	1	NM PA	rimantadine hydrochloride	1				
EPCLUSA TAB 200-50MG	1	NM PA	TABS 100mg					
EPCLUSA TAB 400-100	1	NM PA	valacyclovir hcl (generic of VALTREX) TABS 1gm, 500mg	1				
famciclovir TABS 125mg, 250mg, 500mg	1		valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml; TABS 450mg	1				
ganciclovir sodium SOLR 500mg	1	B/D	VEMLIDY TABS 25mg	1	NM			
HARVONI PAK 33.75-150MG	1	NM PA	VOSEVI TAB	1	NM PA			
HARVONI PAK 45-200MG	1	NM PA	XOFLUZA TBPK 40mg, 80mg	1	QL			
HARVONI TAB 45-200MG	1	NM PA	QL (1 tab / 180 days)					
HARVONI TAB 90-400MG	1	NM PA	CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS					
lamivudine (hbv) TABS 100mg	1	NM	cefaclor CAPS 250mg, 500mg; SUSR 250mg/5ml	1				
MAVYRET PAK 50-20MG	1	NM PA	CEFACLOR ER TB12 500mg	1				
MAVYRET TAB 100-40MG	1	NM PA	cefadroxil CAPS 500mg; SUSR 250mg/5ml, 500mg/5ml	1				
oseltamivir phosphate (generic of TAMIFLU) CAPS 30mg	1	QL	CEFAZOLIN SOLR 2gm, 3gm	1				
QL (168 caps / year)			CEFAZOLIN INJ 1GM/50ML	1				
oseltamivir phosphate (generic of TAMIFLU) CAPS 45mg, 75mg	1	QL	cefaezolin sodium SOLR 1gm, 2gm, 10gm, 500mg	1				
QL (84 caps / year)			CEFAZOLIN SOLN 2GM/100ML-4%	1				
oseltamivir phosphate (generic of TAMIFLU) SUSR 6mg/ml	1	QL	cefdinir CAPS 300mg; SUSR 125mg/5ml, 250mg/5ml	1				
QL (1080 mL / year)			cefpime hcl SOLR 1gm, 2gm	1				
PEGASYS SOLN 180mcg/ml; 1 SOSY 180mcg/0.5ml		NM PA	cefixime CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	1				
			cefoxitin sodium SOLR 1gm, 2gm, 10gm	1				

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

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

Drug Name	Drug Requirements/ Tier	Limits
<i>cefepodoxime proxetil</i> SUSR 50mg/5ml, 100mg/5ml; TABS 100mg, 200mg	1	
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	1	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	1	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	1	
<i>cephalexin</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml	1	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	1	
TEFLARO SOLR 400mg, 600mg	1	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
<i>azithromycin</i> PACK 1gm; TABS 600mg	1	
<i>azithromycin</i> (generic of ZITHROMAX) SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml; TABS 250mg, 500mg	1	
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>clarithromycin</i> (generic of BIAXIN XL) TB24 500mg	1	
DIFICID SUSR 40mg/ml; TABS 200mg	1	
e.e.s. 400 TABS 400mg	1	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	1	
ERYTHROCIN LACTOBIONATE SOLR 500mg	1	

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

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

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

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

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

18

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

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

Drug Name	Drug Requirements/ Tier	Limits
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	1	B/D
<i>doxorubicin hcl liposomal</i> (generic of DOXIL) INJ 2mg/ml	1	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	1	B/D
ANTIMETABOLITES		
<i>azacitidine</i> (generic of VIDAZA) SUSR 100mg	1	B/D NM
<i>cytarabine</i> SOLN 20mg/ml	1	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	1	B/D
<i>gemcitabine hcl</i> (generic of GEMCITABINE HYDROCHLORIDE) SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml	1	B/D
<i>gemcitabine hcl</i> SOLR 1gm, 2gm, 200mg	1	B/D
INQOVI TAB 35-100MG QL (5 tabs / 28 days)	1	QL NM LA PA
LONSURF TAB 15-6.14 QL (100 tabs / 28 days)	1	QL NM LA PA
LONSURF TAB 20-8.19 QL (80 tabs / 28 days)	1	QL NM LA PA
<i>mercaptopurine</i> TABS 50mg	1	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	1	B/D
ONUREG TABS 200mg, 300mg	1	QL NM LA PA
QL (14 tabs / 28 days)		
<i>pemetrexed disodium</i> (generic of ALIMTA) SOLR 100mg, 500mg	1	B/D
<i>pemetrexed disodium</i> SOLR 750mg, 1000mg	1	B/D
PURIXAN SUSP 2000mg/100ml	1	NM LA
TABLOID TABS 40mg	1	

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

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

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

Drug Name	Drug Requirements/ Tier	Limits
NUBEQA TABS 300mg QL (120 tabs / 30 days)	1	QL NM LA PA
ORGOVYX TABS 120mg	1	NM LA PA
ORSERDU TABS 86mg QL (90 tabs / 30 days)	1	QL NM LA PA
ORSERDU TABS 345mg QL (30 tabs / 30 days)	1	QL NM LA PA
SOLTAMOX SOLN 10mg/5ml 10mg, 20mg	1	
toremifene citrate (generic of FARESTON) TABS 60mg	1	
XTANDI CAPS 40mg QL (120 caps / 30 days)	1	QL NM LA PA
XTANDI TABS 40mg QL (120 tabs / 30 days)	1	QL NM LA PA
XTANDI TABS 80mg QL (60 tabs / 30 days)	1	QL NM LA PA
IMMUNOMODULATORS		
lenalidomide CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	1	QL NM LA PA
lenalidomide CAPS 20mg, 25mg QL (21 caps / 28 days)	1	QL NM LA PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg QL (21 caps / 28 days)	1	QL NM LA PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	1	QL NM LA PA
REVLIMID CAPS 20mg, 25mg QL (21 caps / 28 days)	1	QL NM LA PA
THALOMID CAPS 50mg, 100mg QL (28 caps / 28 days)	1	QL NM LA PA
THALOMID CAPS 150mg, 200mg QL (56 caps / 28 days)	1	QL NM LA PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml QL (2 syringes / 28 days)	1	QL NM LA PA

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

20

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
bexarotene (generic of TARGRETIN) CAPS 75mg QL (300 caps / 30 days)	1	QL NM PA
hydroxyurea (generic of HYDREA) CAPS 500mg	1	
irinotecan hcl (generic of CAMPTOSAR) SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml	1	B/D
irinotecan hcl SOLN 500mg/25ml	1	B/D
KISQALI 200 PAK FEMARA QL (49 tabs / 28 days)	1	QL NM PA
KISQALI 400 PAK FEMARA QL (70 tabs / 28 days)	1	QL NM PA
KISQALI 600 PAK FEMARA QL (91 tabs / 28 days)	1	QL NM PA
MATULANE CAPS 50mg	1	NM LA
tretinoin (chemotherapy) CAPS 10mg	1	
WELIREG TABS 40mg QL (90 tabs / 30 days)	1	QL NM LA PA
MITOTIC INHIBITORS		
docetaxel (generic of DOCETAXEL) CONC 20mg/ml, 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
etoposide SOLN 1gm/50ml, 100mg/5ml, 500mg/25ml	1	B/D
paclitaxel CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	1	B/D
paclitaxel protein-bound particles for iv susp 100 mg	1	B/D NM
vincristine sulfate SOLN 1mg/ml	1	B/D
vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml	1	B/D

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
MOLECULAR TARGET AGENTS		
ALECENSA CAPS 150mg QL (240 caps / 30 days)	1	QL NM LA PA
ALUNBRIG TABS 30mg QL (120 tabs / 30 days)	1	QL NM LA PA
ALUNBRIG TABS 90mg, 180mg QL (30 tabs / 30 days)	1	QL NM LA PA
ALUNBRIG PAK QL (30 tabs / 30 days)	1	QL NM LA PA
AUGTYRO CAPS 40mg QL (240 caps / 30 days)	1	QL NM LA PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg QL (30 tabs / 30 days)	1	QL NM LA PA
BALVERSA TABS 3mg QL (84 tabs / 28 days)	1	QL NM LA PA
BALVERSA TABS 4mg QL (56 tabs / 28 days)	1	QL NM LA PA
BALVERSA TABS 5mg QL (28 tabs / 28 days)	1	QL NM LA PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	1	NM PA
bortezomib (generic of VELCADE) SOLR 3.5mg	1	NM PA
BOSULIF TABS 100mg QL (180 tabs / 30 days)	1	QL NM PA
BOSULIF TABS 400mg, 500mg QL (30 tabs / 30 days)	1	QL NM PA
BRAFTOVI CAPS 75mg QL (180 caps / 30 days)	1	QL NM LA PA
BRUKINSA CAPS 80mg QL (120 caps / 30 days)	1	QL NM LA PA
CABOMETYX TABS 20mg, 40mg, 60mg QL (30 tabs / 30 days)	1	QL NM LA PA
CALQUENCE CAPS 100mg QL (60 caps / 30 days)	1	QL NM LA PA
CALQUENCE TABS 100mg QL (60 tabs / 30 days)	1	QL NM LA PA
CAPRELSA TABS 100mg QL (60 tabs / 30 days)	1	QL NM LA PA

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

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

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
CAPRELSA TABS 300mg QL (30 tabs / 30 days)	1 QL NM LA PA	EXKIVITY CAPS 40mg QL (120 caps / 30 days)	1 QL NM LA PA
COMETRIQ (60MG DOSE) KIT 20mg QL (84 caps / 28 days)	1 QL NM LA PA	FOTIVDA CAPS .89mg, 1.34mg QL (21 caps / 28 days)	1 QL NM LA PA
COMETRIQ KIT 100MG QL (56 caps / 28 days)	1 QL NM LA PA	FRUZAQLA CAPS 1mg QL (84 caps / 28 days)	1 QL NM LA PA
COMETRIQ KIT 140MG QL (112 caps / 28 days)	1 QL NM LA PA	FRUZAQLA CAPS 5mg QL (21 caps / 28 days)	1 QL NM LA PA
COPIKTRA CAPS 15mg, 25mg QL (56 caps / 28 days)	1 QL NM LA PA	GAVRETO CAPS 100mg QL (120 caps / 30 days)	1 QL NM LA PA
COTELLIC TABS 20mg QL (63 tabs / 28 days)	1 QL NM LA PA	<i>gefitinib</i> (generic of IRESSA) TABS 250mg QL (30 tabs / 30 days)	1 QL NM PA
DAURISMO TABS 25mg QL (60 tabs / 30 days)	1 QL NM LA PA	GILOTrif TABS 20mg, 30mg, 40mg QL (30 tabs / 30 days)	1 QL NM LA PA
DAURISMO TABS 100mg QL (30 tabs / 30 days)	1 QL NM LA PA	HERCEP HYLEC SOL 60- 10000	1 NM LA PA
ERIVEDGE CAPS 150mg QL (30 caps / 30 days)	1 QL NM LA PA	HERCEPTIN SOLR 150mg	1 NM LA PA
<i>erlotinib hcl</i> (generic of TARCEVA) TABS 25mg QL (90 tabs / 30 days)	1 QL NM PA	HERZUMA SOLR 150mg, 420mg	1 NM PA
<i>erlotinib hcl</i> (generic of TARCEVA) TABS 100mg, 150mg QL (30 tabs / 30 days)	1 QL NM PA	IBRANCE CAPS 75mg, 100mg, 125mg QL (21 caps / 28 days)	1 QL NM LA PA
everolimus (generic of AFINITOR) TABS 2.5mg, 5mg, 7.5mg, 10mg QL (30 tabs / 30 days)	1 QL NM PA	IBRANCE TABS 75mg, 100mg, 125mg QL (21 tabs / 28 days)	1 QL NM LA PA
everolimus (generic of AFINITOR DISPERZ) TBSO 2mg QL (150 tabs / 30 days)	1 QL NM PA	ICLUSIG TABS 10mg, 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1 QL NM LA PA
everolimus (generic of AFINITOR DISPERZ) TBSO 3mg QL (90 tabs / 30 days)	1 QL NM PA	IDHIFA TABS 50mg, 100mg QL (30 tabs / 30 days)	1 QL NM LA PA
everolimus (generic of AFINITOR DISPERZ) TBSO 5mg QL (60 tabs / 30 days)	1 QL NM PA	<i>imatinib mesylate</i> (generic of GLEEVEC) TABS 100mg QL (90 tabs / 30 days)	1 QL NM PA
		<i>imatinib mesylate</i> (generic of GLEEVEC) TABS 400mg QL (60 tabs / 30 days)	1 QL NM PA
		IMBRUVICA CAPS 70mg QL (30 caps / 30 days)	1 QL NM LA PA
		IMBRUVICA CAPS 140mg QL (120 caps / 30 days)	1 QL NM LA PA

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

22

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

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
IMBRUICA SUSP 70mg/ml QL (216 mL / 27 days)	1 QL NM LA PA	LENVIMA 4 MG DAILY DOSE CPPK 4mg QL (30 caps / 30 days)	1 QL NM LA PA
IMBRUICA TABS 140mg, 280mg, 420mg QL (30 tabs / 30 days)	1 QL NM LA PA	LENVIMA 8 MG DAILY DOSE CPPK 4mg QL (60 caps / 30 days)	1 QL NM LA PA
INLYTA TABS 1mg QL (180 tabs / 30 days)	1 QL NM LA PA	LENVIMA 10 MG DAILY DOSE CPPK 10mg QL (30 caps / 30 days)	1 QL NM LA PA
INLYTA TABS 5mg QL (120 tabs / 30 days)	1 QL NM LA PA	LENVIMA 12MG DAILY DOSE CPPK 4mg QL (90 caps / 30 days)	1 QL NM LA PA
INREBIC CAPS 100mg QL (120 caps / 30 days)	1 QL NM LA PA	LENVIMA 20 MG DAILY DOSE CPPK 10mg QL (60 caps / 30 days)	1 QL NM LA PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg QL (60 tabs / 30 days)	1 QL NM LA PA	LENVIMA CAP 14 MG QL (60 caps / 30 days)	1 QL NM LA PA
JAYPIRCA TABS 50mg QL (30 tabs / 30 days)	1 QL NM LA PA	LENVIMA CAP 18 MG QL (90 caps / 30 days)	1 QL NM LA PA
JAYPIRCA TABS 100mg QL (60 tabs / 30 days)	1 QL NM LA PA	LENVIMA CAP 24 MG QL (90 caps / 30 days)	1 QL NM LA PA
KADCYLA SOLR 100mg, 160mg	1 B/D NM LA	LORBRENA TABS 25mg QL (90 tabs / 30 days)	1 QL NM LA PA
KANJINTI SOLR 150mg, 420mg	1 NM LA PA	LORBRENA TABS 100mg QL (30 tabs / 30 days)	1 QL NM LA PA
KEYTRUDA SOLN 100mg/4ml	1 NM LA PA	LUMAKRAS TABS 120mg QL (240 tabs / 30 days)	1 QL NM LA PA
KISQALI 200 DOSE TBPK 200mg QL (21 tabs / 28 days)	1 QL NM PA	LUMAKRAS TABS 320mg QL (90 tabs / 30 days)	1 QL NM LA PA
KISQALI 400 DOSE TBPK 200mg QL (42 tabs / 28 days)	1 QL NM PA	LYNPARZA TABS 100mg, 150mg QL (120 tabs / 30 days)	1 QL NM LA PA
KISQALI 600 DOSE TBPK 200mg QL (63 tabs / 28 days)	1 QL NM PA	LYTGOBI (12 MG DAILY DOSE) TBPK 4mg QL (84 tabs / 28 days)	1 QL NM LA PA
KOSELUGO CAPS 10mg QL (240 caps / 30 days)	1 QL NM LA PA	LYTGOBI (16 MG DAILY DOSE) TBPK 4mg QL (112 tabs / 28 days)	1 QL NM LA PA
KOSELUGO CAPS 25mg QL (120 caps / 30 days)	1 QL NM LA PA	LYTGOBI (20 MG DAILY DOSE) TBPK 4mg QL (140 tabs / 28 days)	1 QL NM LA PA
KRAZATI TABS 200mg QL (180 tabs / 30 days)	1 QL NM LA PA	MEKINIST SOLR .05mg/ml QL (1260 mL / 30 days)	1 QL NM LA PA
<i>lapatinib ditosylate</i> (generic of TYKERB) TABS 250mg QL (180 tabs / 30 days)	1 QL NM PA		

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

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

Drug Name	Drug Requirements/ Tier Limits
MEKINIST TABS 2mg QL (30 tabs / 30 days)	1 QL NM LA PA
MEKINIST TABS .5mg QL (90 tabs / 30 days)	1 QL NM LA PA
MEKTOVI TABS 15mg QL (180 tabs / 30 days)	1 QL NM LA PA
MONJUVI SOLR 200mg	1 NM LA PA
NERLYNX TABS 40mg QL (180 tabs / 30 days)	1 QL NM LA PA
NEXAVAR TABS 200mg QL (120 tabs / 30 days)	1 QL NM LA PA
NINLARO CAPS 2.3mg, 3mg, 4mg QL (3 caps / 28 days)	1 QL NM PA
ODOMZO CAPS 200mg QL (30 caps / 30 days)	1 QL NM LA PA
OGIVRI SOLR 150mg	1 NM LA PA
OGIVRI INJ 420MG	1 NM LA PA
OGSIVEO TABS 50mg QL (180 tabs / 30 days)	1 QL NM LA PA
OJJAARA TABS 100mg, 150mg, 200mg QL (30 tabs / 30 days)	1 QL NM LA PA
ONTRUZANT SOLR 150mg, 420mg	1 NM LA PA
pazopanib hcl (generic of VOTRIENT) TABS 200mg QL (120 tabs / 30 days)	1 QL NM PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg QL (28 tabs / 28 days)	1 QL NM LA PA
PHESGO SOL	1 NM LA PA
PIQRAY 200MG DAILY DOSE TBPK 200mg QL (28 tabs / 28 days)	1 QL NM PA
PIQRAY 250MG TAB DOSE QL (56 tabs / 28 days)	1 QL NM PA
PIQRAY 300MG DAILY DOSE TBPK 150mg QL (56 tabs / 28 days)	1 QL NM PA
QINLOCK TABS 50mg QL (90 tabs / 30 days)	1 QL NM LA PA
RETEVMO CAPS 40mg QL (180 caps / 30 days)	1 QL NM LA PA

Drug Name	Drug Requirements/ Tier Limits
RETEVMO CAPS 80mg QL (120 caps / 30 days)	1 QL NM LA PA
REZLIDHIA CAPS 150mg QL (60 caps / 30 days)	1 QL NM LA PA
ROZLYTREK CAPS 100mg QL (150 caps / 30 days)	1 QL NM LA PA
ROZLYTREK CAPS 200mg QL (90 caps / 30 days)	1 QL NM LA PA
ROZLYTREK PACK 50mg QL (336 packets / 28 days)	1 QL NM LA PA
RUBRACA TABS 200mg, 250mg, 300mg QL (120 tabs / 30 days)	1 QL NM LA PA
RYDAPT CAPS 25mg QL (224 caps / 28 days)	1 QL NM PA
SCEMBLIX TABS 20mg QL (60 tabs / 30 days)	1 QL NM PA
SCEMBLIX TABS 40mg QL (300 tabs / 30 days)	1 QL NM PA
sorafenib tosylate (generic of NEXAVAR) TABS 200mg QL (120 tabs / 30 days)	1 QL NM PA
SPRYCEL TABS 20mg QL (90 tabs / 30 days)	1 QL NM PA
SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg QL (30 tabs / 30 days)	1 QL NM PA
STIVARGA TABS 40mg QL (84 tabs / 28 days)	1 QL NM LA PA
sunitinib malate (generic of SUTENT) CAPS 12.5mg, 25mg, 37.5mg, 50mg QL (30 caps / 30 days)	1 QL NM PA
TABRECTA TABS 150mg, 200mg QL (112 tabs / 28 days)	1 QL NM PA
TAFINLAR CAPS 50mg, 75mg QL (120 caps / 30 days)	1 QL NM LA PA
TAFINLAR TBSO 10mg QL (900 tabs / 30 days)	1 QL NM LA PA

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

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

Drug Name	Drug Requirements/ Tier Limits
TAGRISSO TABS 40mg, 80mg QL (30 tabs / 30 days)	1 QL NM LA PA
TALZENNA CAPS .1mg, .35mg, .5mg, .75mg, 1mg QL (30 caps / 30 days)	1 QL NM LA PA
TALZENNA CAPS .25mg QL (90 caps / 30 days)	1 QL NM LA PA
TASIGNA CAPS 50mg QL (120 caps / 30 days)	1 QL NM PA
TASIGNA CAPS 150mg, 200mg QL (112 caps / 28 days)	1 QL NM PA
TAZVERIK TABS 200mg QL (240 tabs / 30 days)	1 QL NM LA PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	1 NM LA PA
TEPMETKO TABS 225mg QL (60 tabs / 30 days)	1 QL NM LA PA
TIBSOVO TABS 250mg QL (60 tabs / 30 days)	1 QL NM LA PA
TRAZIMERA SOLR 150mg, 420mg	1 NM PA
TRUQAP TABS 160mg, 200mg QL (64 tabs / 28 days)	1 QL NM LA PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	1 NM PA
TUKYSA TABS 50mg, 150mg QL (120 tabs / 30 days)	1 QL NM LA PA
TURALIO CAPS 125mg QL (120 caps / 30 days)	1 QL NM LA PA
VANFLYTA TABS 17.7mg, 26.5mg QL (56 tabs / 28 days)	1 QL NM LA PA
VENCLEXTA TABS 10mg, 50mg QL (112 tabs / 28 days)	1 QL NM LA PA
VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	1 QL NM LA PA
VENCLEXTA TAB START PK	1 QL NM LA PA QL (42 tabs / 28 days)

Drug Name	Drug Requirements/ Tier Limits
VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	1 QL NM LA PA
VITRAKVI CAPS 25mg QL (180 caps / 30 days)	1 QL NM LA PA
VITRAKVI CAPS 100mg QL (60 caps / 30 days)	1 QL NM LA PA
VITRAKVI SOLN 20mg/ml QL (300 mL / 30 days)	1 QL NM LA PA
VIZIMPRO TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1 QL NM LA PA
VONJO CAPS 100mg QL (120 caps / 30 days)	1 QL NM LA PA
VOTRIENT TABS 200mg QL (120 tabs / 30 days)	1 QL NM LA PA
XALKORI CAPS 200mg, 250mg; CPSP 50mg QL (120 caps / 30 days)	1 QL NM LA PA
XALKORI CPSP 20mg QL (240 caps / 30 days)	1 QL NM LA PA
XALKORI CPSP 150mg QL (180 caps / 30 days)	1 QL NM LA PA
XOSPATA TABS 40mg QL (90 tabs / 30 days)	1 QL NM LA PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg QL (4 tabs / 28 days)	1 QL NM LA PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	1 QL NM LA PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg QL (4 tabs / 28 days)	1 QL NM LA PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg QL (24 tabs / 28 days)	1 QL NM LA PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg QL (8 tabs / 28 days)	1 QL NM LA PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg QL (32 tabs / 28 days)	1 QL NM LA PA

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg	1	QL NM LA PA QL (8 tabs / 28 days)
ZEJULA CAPS 100mg	1	QL NM LA PA QL (90 caps / 30 days)
ZEJULA TABS 100mg, 200mg, 300mg	1	QL NM LA PA QL (30 tabs / 30 days)
ZELBORAF TABS 240mg	1	QL NM LA PA QL (240 tabs / 30 days)
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	1	NM LA PA
ZOLINZA CAPS 100mg	1	QL NM PA QL (120 caps / 30 days)
ZYDELIG TABS 100mg, 150mg	1	QL NM LA PA QL (60 tabs / 30 days)
ZYKADIA TABS 150mg	1	QL NM LA PA QL (84 tabs / 28 days)

PROTECTIVE AGENTS

leucovorin calcium SOLN	1	B/D
500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg		
leucovorin calcium TABS	1	
5mg, 10mg, 15mg, 25mg		
MESNEX TABS 400mg	1	

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	1	QL QL (30 caps / 30 days)
amlodipine besylate- benazepril hcl cap 5-10 mg (generic of LOTREL)	1	QL QL (30 caps / 30 days)
amlodipine besylate- benazepril hcl cap 5-20 mg (generic of LOTREL)	1	QL QL (30 caps / 30 days)

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
amlodipine besylate- benazepril hcl cap 5-40 mg	1	QL QL (30 caps / 30 days)
amlodipine besylate- benazepril hcl cap 10-20 mg (generic of LOTREL)	1	QL QL (30 caps / 30 days)
amlodipine besylate- benazepril hcl cap 10-40 mg (generic of LOTREL)	1	QL QL (30 caps / 30 days)
benazepril & hydrochlorothiazide tab 5-6.25mg	1	
benazepril & hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT)	1	
benazepril & hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT)	1	
captopril & hydrochlorothiazide tab 25-15 mg	1	
captopril & hydrochlorothiazide tab 25-25 mg	1	
captopril & hydrochlorothiazide tab 50-15 mg	1	
captopril & hydrochlorothiazide tab 50-25 mg	1	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)	1	

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

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

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

Drug Name	Drug Requirements/ Tier	Limits
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>eplerenone (generic of INSPRA) TABS 25mg, 50mg</i>	1	
<i>KERENDIA TABS 10mg, 20mg</i>	1	QL (30 tabs / 30 days)
<i>spironolactone (generic of ALDACTONE) TABS 25mg, 50mg, 100mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg (generic of AZOR)</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg (generic of AZOR)</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg (generic of AZOR)</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg (generic of AZOR)</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-160 mg (generic of EXFORGE)</i>	1	QL (30 tabs / 30 days)

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

27

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
amlodipine besylate-valsartan tab 5-320 mg (generic of EXFORGE)	1	QL QL (30 tabs / 30 days)	losartan potassium & hydrochlorothiazide tab 100-12.5 mg (generic of HYZAAR)	1	
amlodipine besylate-valsartan tab 10-160 mg (generic of EXFORGE)	1	QL QL (30 tabs / 30 days)	losartan potassium & hydrochlorothiazide tab 100-25 mg (generic of HYZAAR)	1	
amlodipine besylate-valsartan tab 10-320 mg (generic of EXFORGE)	1	QL QL (30 tabs / 30 days)	olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg (generic of BENICAR HCT)	1	QL QL (30 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg (generic of ATACAND HCT)	1	QL QL (60 tabs / 30 days)	olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg (generic of BENICAR HCT)	1	QL QL (30 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg (generic of ATACAND HCT)	1	QL QL (30 tabs / 30 days)	olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg (generic of BENICAR HCT)	1	QL QL (30 tabs / 30 days)
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg (generic of ATACAND HCT)	1	QL QL (30 tabs / 30 days)	olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg (generic of TRIBENZOR)	1	QL QL (30 tabs / 30 days)
ENTRESTO TAB 24-26MG	1	QL QL (60 tabs / 30 days)	olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg (generic of TRIBENZOR)	1	QL QL (30 tabs / 30 days)
ENTRESTO TAB 49-51MG	1	QL QL (60 tabs / 30 days)	olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg (generic of TRIBENZOR)	1	QL QL (30 tabs / 30 days)
ENTRESTO TAB 97-103MG	1	QL QL (60 tabs / 30 days)	olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg (generic of TRIBENZOR)	1	QL QL (30 tabs / 30 days)
irbesartan-hydrochlorothiazide tab 150-12.5 mg (generic of AVALIDE)	1	QL QL (60 tabs / 30 days)			
irbesartan-hydrochlorothiazide tab 300-12.5 mg (generic of AVALIDE)	1	QL QL (30 tabs / 30 days)			
losartan potassium & hydrochlorothiazide tab 50-12.5 mg (generic of HYZAAR)	1				

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

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	1	QL
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
candesartan cilexetil (generic of ATACAND) TABS 4mg, 8mg, 16mg QL (60 tabs / 30 days)		
candesartan cilexetil (generic of ATACAND) TABS 32mg QL (30 tabs / 30 days)		
irbesartan (generic of AVAPRO) TABS 75mg, 150mg, 300mg QL (30 tabs / 30 days)		
losartan potassium (generic of COZAAR) TABS 25mg, 50mg, 100mg		
olmesartan medoxomil (generic of BENICAR) TABS 5mg QL (60 tabs / 30 days)		
olmesartan medoxomil (generic of BENICAR) TABS 20mg, 40mg QL (30 tabs / 30 days)		
telmisartan (generic of MICARDIS) TABS 20mg, 40mg, 80mg QL (30 tabs / 30 days)		
valsartan (generic of DIOVAN) TABS 40mg, 80mg, 160mg QL (60 tabs / 30 days)		
valsartan (generic of DIOVAN) TABS 320mg QL (30 tabs / 30 days)		

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

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

Drug Name	Drug Requirements/ Tier	Limits	Drug Name	Drug Requirements/ Tier	Limits																																																																																													
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM																																																																																																		
amiodarone hcl SOLN	1		atorvastatin calcium (generic of LIPITOR)	1	QL																																																																																													
50mg/ml, 900mg/18ml; TABS			TABS 10mg, 20mg, 40mg																																																																																															
100mg, 200mg, 400mg			QL (30 tabs / 30 days)																																																																																															
disopyramide phosphate (generic of NORPACE)	1		lovastatin TABS 10mg, 20mg, 40mg	1	QL																																																																																													
CAPS 100mg, 150mg			QL (60 tabs / 30 days)																																																																																															
dofetilide (generic of TIKOSYN)	1	NM	pravastatin sodium TABS 10mg, 20mg, 40mg	1	QL																																																																																													
CAPS 125mcg, 250mcg, 500mcg			QL (30 tabs / 30 days)																																																																																															
flecainide acetate TABS	1		rosuvastatin calcium (generic of CRESTOR)	1	QL																																																																																													
50mg, 100mg, 150mg			TABS 5mg, 10mg, 20mg, 40mg																																																																																															
MULTAQ TABS 400mg	1		QL (30 tabs / 30 days)																																																																																															
NORPACE CR CP12 100mg, 150mg	1		simvastatin TABS 5mg, 80mg	1	QL																																																																																													
pacerone TABS 100mg, 200mg, 400mg	1		QL (30 tabs / 30 days)																																																																																															
propafenone hcl CP12	1		simvastatin (generic of ZOCOR)	1	QL																																																																																													
225mg, 325mg, 425mg; TABS			TABS 10mg, 20mg, 40mg																																																																																															
150mg, 225mg, 300mg			QL (30 tabs / 30 days)																																																																																															
quinidine sulfate TABS	1		ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL																																																																																															
200mg, 300mg			sorine (generic of BETAPACE)	1		cholestyramine (generic of QUESTRAN)	1		TABS 80mg, 120mg, 160mg			PACK 4gm; POWD 4gm/dose			sorine TABS 240mg	1		cholestyramine light PACK 4gm	1		sotalol hcl (generic of BETAPACE)	1		cholestyramine light (generic of QUESTRAN LIGHT)	1		TABS 80mg, 120mg, 160mg			POWD 4gm/dose			sotalol hcl TABS 240mg	1		colesevelam hcl (generic of WELCHOL)	1		sotalol hcl (afib/afl) (generic of BETAPACE AF)	1		PACK 3.75gm; TABS 625mg			TABS 80mg, 120mg, 160mg			colestipol hcl (generic of COLESTID)	1		ANTILIPEMICS, FIBRATES			GRAN 5gm; PACK 5gm; TABS 1gm			fenofibrate (generic of TRICOR)	1		ezetimibe (generic of ZETIA)	1		TABS 48mg, 145mg			TABS 10mg			fenofibrate TABS 54mg, 160mg	1		ezetimibe-simvastatin tab 10-10 mg (generic of VYTORIN)	1	QL	fenofibrate micronized CAPS	1		QL (30 tabs / 30 days)			67mg, 134mg, 200mg						gemfibrozil (generic of LOPID)	1					TABS 600mg					
sorine (generic of BETAPACE)	1		cholestyramine (generic of QUESTRAN)	1																																																																																														
TABS 80mg, 120mg, 160mg			PACK 4gm; POWD 4gm/dose																																																																																															
sorine TABS 240mg	1		cholestyramine light PACK 4gm	1																																																																																														
sotalol hcl (generic of BETAPACE)	1		cholestyramine light (generic of QUESTRAN LIGHT)	1																																																																																														
TABS 80mg, 120mg, 160mg			POWD 4gm/dose																																																																																															
sotalol hcl TABS 240mg	1		colesevelam hcl (generic of WELCHOL)	1																																																																																														
sotalol hcl (afib/afl) (generic of BETAPACE AF)	1		PACK 3.75gm; TABS 625mg																																																																																															
TABS 80mg, 120mg, 160mg			colestipol hcl (generic of COLESTID)	1																																																																																														
ANTILIPEMICS, FIBRATES			GRAN 5gm; PACK 5gm; TABS 1gm																																																																																															
fenofibrate (generic of TRICOR)	1		ezetimibe (generic of ZETIA)	1																																																																																														
TABS 48mg, 145mg			TABS 10mg																																																																																															
fenofibrate TABS 54mg, 160mg	1		ezetimibe-simvastatin tab 10-10 mg (generic of VYTORIN)	1	QL																																																																																													
fenofibrate micronized CAPS	1		QL (30 tabs / 30 days)																																																																																															
67mg, 134mg, 200mg																																																																																																		
gemfibrozil (generic of LOPID)	1																																																																																																	
TABS 600mg																																																																																																		

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

30

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ezetimibe-simvastatin tab 10-20 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
ezetimibe-simvastatin tab 10-40 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
ezetimibe-simvastatin tab 10-80 mg (generic of VYTORIN) QL (30 tabs / 30 days)	1	QL
niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg QL (60 tabs / 30 days)	1	QL
omega-3-acid ethyl esters cap 1 gm (generic of LOVAZA)	1	PA
prevalite PACK 4gm	1	
prevalite (generic of QUESTRAN LIGHT) POWD 4gm/dose	1	
REPATHA SOSY 140mg/ml	1	NM PA
REPATHA PUSHTRONEX SYSTEM SOCT 420mg/3.5ml	1	NM PA
REPATHA SURECLICK SOAJ 140mg/ml	1	NM PA
VASCEPA CAPS .5gm, 1gm	1	

BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

atenolol & chlorthalidone tab 50-25 mg (generic of TENORETIC 50)	1	
atenolol & chlorthalidone tab 100-25 mg (generic of TENORETIC 100)	1	
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	

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

31

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

Drug Name	Drug Requirements/ Tier	Limits
<i>nebivolol hcl</i> (generic of BYSTOLIC) TABS 20mg QL (60 tabs / 30 days)	1	QL
<i>pindolol</i> TABS 5mg, 10mg	1	
<i>propranolol hcl</i> (generic of INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg	1	
<i>propranolol hcl</i> SOLN 20mg/5ml, 40mg/5ml; TABS 10mg, 20mg, 40mg, 60mg, 80mg	1	
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	1	
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>amlodipine besylate</i> (generic of NORVASC) TABS 2.5mg, 5mg, 10mg	1	
<i>cartia xt</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	1	
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	1	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg; SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml; TABS 90mg	1	
<i>diltiazem hcl</i> (generic of CARDIZEM) TABS 30mg, 60mg, 120mg	1	
<i>diltiazem hcl coated beads</i> (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>diltiazem hcl extended release beads</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	1	
<i>isradipine</i> CAPS 2.5mg, 5mg	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>nicardipine hcl</i> CAPS 20mg, 30mg	1	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	1	
<i>nifedipine</i> (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	1	
<i>nimodipine</i> CAPS 30mg	1	
<i>NYMALIZE</i> SOLN 6mg/ml	1	
<i>taztia xt</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>tiadylt er</i> (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>verapamil hcl</i> CP24 100mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml; TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	1	
<i>verapamil hcl</i> (generic of VERELAN) CP24 120mg, 180mg, 240mg	1	
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
<i>acetazolamide</i> CP12 500mg; TABS 125mg, 250mg	1	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	
<i>amiloride hcl</i> TABS 5mg	1	
<i>bumetanide</i> SOLN .25mg/ml; TABS 1mg, 2mg	1	
<i>bumetanide</i> (generic of BUMEX) TABS .5mg	1	
<i>chlorthalidone</i> TABS 25mg, 50mg	1	
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml	1	
<i>furosemide</i> (generic of LASIX) TABS 20mg, 40mg, 80mg	1	
<i>furosemide inj</i> SOLN 10mg/ml	1	

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

32

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

Drug Name	Drug Requirements/ Tier	Limits
hydrochlorothiazide CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	
indapamide TABS 1.25mg, 2.5mg	1	
methazolamide TABS 25mg, 50mg	1	
metolazone TABS 2.5mg, 5mg, 10mg	1	
spironolactone & hydrochlorothiazide tab 25-25 mg	1	
torsemide TABS 5mg, 10mg, 20mg, 100mg	1	
triamterene & hydrochlorothiazide cap 37.5- 25 mg	1	
triamterene & hydrochlorothiazide tab 37.5- 25 mg (generic of MAXZIDE- 25)	1	
triamterene & hydrochlorothiazide tab 75-50 mg (generic of MAXZIDE)	1	
MISCELLANEOUS		
aliskiren fumarate (generic of TEKTURNA) TABS 150mg, 300mg	1	
clonidine (generic of CATAPRES-TTS-1) PTWK .1mg/24hr	1	
clonidine (generic of CATAPRES-TTS-2) PTWK .2mg/24hr	1	
clonidine (generic of CATAPRES-TTS-3) PTWK .3mg/24hr	1	
clonidine hcl TABS .1mg, .2mg, .3mg	1	
CORLANOR SOLN 5mg/5ml QL (450 mL / 30 days)	1	QL
CORLANOR TABS 5mg, 7.5mg QL (60 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
digoxin SOLN .05mg/ml	1	
digoxin (generic of LANOXIN) SOLN .25mg/ml	1	
digoxin (generic of LANOXIN) TABS 125mcg, 250mcg QL (30 tabs / 30 days)	1	QL
droxidopa (generic of NORTHERA) CAPS 100mg QL (90 caps / 30 days)	1	QL NM PA
droxidopa (generic of NORTHERA) CAPS 200mg, 300mg QL (180 caps / 30 days)	1	QL NM PA
epinephrine (anaphylaxis) SOLN 1mg/ml	1	
guanfacine hcl TABS 1mg, 2mg PA if 70 years and older	1	PA
hydralazine hcl SOLN 20mg/ml; TABS 10mg, 25mg, 50mg, 100mg	1	
metyrosine (generic of DEMSER) CAPS 250mg	1	PA
midodrine hcl TABS 2.5mg, 5mg, 10mg	1	
minoxidil TABS 2.5mg, 10mg	1	
ranolazine TB12 500mg, 1000mg	1	
VERQUVO TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	1	QL
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg	1	
isosorbide dinitrate TABS 10mg, 20mg, 30mg	1	
isosorbide mononitrate TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	1	
NITRO-BID OINT 2%	1	
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	1	

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

33

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>nitroglycerin</i> (generic of NITROLINGUAL) SOLN .4mg/spray	1	
<i>nitroglycerin</i> (generic of NITROSTAT) SUBL .3mg, .4mg, .6mg	1	
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	1	QL NM LA PA QL (90 tabs / 30 days)
<i>ambrisentan</i> (generic of LETAIRIS) TABS 5mg, 10mg	1	QL NM LA PA QL (30 tabs / 30 days)
<i>bosentan</i> (generic of TRACLEER) TABS 62.5mg, 125mg	1	QL NM LA PA QL (60 tabs / 30 days)
OPSUMIT TABS 10mg	1	QL NM LA PA QL (30 tabs / 30 days)
<i>sildenafil citrate</i> (pulmonary hypertension) (generic of REVATIO) TABS 20mg	1	QL NM PA QL (360 tabs / 30 days)
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	1	NM LA PA NM LA PA NM LA PA NM LA PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	1	NM LA PA NM LA PA
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ANTIANXIETY - DRUGS TO TREAT ANXIETY		
<i>alprazolam</i> (generic of XANAX) TABS .25mg, .5mg, 1mg, 2mg	1	QL QL (150 tabs / 30 days)
<i>buspirone hcl</i> TABS 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	1	

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

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

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

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

Drug Name	Drug Requirements/ Tier	Limits
<i>bupropion hcl</i> (generic of WELLBUTRIN XL) TB24 300mg QL (30 tabs / 30 days)	1	QL
<i>citalopram hydrobromide</i> SOLN 10mg/5ml	1	
<i>citalopram hydrobromide</i> (generic of CELEXA) TABS 10mg, 20mg, 40mg	1	
<i>clomipramine hcl</i> (generic of ANAFRANIL) CAPS 25mg, 50mg, 75mg	1	PA
<i>desipramine hcl</i> (generic of NORPRAMIN) TABS 10mg, 25mg	1	
<i>desipramine hcl</i> TABS 50mg, 75mg, 100mg, 150mg	1	
<i>desvenlafaxine succinate</i> (generic of PRISTIQ) TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)	1	QL PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	1	
<i>duloxetine hcl</i> (generic of CYMBALTA) CPEP 20mg, 30mg, 60mg QL (60 caps / 30 days)	1	QL
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr QL (30 patches / 30 days)	1	QL PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml	1	
<i>escitalopram oxalate</i> (generic of LEXAPRO) TABS 5mg, 10mg, 20mg FETZIMA CP24 20mg, 40mg QL (60 caps / 30 days)	1	QL PA
FETZIMA CP24 80mg, 120mg QL (30 caps / 30 days)	1	QL PA
FETZIMA CAP TITRATIO QL (2 packs / year)	1	QL PA

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

35

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>fluoxetine hcl</i> (generic of PROZAC) CAPS 10mg, 20mg, 40mg	1	
<i>fluoxetine hcl</i> SOLN 20mg/5ml	1	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	1	
MARPLAN TABS 10mg QL (180 tabs / 30 days)	1	QL
<i>mirtazapine</i> TABS 7.5mg, 45mg	1	
<i>mirtazapine</i> (generic of REMERON) TABS 15mg, 30mg	1	
<i>mirtazapine</i> (generic of REMERON SOLTAB) TBDP 15mg, 30mg, 45mg	1	
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	1	
<i>nortriptyline hcl</i> (generic of PAMELOR) CAPS 10mg, 25mg, 50mg, 75mg	1	
<i>nortriptyline hcl</i> SOLN 10mg/5ml	1	
<i>paroxetine hcl</i> (generic of PAXIL) SUSP 10mg/5ml QL (900 mL / 30 days)	1	QL PA
<i>paroxetine hcl</i> (generic of PAXIL) TABS 10mg, 20mg, 30mg, 40mg	1	
<i>phenelzine sulfate</i> (generic of NARDIL) TABS 15mg	1	
<i>protriptyline hcl</i> TABS 5mg, 10mg	1	
<i>sertraline hcl</i> (generic of ZOLOFT) CONC 20mg/ml; TABS 25mg, 50mg, 100mg	1	
<i>tranylcypromine sulfate</i> (generic of PARNATE) TABS 10mg	1	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	

Drug Name	Drug Requirements/ Tier	Limits
<i>trimipramine maleate</i> CAPS 25mg, 50mg QL (120 caps / 30 days)	1	QL
<i>trimipramine maleate</i> CAPS 100mg QL (60 caps / 30 days)	1	QL
TRINTELLIX TABS 5mg, 10mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>venlafaxine hcl</i> (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg	1	
<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	1	
<i>vilazodone hcl</i> (generic of VIIBRYD) TABS 10mg, 20mg, 40mg QL (30 tabs / 30 days)	1	QL
ZURZUVAE CAPS 20mg, 25mg QL (28 caps / 14 days)	1	QL NM LA PA
ZURZUVAE CAPS 30mg QL (14 caps / 14 days)	1	QL NM LA PA
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
<i>amantadine hcl</i> CAPS 100mg QL (120 caps / 30 days)	1	QL
<i>amantadine hcl</i> SOLN 50mg/5ml; TABS 100mg	1	
<i>benztropine mesylate</i> SOLN 1mg/ml benztropine mesylate TABS .5mg, 1mg, 2mg PA if 70 years and older	1	PA
<i>bromocriptine mesylate</i> (generic of PARLODEL) CAPS 5mg; TABS 2.5mg	1	
<i>carb/levo orally disintegrating</i> tab 10-100mg	1	
<i>carb/levo orally disintegrating</i> tab 25-100mg	1	
<i>carb/levo orally disintegrating</i> tab 25-250mg	1	

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

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

Drug Name	Drug Requirements/ Tier	Limits
carbidopa & levodopa tab 10-100 mg (generic of SINEMET)	1	
carbidopa & levodopa tab 25-100 mg (generic of SINEMET)	1	
carbidopa & levodopa tab 25-250 mg	1	
carbidopa & levodopa tab er 25-100 mg	1	
carbidopa & levodopa tab er 50-200 mg	1	
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg (generic of STALEVO 50)	1	
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg (generic of STALEVO 75)	1	
carbidopa-levodopa-entacapone tabs 25-100-200 mg (generic of STALEVO 100)	1	
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg (generic of STALEVO 125)	1	
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg (generic of STALEVO 150)	1	
carbidopa-levodopa-entacapone tabs 50-200-200 mg (generic of STALEVO 200)	1	
entacapone (generic of COMTAN) TABS 200mg	1	
INBRIJA CAPS 42mg	1	QL NM LA PA QL (300 caps / 30 days)
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	1	
pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg	1	

Drug Name	Drug Requirements/ Tier	Limits
rasagiline mesylate (generic of AZILECT) TABS .5mg, 1mg QL (30 tabs / 30 days)	1	QL
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	1	
selegiline hcl CAPS 5mg; TABS 5mg	1	
trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg PA if 70 years and older	1	PA
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
ABILIFY MAINTENA PRSY 300mg, 400mg QL (1 syringe / 28 days)	1	QL
ABILIFY MAINTENA SRER 300mg, 400mg QL (1 injection / 28 days)	1	QL
ariPIPrazole SOLN 1mg/ml QL (900 mL / 30 days)	1	QL
ariPIPrazole (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg QL (30 tabs / 30 days)	1	QL
ariPIPrazole TBDP 10mg, 15mg QL (60 tabs / 30 days)	1	QL
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	1	QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	1	QL
ARISTADA INITIO PRSY 675mg/2.4ml	1	
asenapine maleate (generic of SAPHRIS) SUBL 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	1	QL

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

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
CAPLYTA CAPS 10.5mg, 21mg, 42mg QL (30 caps / 30 days)	1	QL	<i>haloperidol decanoate</i> (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	1	
<i>chlorpromazine hcl</i> CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	1		<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	1	
<i>clozapine</i> (generic of CLOZARIL) TABS 25mg, 50mg	1		INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml QL (1 injection / 180 days)	1	QL
<i>clozapine</i> (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30 days)	1	QL	INVEGA SUSTENNA SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml QL (1 syringe / 28 days)	1	QL
<i>clozapine</i> (generic of CLOZARIL) TABS 200mg QL (120 tabs / 30 days)	1	QL	INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml QL (1 syringe / 90 days)	1	QL
<i>clozapine</i> TBDP 12.5mg, 25mg	1	PA	<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	1	
<i>clozapine</i> TBDP 100mg QL (270 tabs / 30 days)	1	QL PA	<i>lurasidone hcl</i> (generic of LATUDA) TABS 20mg, 40mg, 60mg, 120mg QL (30 tabs / 30 days)	1	QL
<i>clozapine</i> TBDP 150mg QL (180 tabs / 30 days)	1	QL PA	<i>lurasidone hcl</i> (generic of LATUDA) TABS 80mg QL (60 tabs / 30 days)	1	QL
<i>clozapine</i> TBDP 200mg QL (120 tabs / 30 days)	1	QL PA	<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	1	
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	1	QL PA	NUPLAZID CAPS 34mg QL (30 caps / 30 days)	1	QL NM LA PA
FANAPT PAK QL (2 packs / year)	1	QL PA	NUPLAZID TABS 10mg QL (30 tabs / 30 days)	1	QL NM LA PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	1		<i>olanzapine</i> (generic of ZYPREXA) SOLR 10mg QL (3 vials / 1 day)	1	QL
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	1		<i>olanzapine</i> (generic of ZYPREXA) TABS 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	1	QL
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	1		<i>olanzapine</i> (generic of ZYPREXA) TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>haloperidol decanoate</i> (generic of HALDOL DECANOATE 50) SOLN 50mg/ml	1				

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

38

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
olanzapine (generic of ZYPREXA ZYDIS) TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	1	QL
olanzapine (generic of ZYPREXA ZYDIS) TBDP 10mg QL (60 tabs / 30 days)	1	QL
paliperidone TB24 1.5mg QL (30 tabs / 30 days)	1	QL
paliperidone (generic of INVEGA) TB24 3mg, 9mg QL (30 tabs / 30 days)	1	QL
paliperidone (generic of INVEGA) TB24 6mg QL (60 tabs / 30 days)	1	QL
perphenazine TABS 2mg, 4mg, 8mg, 16mg	1	
PERSERIS PRSY 90mg, 120mg QL (1 syringe / 30 days)	1	QL
pimozide TABS 1mg, 2mg	1	
quetiapine fumarate (generic of SEROQUEL) TABS 25mg QL (180 tabs / 30 days)	1	QL
quetiapine fumarate (generic of SEROQUEL) TABS 50mg, 100mg, 200mg QL (90 tabs / 30 days)	1	QL
quetiapine fumarate TABS 150mg QL (90 tabs / 30 days)	1	QL
quetiapine fumarate (generic of SEROQUEL) TABS 300mg, 400mg QL (60 tabs / 30 days)	1	QL
quetiapine fumarate (generic of SEROQUEL XR) TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days)	1	QL PA
quetiapine fumarate (generic of SEROQUEL XR) TB24 150mg, 200mg QL (30 tabs / 30 days)	1	QL PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
REXULTI TABS 3mg, 4mg QL (30 tabs / 30 days)	1	QL
REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days)	1	QL
RISPERDAL CONSTA SRER 12.5mg, 25mg, 37.5mg, 50mg QL (2 injections / 28 days)	1	QL
risperidone (generic of RISPERDAL) SOLN 1mg/ml QL (240 mL / 30 days)	1	QL
risperidone (generic of RISPERDAL) TABS .5mg, 1mg, 2mg, 3mg, 4mg	1	
risperidone TABS .25mg	1	
risperidone TBDP 1mg, 2mg, 3mg QL (60 tabs / 30 days)	1	QL
risperidone TBDP 4mg QL (120 tabs / 30 days)	1	QL
risperidone TBDP .25mg, .5mg QL (90 tabs / 30 days)	1	QL
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr QL (30 patches / 30 days)	1	QL
thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	1	
thiothixene CAPS 1mg, 2mg, 5mg, 10mg	1	
trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	1	
VERSACLOZ SUSP 50mg/ml QL (600 mL / 30 days)	1	QL PA
VRAYLAR CAPS 1.5mg QL (60 caps / 30 days)	1	QL
VRAYLAR CAPS 3mg, 4.5mg, 6mg QL (30 caps / 30 days)	1	QL
VRAYLAR CAP 1.5-3MG QL (2 packs / year)	1	QL

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

39

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
ziprasidone hcl (generic of GEODON) CAPS 20mg, 40mg, 60mg, 80mg QL (60 caps / 30 days)	1	QL
ziprasidone mesylate (generic of GEODON) SOLR 20mg QL (6 injections / 3 days)	1	QL
ZYPREXA RELPREVV SUSR 210mg, 300mg QL (2 vials / 28 days)	1	QL NM PA
ZYPREXA RELPREVV SUSR 405mg QL (1 vial / 28 days)	1	QL NM PA
ANTISEIZURE AGENTS		
APTIOM TABS 200mg, 400mg QL (30 tabs / 30 days)	1	QL
APTIOM TABS 600mg, 800mg QL (60 tabs / 30 days)	1	QL
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	1	QL PA
BRIVIACT SOLN 50mg/5ml QL (60 tabs / 30 days)	1	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days)	1	QL PA
carbamazepine CHEW 100mg carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml; TABS 200mg carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg clobazam (generic of ONFI) SUSP 2.5mg/ml QL (480 mL / 30 days)	1	
clobazam (generic of ONFI) TABS 10mg, 20mg QL (60 tabs / 30 days)	1	QL PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
clonazepam (generic of KLOONOPIN) TABS 2mg QL (300 tabs / 30 days)	1	QL
clonazepam (generic of KLOONOPIN) TABS .5mg, 1mg QL (90 tabs / 30 days)	1	QL
clonazepam TBDP 2mg QL (300 tabs / 30 days)	1	QL
clonazepam TBDP .125mg, .25mg, .5mg, 1mg QL (90 tabs / 30 days)	1	QL
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg QL (180 tabs / 30 days) PA if 65 years and older	1	QL PA
DIACOMIT CAPS 250mg QL (360 caps / 30 days)	1	QL NM LA PA
DIACOMIT CAPS 500mg QL (180 caps / 30 days)	1	QL NM LA PA
DIACOMIT PACK 250mg QL (360 packets / 30 days)	1	QL NM LA PA
DIACOMIT PACK 500mg QL (180 packets / 30 days)	1	QL NM LA PA
diazepam SOLN 5mg/5ml QL (1200 mL / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA
diazepam (generic of VALIUM) TABS 2mg, 5mg, 10mg QL (120 tabs / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA
diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	1	
diazepam inj SOLN 5mg/ml	1	

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

40

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>diazepam intensol</i> CONC 5mg/ml QL (240 mL / 30 days) PA applies if 65 years and older after a 5 day supply in a calendar year	1	QL PA	<i>gabapentin</i> (generic of NEURONTIN) CAPS 100mg, 300mg, 400mg QL (180 caps / 30 days)	1	QL
DILANTIN CAPS 30mg, 100mg	1		<i>gabapentin</i> (generic of NEURONTIN) SOLN 250mg/5ml, 300mg/6ml QL (2160 mL / 30 days)	1	QL
DILANTIN INFATABS CHEW 50mg	1		<i>gabapentin</i> (generic of NEURONTIN) TABS 600mg QL (180 tabs / 30 days)	1	QL
DILANTIN-125 SUSP 125mg/5ml	1		<i>gabapentin</i> (generic of NEURONTIN) TABS 800mg QL (120 tabs / 30 days)	1	QL
<i>divalproex sodium</i> (generic of DEPAKOTE SPRINKLES) CSDR 125mg	1		<i>lacosamide</i> (generic of VIMPAT) SOLN 200mg/20ml	1	
<i>divalproex sodium</i> (generic of DEPAKOTE ER) TB24 250mg, 500mg	1		<i>lacosamide</i> (generic of VIMPAT) TABS 50mg QL (120 tabs / 30 days)	1	QL
<i>divalproex sodium</i> (generic of DEPAKOTE) TBEC 125mg, 250mg, 500mg	1		<i>lacosamide</i> (generic of VIMPAT) TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	1	QL
EPIDIOLEX SOLN 100mg/ml QL (600 mL / 30 days)	1	QL NM LA PA	<i>lacosamide oral</i> (generic of VIMPAT) SOLN 10mg/ml QL (1200 mL / 30 days)	1	QL
<i>epitol</i> (generic of TEGRETOL) 1 TABS 200mg			<i>lamotrigine</i> (generic of LAMICTAL CHEWABLE DISPERS) CHEW 5mg, 25mg	1	
EPRONTIA SOLN 25mg/ml QL (480 mL / 30 days)	1	QL PA	<i>lamotrigine</i> (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	1	
<i>ethosuximide</i> (generic of ZARONTIN) CAPS 250mg; SOLN 250mg/5ml	1		<i>lamotrigine</i> (generic of LAMICTAL XR) TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	1	
<i>felbamate</i> SUSP 600mg/5ml	1		<i>levetiracetam</i> (generic of KEPPRA) SOLN 100mg/ml, 500mg/5ml; TABS 250mg, 500mg, 750mg, 1000mg	1	
<i>felbamate</i> (generic of FELBATOL) TABS 400mg, 600mg	1		<i>levetiracetam</i> (generic of KEPPRA XR) TB24 500mg, 750mg	1	
FINTEPLA SOLN 2.2mg/ml QL (360 mL / 30 days)	1	QL NM LA PA			
FYCOMPA SUSP .5mg/ml QL (720 mL / 30 days)	1	QL PA			
FYCOMPA TABS 2mg QL (60 tabs / 30 days)	1	QL PA			
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg QL (30 tabs / 30 days)	1	QL PA			

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

41

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

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

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

42

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

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

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

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

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

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

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

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

Drug Name	Drug Requirements/ Tier	Limits
MIGRAINE - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SOAJ 70mg/ml, 140mg/ml QL (1 pen / 30 days)	1	QL NM PA
dihydroergotamine mesylate SOLN 1mg/ml dihydroergotamine mesylate (generic of MIGRANAL) SOLN 4mg/ml QL (8 mL / 30 days)	1	QL PA
ergotamine w/ caffeine tab 1- 100 mg QL (40 tabs / 28 days)	1	QL PA
naratriptan hcl TABS 1mg, 2.5mg QL (12 tabs / 30 days)	1	QL
NURTEC TBDP 75mg QL (16 tabs / 30 days)	1	QL PA
QUILPTA TABS 10mg, 30mg, 60mg QL (30 tabs / 30 days)	1	QL PA
rizatriptan benzoate TABS 5mg; TBDP 5mg QL (18 tabs / 30 days)	1	QL
rizatriptan benzoate (generic of MAXALT) TABS 10mg QL (18 tabs / 30 days)	1	QL
rizatriptan benzoate (generic of MAXALT-MLT) TBDP 10mg QL (18 tabs / 30 days)	1	QL
sumatriptan SOLN 5mg/act QL (24 units / 30 days)	1	QL
sumatriptan SOLN 20mg/act QL (12 units / 30 days)	1	QL
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml QL (18 injections / 30 days)	1	QL

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

45

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>pyridostigmine bromide</i> (generic of MESTINON) TABS 60mg	1	
<i>riluzole</i> (generic of RILUTEK) TABS 50mg	1	
<i>tetrabenazine</i> (generic of XENAZINE) TABS 12.5mg QL (90 tabs / 30 days)	1	QL NM PA
<i>tetrabenazine</i> (generic of XENAZINE) TABS 25mg QL (120 tabs / 30 days)	1	QL NM PA
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BAFIERTAM CPDR 95mg QL (120 caps / 30 days)	1	QL NM LA PA
BETASERON KIT .3mg QL (14 syringes / 28 days)	1	QL NM PA
<i>dalfampridine</i> (generic of AMPYRA) TB12 10mg QL (60 tabs / 30 days)	1	QL NM PA
<i>fingolimod hcl</i> (generic of GILENYA) CAPS .5mg QL (30 caps / 30 days)	1	QL NM PA
<i>glatiramer acetate</i> (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	1	QL NM PA
<i>glatiramer acetate</i> (generic of COPAXONE) SOSY 40mg/ml QL (12 syringes / 28 days)	1	QL NM PA
<i>glatopa</i> (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	1	QL NM PA
<i>glatopa</i> (generic of COPAXONE) SOSY 40mg/ml QL (12 syringes / 28 days)	1	QL NM PA
KESIMPTA SOAJ 20mg/0.4ml QL (16 pens / year)	1	QL NM LA PA

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

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

Drug Name	Drug Requirements/ Tier	Limits
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
<i>baclofen TABS 5mg QL (90 tabs / 30 days)</i>		
<i>baclofen TABS 10mg, 20mg</i>	1	
<i>carisoprodol (generic of SOMA) TABS 350mg QL (120 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year</i>	1	QL PA
<i>cyclobenzaprine hcl TABS 5mg, 10mg QL (90 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year</i>	1	QL PA
<i>dantrolene sodium (generic of DANTRIUM) CAPS 25mg</i>	1	
<i>dantrolene sodium CAPS 50mg, 100mg</i>	1	
<i>methocarbamol TABS 500mg QL (360 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year</i>	1	QL PA
<i>methocarbamol TABS 750mg QL (240 tabs / 30 days) PA applies if 70 years and older after a 30 day supply in a calendar year</i>	1	QL PA
<i>tizanidine hcl TABS 2mg</i>	1	
<i>tizanidine hcl (generic of ZANAFLEX) TABS 4mg</i>	1	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
<i>armodafinil (generic of NUVIGIL) TABS 50mg QL (60 tabs / 30 days)</i>	1	QL PA
<i>armodafinil (generic of NUVIGIL) TABS 150mg, 200mg, 250mg QL (30 tabs / 30 days)</i>	1	QL PA

Drug Name	Drug Requirements/ Tier	Limits
<i>modafinil (generic of PROVIGIL) TABS 100mg QL (30 tabs / 30 days)</i>	1	QL PA
<i>modafinil (generic of PROVIGIL) TABS 200mg QL (60 tabs / 30 days)</i>	1	QL PA
<i>SODIUM OXYBATE SOLN 500mg/ml QL (540 mL / 30 days)</i>	1	QL NM LA PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium TBEC 333mg</i>	1	
<i>buprenorphine hcl SUBL 2mg, 8mg QL (90 tabs / 30 days)</i>	1	QL PA
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)</i>	1	QL
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)</i>	1	QL
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)</i>	1	QL
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE) QL (60 films / 30 days)</i>	1	QL
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv) QL (90 tabs / 30 days)</i>	1	QL
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv) QL (90 tabs / 30 days)</i>	1	QL
<i>bupropion hcl (smoking deterrent) TB12 150mg QL (60 tabs / 30 days)</i>	1	QL

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

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

Drug Name	Drug Requirements/ Tier	Limits
disulfiram TABS 250mg, 500mg	1	
naloxone hcl LIQD 4mg/0.1ml; SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	1	
naltrexone hcl TABS 50mg	1	
NICOTROL INHALER INHA 10mg	1	
NICOTROL NS SOLN 10mg/ml	1	
varenicline tartrate TABS .5mg, 1mg QL (56 tabs / 28 days)	1	QL PA
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack QL (2 packs / year)	1	QL PA
VIVITROL SUSR 380mg	1	NM
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
depo-testosterone SOLN 100mg/ml, 200mg/ml	1	PA
methyltestosterone CAPS 10mg QL (600 caps / 30 days)	1	QL PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	1	QL PA
testosterone (generic of ANDROGEL PUMP) GEL 1.62% QL (150 gm / 30 days)	1	QL PA
testosterone cypionate SOLN 100mg/ml, 200mg/ml	1	PA
testosterone enanthate SOLN 200mg/ml	1	PA
ANTIDIABETICS		
acarbose TABS 25mg, 50mg, 1 100mg		

Drug Name	Drug Requirements/ Tier	Limits
BYDUREON BCISE AUIJ 2mg/0.85ml QL (4 pens / 28 days)	1	QL PA
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml QL (1 pen / 30 days)	1	QL PA
FARXIGA TABS 5mg, 10mg QL (30 tabs / 30 days)	1	QL
glimepiride TABS 1mg, 2mg QL (90 tabs / 30 days)	1	QL
glimepiride TABS 4mg QL (60 tabs / 30 days)	1	QL
glipizide TABS 5mg QL (240 tabs / 30 days)	1	QL
glipizide TABS 10mg QL (120 tabs / 30 days)	1	QL
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	QL
glipizide (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 2.5-250 mg QL (240 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 2.5-500 mg QL (120 tabs / 30 days)	1	QL
glipizide-metformin hcl tab 5- 500 mg QL (120 tabs / 30 days)	1	QL
GLYXAMBI TAB 10-5 MG QL (30 tabs / 30 days)	1	QL

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
GLYXAMBI TAB 25-5 MG QL (30 tabs / 30 days)	1	QL
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	1	QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 50- 500MG QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)	1	QL
JANUMET XR TAB 100-1000 QL (30 tabs / 30 days)	1	QL
JANUVIA TABS 25mg, 50mg, 1 100mg QL (30 tabs / 30 days)	1	QL
JARDIANCE TABS 10mg, 25mg QL (30 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB 2.5-1000 QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB XR 2.5- 1000MG QL (60 tabs / 30 days)	1	QL
JENTADUETO TAB XR 5- 1000MG QL (30 tabs / 30 days)	1	QL
metformin hcl TABS 500mg QL (150 tabs / 30 days)	1	QL
metformin hcl TABS 850mg QL (90 tabs / 30 days)	1	QL
metformin hcl TABS 1000mg QL (75 tabs / 30 days)	1	QL
metformin hcl TB24 500mg QL (120 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
metformin hcl TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	1	QL
MOUNJARO SOPN 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml QL (4 pens / 28 days)	1	QL PA
nateglinide TABS 60mg, 120mg QL (90 tabs / 30 days)	1	QL
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml QL (1 pen / 28 days)	1	QL PA
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml QL (1 pen / 28 days)	1	QL PA
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	1	QL PA
OZEMPIC (2MG/DOSE) SOPN 8mg/3ml QL (1 pen / 28 days)	1	QL PA
pioglitazone hcl (generic of ACTOS) TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	1	QL
pioglitazone hcl-metformin hcl tab 15-500 mg QL (90 tabs / 30 days)	1	QL
pioglitazone hcl-metformin hcl tab 15-850 mg (generic of ACTOPLUS MET) QL (90 tabs / 30 days)	1	QL
repaglinide TABS 2mg QL (240 tabs / 30 days)	1	QL
repaglinide TABS .5mg, 1mg QL (120 tabs / 30 days)	1	QL
RYBELSUS TABS 3mg, 7mg, 1 14mg QL (30 tabs / 30 days)	1	QL PA
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	1	QL

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

49

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY TAB 12.5-500 QL (60 tabs / 30 days)	1	QL
SYNJARDY TAB 12.5- 1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 5- 1000MG QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 10-1000 QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 12.5- 1000 QL (60 tabs / 30 days)	1	QL
SYNJARDY XR TAB 25-1000 QL (30 tabs / 30 days)	1	QL
TRADJENTA TABS 5mg QL (30 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG QL (60 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 10-5-1000MG QL (30 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG QL (60 tabs / 30 days)	1	QL
TRIJARDY XR TAB ER 24HR 25-5-1000MG QL (30 tabs / 30 days)	1	QL
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml QL (4 pens / 28 days)	1	QL PA
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 5-1000MG QL (60 tabs / 30 days)	1	QL
XIGDUO XR TAB 10-500MG QL (30 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
XIGDUO XR TAB 10-1000 QL (30 tabs / 30 days)	1	QL
ANTIDIABETICS, INSULINS		
ADMELOG SOLN 100unit/ml	1	V/I
ADMELOG SOLOSTAR SOPN 100unit/ml	1	V/I
BASAGLAR KWIKPEN SOPN 100unit/ml	1	V/I
BD ALCOHOL SWABS	1	
FIASP SOLN 100unit/ml	1	V/I
FIASP FLEXTOUCH SOPN 100unit/ml	1	V/I
FIASP PENFILL SOCT 100unit/ml	1	V/I
FIASP PUMPCART SOCT 100unit/ml	1	B/D
GAUZE PADS 2" X 2"	1	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	1	V/I B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	1	V/I
INSULIN PEN NEEDLES: BD/NOVO	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGES: BD	1	
LANTUS SOLN 100unit/ml	1	V/I
LANTUS SOLOSTAR SOPN 100unit/ml	1	V/I
NOVOLIN INJ 70/30 (brand RELION not covered)	1	V/I
NOVOLIN INJ 70/30 FP (brand RELION not covered)	1	V/I
NOVOLIN N SUSP 100unit/ml (brand RELION not covered)	1	V/I
NOVOLIN N FLEXPEN SUPN 100unit/ml (brand RELION not covered)	1	V/I

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

50

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

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

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

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

51

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	1	LA PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	1	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml	1	B/D
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	1	QL NM
risedronate sodium TABS 5mg	1	
risedronate sodium (generic of 1 ACTONEL) TABS 35mg, 150mg		
risedronate sodium (generic of 1 ATELVIA) TBEC 35mg		
TERIPARATIDE SOPN 620mcg/2.48ml	1	NM PA
XGEVA SOLN 120mg/1.7ml	1	NM PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml	1	B/D NM
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	1	B/D NM
CHELATING AGENTS		
CHEMET CAPS 100mg	1	
deferasirox (generic of JADENU SPRINKLE) PACK 90mg, 180mg, 360mg	1	NM PA
deferasirox (generic of JADENU) TABS 90mg, 180mg, 360mg	1	NM PA
LOKELMA PACK 5gm, 10gm	1	
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	1	NM
sodium polystyrene sulfonate powder	1	
sps SUSP 15gm/60ml	1	
trientine hcl (generic of SYPRINE) CAPS 250mg	1	NM PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	1	

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
afirmelle		1
altavera		1
alyacen 1/35		1
alyacen 7/7/7		1
amethia		1
apri		1
aranelle		1
ashlyna		1
aubra eq		1
aurovela 1/20		1
aurovela 24 fe		1
aurovela fe 1.5/30		1
aurovela fe 1/20		1
aviane		1
ayuna		1
azurette		1
balziva		1
blisovi 24 fe		1
blisovi fe 1.5/30		1
briellyn		1
camila TABS .35mg		1
camrese		1
camrese lo		1
chateal		1
cryselle-28		1
cyred eq		1
dasetta 1/35		1
dasetta 7/7/7		1
daysee		1
deblitane TABS .35mg		1
DEPO-SUBQ PROVERA 104		1
SUSY 104mg/0.65ml		
desogest-eth estrad & eth estradiol tab 0.15-0.02/0.01 mg(21/5)		1
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg		

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

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

Drug Name	Drug Requirements/ Tier	Limits
drospirenone-ethynodiol estradiol levomefolate tab 3-0.03-0.451 mg (generic of SAFYRAL)	1	
drospirenone-ethynodiol estradiol tab 3-0.02 mg (generic of YAZ)	1	
drospirenone-ethynodiol estradiol tab 3-0.03 mg (generic of YASMIN 28)	1	
elonest	1	
eluryng (generic of NUVARING)	1	
enilloring (generic of NUVARING)	1	
enpresse-28	1	
enskyce	1	
errin TABS .35mg	1	
estarrylla	1	
ethynodiol diacetate & ethynodiol estradiol tab 1 mg-35 mcg	1	
ethynodiol diacetate & ethynodiol estradiol tab 1 mg-50 mcg	1	
etonogestrel-ethynodiol estradiol va ring 0.120-0.015 mg/24hr (generic of NUVARING)	1	
falmina	1	
finzala (generic of MINASTRIN 24 FE)	1	
hailey 1.5/30	1	
hailey 24 fe	1	
haloette (generic of NUVARING)	1	
heather TABS .35mg	1	
iclevia	1	
incassia TABS .35mg	1	
introvale	1	
isibloom	1	
jasmiel (generic of YAZ)	1	
jolessa	1	
juleber	1	
junel 1.5/30	1	
junel 1/20	1	

Drug Name	Drug Requirements/ Tier	Limits
junel fe 1.5/30	1	
junel fe 1/20	1	
junel fe 24	1	
kaitlib fe	1	
kariva	1	
kelnor 1/35	1	
kelnor 1/50	1	
kurvelo	1	
larin 1.5/30	1	
larin 1/20	1	
larin 24 fe	1	
larin fe 1.5/30	1	
larin fe 1/20	1	
layolis fe	1	
leena	1	
lessina	1	
levonest	1	
levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg	1	
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	1	
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	1	
levonorgestrel & ethynodiol estradiol (91-day) tab 0.15-0.03 mg	1	
levonorgestrel & ethynodiol estradiol tab 0.1 mg-20 mcg	1	
levonorgestrel & ethynodiol estradiol tab 0.15 mg-30 mcg	1	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	1	
levora 0.15/30-28	1	
loestrin 1.5/30-21	1	
loestrin 1/20-21	1	
loestrin fe 1.5/30	1	
loestrin fe 1/20	1	
loryna (generic of YAZ)	1	

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

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

Drug Name	Drug Requirements/ Tier Limits
low-ogestrel	1
lulera	1
lyeq TABS .35mg	1
lyza TABS .35mg	1
marlissa	1
medroxyprogesterone acetate (contraceptive) (generic of DEPO-PROVERA CONTRACEPTIV) SUSP 150mg/ml; SUSY 150mg/ml	1
mibelas 24 fe (generic of MINASTRIN 24 FE)	1
microgestin 1.5/30	1
microgestin 1/20	1
microgestin 24 fe	1
microgestin fe 1.5/30	1
microgestin fe 1/20	1
mini	1
mono-linyah	1
necon 0.5/35-28	1
nikki (generic of YAZ)	1
nora-be TABS .35mg	1
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	1
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg	1
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg	1
norethindrone (contraceptive) TABS .35mg	1
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	1
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	1
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	1
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	1

Drug Name	Drug Requirements/ Tier Limits
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (generic of MINASTRIN 24 FE)	1
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	1
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg- mcg (generic of ORTHO TRICYCLEN LO)	1
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg- mcg	1
norlyroc TABS .35mg	1
nortrel 0.5/35 (28)	1
nortrel 1/35 (21)	1
nortrel 1/35 (28)	1
nortrel 7/7/7	1
nylia 1/35	1
nylia 7/7/7	1
nymyo	1
ocella (generic of YASMIN 28)	1
philith	1
pimtrea	1
portia-28	1
reclipsen	1
rivelsa	1
setlakin	1
sharobel TABS .35mg	1
similiya	1
simpesse	1
sprintec 28	1
sronyx	1
syeda (generic of YASMIN 28)	1
tarina 24 fe	1
tarina fe 1/20 eq	1
tilia fe	1
tri-estarylla	1
tri-legest fe	1
tri-linyah	1

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

54

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

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

Drug Name	Drug Requirements/ Tier	Limits
<i>estradiol</i> (generic of VIVELLE- 1 DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
<i>estradiol</i> (generic of CLIMARA) PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	1	
<i>estradiol</i> (generic of ESTRACE) TABS .5mg, 1mg, 2mg	1	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i> (generic of ACTIVELLA)	1	
<i>estradiol vaginal</i> (generic of ESTRACE) CREA .1mg/gm	1	
<i>estradiol vaginal</i> (generic of VAGIFEM) TABS 10mcg	1	
<i>estradiol valerate</i> (generic of DELESTROGEN) OIL 10mg/ml, 20mg/ml, 40mg/ml	1	
<i>fyavolv tab 0.5mg-2.5mcg</i>	1	
<i>fyavolv tab 1mg-5mcg</i>	1	
<i>jinteli</i>	1	
<i>lyllana</i> (generic of MINIVELLE) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	1	
<i>mimvey</i> (generic of ACTIVELLA)	1	
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	
<i>yuvafem</i> (generic of VAGIFEM) TABS 10mcg	1	

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

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

Drug Name	Drug Requirements/ Tier	Limits
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	1	B/D
DEXAMETHASONE INTENSOL CONC 1mg/ml	1	B/D
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	1	
fludrocortisone acetate TABS .1mg	1	
hydrocortisone (generic of CORTEF) TABS 5mg, 10mg, 20mg	1	
methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg	1	B/D
methylprednisolone TABS 32mg	1	B/D
methylprednisolone (generic of MEDROL DOSEPAK) TBPK 4mg	1	
methylprednisolone acetate (generic of DEPO-MEDROL) SUSP 40mg/ml, 80mg/ml	1	B/D
methylprednisolone sod succ SOLR 40mg, 125mg	1	B/D
methylprednisolone sod succ (generic of SOLU-MEDROL) SOLR 1000mg	1	B/D
prednisolone SOLN 15mg/5ml	1	B/D
prednisolone sodium phosphate (generic of PEDIAPRED) SOLN 5mg/5ml	1	B/D
prednisolone sodium phosphate SOLN 15mg/5ml, 25mg/5ml	1	B/D
prednisone SOLN 5mg/5ml; TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	1	B/D

Drug Name	Drug Requirements/ Tier	Limits
prednisone TBPK 5mg, 10mg	1	
PREDNISONE INTENSOL CONC 5mg/ml	1	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	1	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
diazoxide (generic of PROGLYCEM) SUSP 50mg/ml	1	
GVOKE HYPOOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	1	
GVOKE KIT SOLN 1mg/0.2ml	1	
GVOKE PFS SOSY 1mg/0.2ml	1	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	1	NM LA PA
betaine powder for oral solution (generic of CYSTADANE)	1	NM LA
cabergoline TABS .5mg	1	
carglumic acid (generic of CARBAGLU) TBSO 200mg	1	NM LA PA
CERDELGA CAPS 84mg	1	NM LA PA
CEREZYME SOLR 400unit	1	NM LA PA
cinacalcet hcl (generic of SENSIPIAR) TABS 30mg, 60mg	1	B/D QL NM
QL (60 tabs / 30 days)		
cinacalcet hcl (generic of SENSIPIAR) TABS 90mg	1	B/D QL NM
QL (120 tabs / 30 days)		
CYSTAGON CAPS 50mg, 150mg	1	NM LA PA
desmopressin acetate (generic of DDAVP) SOLN 4mcg/ml; TABS .1mg, .2mg	1	
desmopressin acetate spray SOLN .01%	1	
desmopressin acetate spray refrigerated SOLN .01%	1	

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

56

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
FABRAZYME SOLR 5mg, 35mg	1	NM LA PA
GENOTROPIN CART 5mg, 12mg	1	NM PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	1	NM PA
INCRELEX SOLN 40mg/4ml <i>javygtor</i> (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	1	NM LA PA
KORLYM TABS 300mg <i>levocarnitine (metabolic modifiers)</i> (generic of CARNITOR) SOLN 1gm/10ml; TABS 330mg	1	NM LA PA
LUMIZYME SOLR 50mg	1	NM LA PA
LUPRON DEPOT-PED (1- MONTH KIT 7.5mg, 11.25mg, 15mg	1	NM PA
LUPRON DEPOT-PED (3- MONTH KIT 11.25mg, 30mg	1	NM PA
LUPRON DEPOT-PED (6- MONTH KIT 45mg	1	NM PA
<i>miglustat</i> (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	1	QL NM PA
NAGLAZYME SOLN 1mg/ml	1	NM LA PA
<i>nitisinone</i> (generic of ORFADIN) CAPS 2mg, 5mg, 10mg, 20mg	1	NM PA
<i>octreotide acetate</i> (generic of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM PA
<i>octreotide acetate</i> SOLN 200mcg/ml, 1000mcg/ml; SOSY 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM PA
<i>raloxifene hcl</i> (generic of EVISTA) TABS 60mg	1	

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

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

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

Drug Name	Drug Requirements/ Tier	Limits
megestrol acetate SUSP 40mg/ml	1	
megestrol acetate (appetite) SUSP 625mg/5ml	1	PA
norethindrone acetate TABS 5mg	1	
progesterone (generic of PROMETRIUM) CAPS 100mg, 200mg	1	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
euthyrox (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
levo-t (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
levothyroxine sodium (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
levoxyl (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
liothyronine sodium (generic of CYTOMEL) TABS 5mcg, 25mcg, 50mcg	1	
methimazole TABS 5mg, 10mg	1	
propylthiouracil TABS 50mg	1	

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

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

58

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>metoclopramide hcl</i> SOLN 5mg/5ml, 5mg/ml	1	
<i>metoclopramide hcl</i> (generic of REGLAN) TABS 5mg, 10mg	1	
<i>ondansetron</i> TBDP 4mg, 8mg 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	1	B/D
<i>ondansetron hcl</i> SOLN 4mg/5ml; TABS 4mg, 8mg	1	B/D
<i>prochlorperazine</i> SUPP 25mg	1	
<i>prochlorperazine edisylate</i> SOLN 10mg/2ml	1	
<i>prochlorperazine maleate</i> TABS 5mg, 10mg	1	
<i>promethazine hcl</i> (generic of PHENERGAN) SOLN 25mg/ml, 50mg/ml PA if 70 years and older	1	PA
<i>promethazine hcl</i> SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg PA if 70 years and older	1	PA
<i>scopolamine</i> (generic of TRANSDERM-SCOP) PT72 1mg/3days QL (10 patches / 30 days) PA if 70 years and older	1	QL PA
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS		
<i>dicyclomine hcl</i> CAPS 10mg; SOLN 10mg/5ml; TABS 20mg	1	
<i>glycopyrrolate</i> (generic of ROBINUL) TABS 1mg QL (90 tabs / 30 days)	1	QL
<i>glycopyrrolate</i> (generic of ROBINUL FORTE) TABS 2mg QL (120 tabs / 30 days)	1	QL

Drug Name	Drug Requirements/ Tier	Limits
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
<i>famotidine</i> SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	1	
<i>famotidine</i> SUSR 40mg/5ml QL (300 mL / 30 days)	1	QL
<i>famotidine</i> (generic of PEPCID) TABS 20mg QL (120 tabs / 30 days)	1	QL
<i>famotidine</i> (generic of PEPCID) TABS 40mg QL (60 tabs / 30 days)	1	QL
<i>famotidine in nacl 0.9% iv soln</i> 20 mg/50ml	1	
<i>nizatidine</i> CAPS 150mg, 300mg	1	
INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium</i> (generic of COLAZAL) CAPS 750mg	1	
<i>budesonide</i> CPEP 3mg QL (90 caps / 30 days)	1	QL PA
<i>budesonide</i> (generic of UCERIS) TB24 9mg QL (30 tabs / 30 days)	1	QL PA
<i>hydrocortisone (intrarectal)</i> (generic of CORTENEMA) ENEM 100mg/60ml	1	
<i>mesalamine</i> (generic of APRISO) CP24 .375gm QL (120 caps / 30 days)	1	QL
<i>mesalamine</i> (generic of DELZICOL) CPDR 400mg QL (180 caps / 30 days)	1	QL
<i>mesalamine</i> ENEM 4gm	1	
<i>mesalamine</i> (generic of CANASA) SUPP 1000mg	1	
<i>mesalamine</i> (generic of LIALDA) TBEC 1.2gm QL (120 tabs / 30 days)	1	QL
<i>mesalamine w/ cleanser</i> (generic of ROWASA) KIT 4gm	1	
<i>sulfasalazine</i> (generic of AZULFIDINE) TABS 500mg	1	

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

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

Drug Name	Drug Requirements/ Tier	Limits
sulfasalazine (generic of AZULFIDINE EN-TABS) TBEC 500mg	1	
LAXATIVES		
constulose SOLN 10gm/15ml	1	
enulose SOLN 10gm/15ml	1	
gavilyte-c	1	
gavilyte-g (generic of GOLYTELY)	1	
generlac SOLN 10gm/15ml	1	
lactulose SOLN 10gm/15ml	1	
lactulose (encephalopathy) SOLN 10gm/15ml	1	
peg 3350-kcl-na bicarb-nacl- na sulfate for soln 236 gm (generic of GOLYTELY)	1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
PLENUV SOL	1	
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml (generic of SUPREP BOWEL PREP KIT)	1	
MISCELLANEOUS		
alosetron hcl (generic of LOTRONEX) TABS .5mg, 1mg	1	QL PA
QL (60 tabs / 30 days)		
cromolyn sodium (mastocytosis) (generic of GASTROCROM) CONC 100mg/5ml	1	
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg (generic of LOMOTIL)	1	
GATTEX KIT 5mg	1	NM LA PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	1	QL
QL (30 caps / 30 days)		
loperamide hcl CAPS 2mg	1	

Drug Name	Drug Requirements/ Tier	Limits
misoprostol (generic of CYTOTEC) TABS 100mcg, 200mcg	1	
MOVANTIK TABS 12.5mg, 25mg	1	QL
QL (30 tabs / 30 days)		
RELISTOR SOLN 8mg/0.4ml, 1 12mg/0.6ml	1	QL PA
QL (28 syringes / 28 days)		
sucralfate (generic of CARAFATE) TABS 1gm	1	
ursodiol CAPS 300mg	1	
ursodiol (generic of URSO 250) TABS 250mg	1	
ursodiol (generic of URSO FORTE) TABS 500mg	1	
XERMELO TABS 250mg	1	QL NM LA PA
QL (84 tabs / 28 days)		
XIFAXAN TABS 550mg	1	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	1	
CREON CAP 6000UNIT	1	
CREON CAP 12000UNT	1	
CREON CAP 24000UNT	1	
CREON CAP 36000UNT	1	
ZENPEP CAP 3000UNIT	1	
ZENPEP CAP 5000UNIT	1	
ZENPEP CAP 10000UNT	1	
ZENPEP CAP 15000UNT	1	
ZENPEP CAP 20000UNT	1	
ZENPEP CAP 25000UNT	1	
ZENPEP CAP 40000UNT	1	
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
esomeprazole magnesium (generic of NEXIUM) CPDR 20mg, 40mg	1	QL ST
QL (30 caps / 30 days)		
lansoprazole CPDR 15mg	1	QL
QL (60 caps / 30 days)		

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

60

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

Drug Name	Drug Requirements/ Tier	Limits
<i>potassium citrate (alkalinizer)</i> (generic of UROCIT-K 10) TBCR 1080mg	1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
<i>fesoterodine fumarate</i> (generic of TOVIAZ) TB24 4mg, 8mg QL (30 tabs / 30 days)	1	QL
<i>GEMTESA</i> TABS 75mg QL (30 tabs / 30 days)	1	QL
<i>MYRBETRIQ</i> SRER 8mg/ml QL (300 mL / 28 days)	1	QL
<i>MYRBETRIQ</i> TB24 25mg, 50mg QL (30 tabs / 30 days)	1	QL
<i>oxybutynin chloride</i> SOLN 5mg/5ml QL (600 mL / 30 days)	1	QL
<i>oxybutynin chloride</i> TABS 5mg QL (120 tabs / 30 days)	1	QL
<i>oxybutynin chloride</i> TB24 5mg QL (30 tabs / 30 days)	1	QL
<i>oxybutynin chloride</i> TB24 10mg, 15mg QL (60 tabs / 30 days)	1	QL
<i>solifenacin succinate</i> (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days)	1	QL
<i>tolterodine tartrate</i> (generic of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days)	1	QL ST
<i>tolterodine tartrate</i> (generic of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days)	1	QL
<i>trospium chloride</i> TABS 20mg QL (60 tabs / 30 days)	1	QL

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

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
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate</i>	1	
<i>vaginal</i> (generic of CLEOCIN)		
CREA 2%		
<i>metronidazole vaginal</i> GEL	1	
.75%		
<i>terconazole vaginal</i> CREA	1	
.4%, .8%; SUPP 80mg		
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
<i>dabigatran etexilate mesylate</i>	1	QL
CAPS 75mg		
QL (60 caps / 30 days)		
<i>dabigatran etexilate mesylate</i>	1	QL
(generic of PRADAXA) CAPS		
150mg		
QL (60 caps / 30 days)		
ELIQUIS TABS 2.5mg	1	QL
QL (60 tabs / 30 days)		
ELIQUIS TABS 5mg	1	QL
QL (74 tabs / 30 days)		
ELIQUIS STARTER PACK	1	QL
TBPK 5mg		
QL (74 tabs / 30 days)		
<i>enoxaparin sodium</i> (generic of LOVENOX) SOLN	1	
300mg/3ml; SOSY		
30mg/0.3ml, 40mg/0.4ml,		
60mg/0.6ml, 80mg/0.8ml,		
100mg/ml, 120mg/0.8ml,		
150mg/ml		
<i>fondaparinux sodium</i> (generic of ARIXTRA) SOLN	1	
2.5mg/0.5ml, 5mg/0.4ml,		
7.5mg/0.6ml, 10mg/0.8ml		
HEP SOD/D5W INJ	1	
20000UNT		
HEP SOD/D5W INJ	1	
25000UNT		
HEP SOD/NACL INJ	1	
12500UNT		
HEP SOD/NACL INJ	1	
25000UNT		

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

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

62

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

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

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

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

63

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml QL (6 pens / 28 days)	1	QL NM PA	OTEZLA TAB 10/20/30 QL (110 tabs / year)	1	QL NM PA
HUMIRA PEN PNKT 80mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA	REMICADE SOLR 100mg	1	NM LA PA
HUMIRA PEN KIT PS/UV QL (3 pens / 28 days)	1	QL NM PA	RENFLEXIS SOLR 100mg	1	NM LA PA
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml QL (6 pens / 28 days)	1	QL NM PA	RINVOQ TB24 15mg, 30mg QL (30 tabs / 30 days)	1	QL NM PA
HUMIRA PEN-CD/UC/HS START PNKT 80mg/0.8ml QL (3 pens / 28 days)	1	QL NM PA	RINVOQ TB24 45mg QL (168 tabs / year)	1	QL NM PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA	SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml QL (1 cartridge / 56 days)	1	QL NM PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml QL (4 pens / 28 days)	1	QL NM PA	SKYRIZI SOLN 600mg/10ml QL (6 vials / year)	1	QL NM PA
IDACIO (2 PEN) AJKT 40mg/0.8ml QL (56 pens / 365 days)	1	QL NM PA	SKYRIZI SOSY 150mg/ml QL (6 syringes / 365 days)	1	QL NM PA
IDACIO (2 SYRINGE) PSKT 40mg/0.8ml QL (56 syringes / 365 days)	1	QL NM PA	SKYRIZI PEN SOAJ 150mg/ml QL (6 pens / 365 days)	1	QL NM PA
IDACIO CROHN INJ DISEASE AJKT 40mg/0.8ml QL (2 packs / year)	1	QL NM PA	STELARA SOLN 45mg/0.5ml QL (1 vial / 28 days)	1	QL NM LA PA
IDACIO PLAQU INJ PSORIASIS AJKT 40mg/0.8ml QL (2 packs / year)	1	QL NM PA	STELARA 130mg/26ml	1	NM LA PA
INFLIXIMAB SOLR 100mg	1	NM LA PA	STELARA SOSY 45mg/0.5ml, 90mg/ml QL (1 syringe / 28 days)	1	QL NM PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml QL (2 pens / 28 days)	1	QL NM PA	TALTZ SOAJ 80mg/ml; SOSY 80mg/ml QL (3 syringes / 28 days)	1	QL NM LA PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml QL (2 syringes / 28 days)	1	QL NM PA	XELJANZ SOLN 1mg/ml QL (480 mL / 24 days)	1	QL NM PA
OTEZLA TABS 30mg QL (60 tabs / 30 days)	1	QL NM PA	XELJANZ TABS 5mg, 10mg QL (60 tabs / 30 days)	1	QL NM PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDs) - DRUGS TO TREAT RHEUMATOID ARTHRITIS					
hydroxychloroquine sulfate (generic of PLAQUENIL) TABS 200mg					

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>leflunomide</i> (generic of ARAVA) TABS 10mg, 20mg QL (30 tabs / 30 days)	1	QL
<i>methotrexate sodium</i> TABS 2.5mg XATMEP SOLN 2.5mg/ml	1	B/D
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml, 10%	1	NM LA PA
FLEBOGAMMA DIF SOLN 5gm/100ml, 10gm/200ml, 20gm/400ml	1	NM PA
GAMASTAN INJ	1	B/D NM LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	1	NM PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	1	NM PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM LA PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 30gm/300ml	1	NM PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	1	NM LA PA
ARCALYST SOLR 220mg	1	NM LA PA
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 .5mg, 1mg, 5mg	1	B/D NM
<i>azathioprine</i> (generic of IMURAN) TABS 50mg BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	1	B/D
QL (8 syringes / 28 days)		
BENLYSTA SOLR 120mg, 400mg	1	NM LA PA
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg; SOLN 50mg/ml	1	B/D NM
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	1	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg, .5mg, .75mg, 1mg	1	B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; SUSR 200mg/ml; TABS 500mg	1	B/D NM
mycophenolate sodium (generic of MYFORTIC) TBEC 180mg, 360mg	1	B/D NM
NULOJIX SOLR 250mg	1	B/D NM
PROGRAF PACK .2mg, 1mg	1	B/D NM
REZUROCK TABS 200mg	1	NM LA PA
SANDIMMUNE SOLN 100mg/ml	1	B/D NM

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

65

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml; TABS .5mg, 1mg, 2mg	1	B/D NM
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	1	B/D NM
VACCINES		
ABRYSVO SOLR 120mcg/0.5ml	1	V/I
ACTHIB INJ	1	V/I
ADACEL INJ	1	V/I
AREXVY SUSR 120mcg/0.5ml	1	V/I
BCG VACCINE SOLR 50mg	1	V/I
BEXSERO INJ	1	V/I
BOOSTRIX INJ	1	V/I
DAPTACEL INJ	1	
DENGVAXIA SUS	1	
DIP/TET PED INJ 25-5LFU	1	B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	V/I B/D
GARDASIL 9 INJ	1	V/I
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	V/I
HEPLISAV-B SOSY 20mcg/0.5ml	1	V/I B/D
HIBERIX SOLR 10mcg	1	V/I
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	V/I B/D
INFANRIX INJ	1	
IPOL INJ INACTIVE	1	V/I
IXIARO INJ	1	V/I
JYNNEOS SUSP .5ml	1	V/I B/D
KINRIX INJ	1	V/I
M-M-R II INJ	1	V/I
MENACTRA INJ	1	V/I
MENQUADFI INJ	1	V/I
MENVEO INJ	1	V/I
MENVEO SOL	1	V/I
PEDIARIX INJ 0.5ML	1	V/I
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	V/I

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

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

66

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits	Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
dextrose 5% in lactated ringers	1		kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	1	
dextrose 5% w/ sodium chloride 0.2%	1		kcl 40 meq/l (0.3%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM)	1	
dextrose 5% w/ sodium chloride 0.3% (generic of DEXTROSE 5%/NACL 0.3%)	1		KCL/D5W/NACL INJ 0.3/0.9% 1		
dextrose 5% w/ sodium chloride 0.9%	1		lactated ringer's solution	1	
dextrose 5% w/ sodium chloride 0.45%	1		MAGNESIUM SULFATE	1	
dextrose 5% w/ sodium chloride 0.225% (generic of DEXTROSE/SODIUM CHLORIDE)	1		SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml		
dextrose 10% w/ sodium chloride 0.45%	1		magnesium sulfate (generic of MAGNESIUM SULFATE) SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml		
ISOLYTE-P INJ /D5W	1		magnesium sulfate SOLN 50%	1	
ISOLYTE-S INJ	1		magnesium sulfate in dextrose 5% iv soln 1 gm/100ml (generic of MAGNESIUM SULFATE IN D5W)	1	
ISOLYTE-S INJ PH 7.4	1		MG SO4/D5W INJ 10MG/ML	1	
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	1		multiple electrolytes ph 5.5	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	1		(generic of PLASMA-LYTE- 148)		
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	1		multiple electrolytes ph 7.4	1	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	1		(generic of PLASMA-LYTE A)		
kcl 20 meq/l (0.15%) in nacl 0.9% inj (generic of POTASSIUM CHLORIDE/SODIUM)	1		PLASMA-LYTE INJ -148	1	
kcl 20 meq/l (0.15%) in nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM)	1		PLASMA-LYTE INJ -A	1	
kcl 20 meq/l (0.149%) in nacl 0.45% inj	1		POT CHL 20MEQ/L IN NACL	1	
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	1		0.9% INJ		
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj (generic of KCL 0.3%/D5W/NACL 0.9%)	1		POT CHL 20MEQ/L IN NACL	1	
			0.45% INJ		
			POT CHL 40MEQ/L IN NACL	1	
			0.9% INJ		
			potassium chloride SOLN 2meq/ml	1	
			POTASSIUM CHLORIDE SOLN 10meq/50ml	1	

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

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

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

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

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

68

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

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

ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION

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

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

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

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

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

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

70

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
ipratropium bromide SOLN .02%	1	B/D	albuterol sulfate (generic of PROVENTIL HFA) AERS 108mcg/act	1	QL
ipratropium bromide (nasal) SOLN .03%, .06%	1		(generic of Proventil HFA) QL (2 inhalers / 30 days)		
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES					
azelastine hcl SOLN .1%	1		albuterol sulfate NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	1	B/D
cetirizine hcl SOLN 1mg/ml QL (300 mL / 30 days)	1	QL	albuterol sulfate SYRP 2mg/5ml; TABS 2mg, 4mg	1	
cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg PA if 70 years and older	1	PA	levalbuterol hcl NEBU .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	1	B/D
diphenhydramine hcl SOLN 50mg/ml	1		levalbuterol tartrate AERO 45mcg/act	1	QL ST
hydroxyzine hcl SOLN 25mg/ml, 50mg/ml; SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg PA if 70 years and older	1	PA	QL (2 inhalers / 30 days)		
hydroxyzine pamoate (generic of VISTARIL) CAPS 25mg PA if 70 years and older	1	PA	SEREVENT DISKUS AEPB 50mcg/dose	1	QL
hydroxyzine pamoate CAPS 50mg PA if 70 years and older	1	PA	QL (60 inhalations / 30 days)		
levocetirizine dihydrochloride SOLN 2.5mg/5ml QL (300 mL / 30 days)	1	QL	terbutaline sulfate TABS 2.5mg, 5mg	1	
levocetirizine dihydrochloride TABS 5mg QL (30 tabs / 30 days)	1	QL	VENTOLIN HFA AERS 108mcg/act	1	QL
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD			QL (2 inhalers / 30 days)		
albuterol sulfate AERS 108mcg/act	1	QL	VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	1	QL
QL (2 inhalers / 30 days) (generic of Proair HFA)			QL (6 inhalers / 30 days)		
albuterol sulfate AERS 108mcg/act	1	QL	LEUKOTRIENE MODULATORS		
QL (2 inhalers / 30 days) (generic of Ventolin HFA)			montelukast sodium (generic of SINGULAIR) CHEW 4mg, 5mg; PACK 4mg; TABS 10mg	1	
MISCELLANEOUS			zaflurkast (generic of ACCOLATE) TABS 10mg, 20mg	1	
acetylcysteine SOLN 10%, 20%	1	B/D	MISCELLANEOUS		
ARALAST NP SOLR 500mg, 1000mg	1	NM LA PA	acetylcysteine SOLN 10%, 20%	1	B/D
BRONCHITOL CAPS 40mg QL (560 caps / 28 days)	1	QL NM LA PA	ARALAST NP SOLR 500mg, 1000mg	1	NM LA PA

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
cromolyn sodium NEBU 20mg/2ml	1	B/D
epinephrine (anaphylaxis) (generic of EPIPEN 2-PAK) SOAJ .3mg/0.3ml (generic of EpiPen)	1	
epinephrine (anaphylaxis) (generic of EPIPEN-JR 2- PAK) SOAJ .15mg/0.3ml (generic of EpiPen)	1	
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)	1	
FASENRA SOSY 30mg/ml	1	NM LA PA
FASENRA PEN SOAJ 30mg/ml	1	NM LA PA
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg QL (56 packs / 28 days)	1	QL NM LA PA
KALYDECO TABS 150mg QL (60 tabs / 30 days)	1	QL NM LA PA
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)	1	QL NM LA PA
ORKAMBI GRA 75-94MG QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI GRA 100-125 QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI GRA 150-188 QL (56 packs / 28 days)	1	QL NM LA PA
ORKAMBI TAB 100-125 QL (112 tabs / 28 days)	1	QL NM LA PA
ORKAMBI TAB 200-125 QL (112 tabs / 28 days)	1	QL NM LA PA
pirfenidone (generic of ESBRIET) CAPS 267mg QL (270 caps / 30 days)	1	QL NM PA
pirfenidone (generic of ESBRIET) TABS 267mg QL (270 tabs / 30 days)	1	QL NM PA
pirfenidone TABS 534mg QL (90 tabs / 30 days)	1	QL NM PA

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
pirfenidone (generic of ESBRIET) TABS 801mg QL (90 tabs / 30 days)	1	QL NM PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg 2.5mg/2.5ml	1	NM LA PA
PULMOZYME SOLN roflumilast (generic of DALIRESP) TABS 250mcg QL (56 tabs / year)	1	NM PA
roflumilast (generic of DALIRESP) TABS 500mcg QL (30 tabs / 30 days)	1	QL
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	1	QL NM LA PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	1	QL NM LA PA
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	1	
theophylline ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 100mg, 200mg, 300mg, 450mg; TB24 400mg, 600mg	1	
TRIKAFTA PAK 59.5MG QL (56 packs / 28 days)	1	QL NM LA PA
TRIKAFTA PAK 75MG QL (56 packs / 28 days)	1	QL NM LA PA
TRIKAFTA TAB 50-25- 37.5MG & 75MG QL (84 tabs / 28 days)	1	QL NM LA PA
TRIKAFTA TAB 100-50-75MG & 150MG QL (84 tabs / 28 days)	1	QL NM LA PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	1	NM LA PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	1	NM LA PA
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
flunisolide (nasal) SOLN .025% QL (3 bottles / 30 days)	1	QL

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

72

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

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

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

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

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

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

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

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

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

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

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

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

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

75

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

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

Drug Name	Drug Requirements/ Tier	Drug Requirements/ Limits
<i>hydrocortisone (rectal)</i> (generic of ANUSOL-HC)	1	CREA 2.5%
<i>imiquimod</i> CREA 5%	1	QL QL (24 packets / 30 days)
<i>lactic acid (ammonium lactate)</i> 12%	1	LOTN 12%
<i>metronidazole (topical)</i> (generic of METROCREAM)	1	CREA .75% QL (45 gm / 30 days)
<i>metronidazole (topical)</i> (.75%)	1	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> (generic of METROLOTION)	1	LOTN .75% QL (59 mL / 30 days)
<i>PANRETIN</i> GEL .1%	1	QL (60 gm / 30 days)
<i>podofilox</i> SOLN .5%	1	QL QL (7 mL / 28 days)
<i>procto-med hc</i> (generic of ANUSOL-HC)	1	CREA 2.5%
<i>proctosol hc</i> (generic of ANUSOL-HC)	1	CREA 2.5%
<i>proctozone-hc</i> (generic of ANUSOL-HC)	1	CREA 2.5%
<i>RECTIV</i> OINT .4%	1	QL QL (30 gm / 30 days)
<i>tacrolimus (topical)</i> OINT .03%, .1%	1	QL QL (100 gm / 30 days)
<i>VALCHLOR</i> GEL .016%	1	QL NM LA PA QL (60 gm / 30 days)
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i> LOTN .5%	1	QL QL (59 mL / 30 days)
<i>permethrin</i> CREA 5%	1	QL 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 **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
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01% QL (30 gm / 30 days)	1	QL PA
SANTYL OINT 250unit/gm QL (180 gm / 30 days)	1	QL
sodium chloride (gu irrigant) SOLN .9%	1	
water for irrigation, sterile irrigation soln	1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl (generic of EVOXAC) CAPS 30mg	1	
chlorhexidine gluconate (mouth-throat) (generic of PERIDEX) SOLN .12%	1	
clotrimazole TROC 10mg QL (150 lozenges / 30 days)	1	QL
kourzeq PSTE .1%	1	
lidocaine hcl (mouth-throat) SOLN 2%	1	
nystatin (mouth-throat) SUSP 1 100000unit/ml	1	
periogard (generic of PERIDEX) SOLN .12%	1	
pilocarpine hcl (oral) (generic of SALAGEN) TABS 5mg, 7.5mg	1	
triamcinolone acetonide (mouth) PSTE .1%	1	

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

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

Index

- A**
- abacavir sulfate.....14
abacavir sulfate-lamivudine
tab 600-300 mg.....15
- ABELCET13
- ABILIFY
 see aripiprazole.....37
- ABILITY MAINTENA.....37
- abiraterone acetate.....20
- ABRYSVO66
- acamprosate calcium.....47
- acarbose.....48
- ACCOLATE
 see zafirlukast.....71
- ACCUPRIL
 see quinapril hcl27
- accutane73
- acebutolol hcl.....31
- acetaminophen w/ codeine
 soln 120-12 mg/5ml....10
- acetaminophen w/ codeine
 tab 300-15 mg.....10
- acetaminophen w/ codeine
 tab 300-30 mg.....10
- acetaminophen w/ codeine
 tab 300-60 mg.....10
- acetazolamide32
- acetic acid.....61
- acetic acid (otic).....70
- acetylcysteine71
- ACIPHEX
 see rabeprazole sodium
.....61
- acitretin74
- ACTHIB INJ66
- ACTIMMUNE65
- ACTIVELLA
 see estradiol &
 norethindrone acetate
 tab 1-0.5 mg55
 see mimvey.....55
- ACTONEL
 see risedronate sodium
.....52
- ACTOPLUS MET
- see pioglitazone hcl-
 metformin hcl tab 15-
 850 mg49
- ACTOS
 see pioglitazone hcl....49
- ACULAR
 see ketorolac
 tromethamine (ophth)
 69
- ACULAR LS
 see ketorolac
 tromethamine (ophth)
 69
- acyclovir.....16
- acyclovir sodium16
- ADACEL INJ66
- ADALIMUMAB-AACF (2
 PEN)63
- ADDERALL
 see amphetamine-
 dextroamphetamine
 tab 10 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 12.5 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 15 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 20 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 30 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 5 mg.....44
- see amphetamine-
 dextroamphetamine
 tab 7.5 mg.....44
- ADDERALL XR
 see amphetamine-
 dextroamphetamine
 cap er 24hr 10 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 15 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 20 mg ...43
- see amphetamine-
 dextroamphetamine
 cap er 24hr 25 mg ...44
- see amphetamine-
 dextroamphetamine
 cap er 24hr 30 mg ...44
- see amphetamine-
 dextroamphetamine
 cap er 24hr 5 mg43
- adefovir dipivoxil16
- ADEMPAS34
- ADMELOG50
- ADMELOG SOLOSTAR .50
- ADVAIR DISKUS
 see fluticasone-
 salmeterol aer powder
 ba 100-50 mcg/act...73
- see fluticasone-
 salmeterol aer powder
 ba 250-50 mcg/act...73
- see fluticasone-
 salmeterol aer powder
 ba 500-50 mcg/act...73
- see wixela inhub.....73
- ADVAIR HFA AER 115/21
.....73
- ADVAIR HFA AER 230/21
.....73
- ADVAIR HFA AER 45/21 73
- AFINITOR
 see everolimus22
- AFINITOR DISPERZ
 see everolimus22
- afirmelle52
- AGRYLIN
 see anagrelide hcl.....62
- AIMOVIG45
- AKEEGA TAB 100/500 ..20
- AKEEGA TAB 50/500MG
.....20
- ala-cort.....75
- albendazole11
- albuterol sulfate71
- ALCAINE

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

amphetamine-	
dextroamphetamine tab	
30 mg	44
amphetamine-	
dextroamphetamine tab 5	
mg.....	44
amphetamine-	
dextroamphetamine tab 7.5 mg.....	44
amphotericin b	13
amphotericin b liposome.	13
ampicillin.....	18
ampicillin & sulbactam	
sodium for inj 1.5 (1-0.5) gm.....	18
ampicillin & sulbactam	
sodium for inj 3 (2-1) gm	18
ampicillin & sulbactam	
sodium for iv soln 1.5 (1-0.5) gm.....	18
ampicillin & sulbactam	
sodium for iv soln 15 (10-5) gm.....	18
ampicillin & sulbactam	
sodium for iv soln 3 (2-1) gm.....	18
ampicillin sodium	18
AMPYRA	
see <i>dalfampridine</i>	46
ANAFRANIL	
see <i>clomipramine hcl</i> ..	35
anagrelide hcl	62
ANAPROX DS	
see <i>naproxen sodium</i>	9
anastrozole	20
ANCOBON	
see <i>flucytosine</i>	13
ANDROGEL PUMP	
see <i>testosterone</i>	48
ANORO ELLIPT AER	
62.5-25	70
ANUSOL-HC	
see <i>hydrocortisone (rectal)</i>	76
see <i>procto-med hc</i>	76
see <i>proctosol hc</i>	76
see <i>protozone-hc</i>	76
aprepitant.....	58
aprepitant capsule therapy	
pack 80 & 125 mg	58
api.....	52
APRISO	
see <i>mesalamine</i>	59
APTIOM	40
APTIVUS	14
ARALAST NP	71
aranelle.....	52
ARAVA	
see <i>leflunomide</i>	65
ARCALYST	65
AREXVY	66
ARICEPT	
see <i>donepezil hydrochloride</i>	34
ARIMIDEX	
see <i>anastrozole</i>	20
ariPIPRAZOLE	37
ARISTADA.....	37
ARISTADA INITIO	37
ARIIXTRA	
see <i>fondaparinux sodium</i>	62
armodafinil.....	47
ARNUTITY ELLIPTA.....	73
AROMASIN	
see <i>exemestane</i>	20
asenapine maleate	37
ashlyna	52
aspirin-dipyridamole cap er 12hr	
25-200 mg.....	63
ASTAGRAF XL	65
ATACAND	
see <i>candesartan cilexetil</i>	29
ATACAND HCT	
see <i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	28
see <i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	28
see <i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	28
atazanavir sulfate.....	14
ATELVIA	
see risedronate sodium	52
atenolol.....	31
atenolol & chlorthalidone tab	
100-25 mg.....	31
atenolol & chlorthalidone tab	
50-25 mg.....	31
ATIVAN	
see <i>lorazepam</i>	34
atomoxetine hcl.....	44
atorvastatin calcium.....	30
atovaquone	11
atovaquone-proguanil hcl tab	
250-100 mg	13
atovaquone-proguanil hcl tab	
62.5-25 mg	13
ATRIPLA	
see <i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	15
ATROPINE SULFATE	70
atropine sulfate (ophthalmic)	70
ATROVENT HFA	70
aubra eq	52
AUGMENTIN	
see <i>amoxicillin & k clavulanate tab 500-125 mg</i>	18
AUGMENTIN ES-600	
see <i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml.....</i>	18
AUGTYRO	21
aurovela 1/20	52
aurovela 24 fe	52
aurovela fe 1.5/30	52
aurovela fe 1/20	52
AUSTEDO	46
AUSTEDO XR	46
AUSTEDO XR TAB TITR KIT	46
AUVELITY TAB 45-105MG	35
AVALIDE	
see <i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	28

see <i>irbesartan</i> - hydrochlorothiazide tab 300-12.5 mg	28
AVAPRO	
see <i>irbesartan</i>	29
aviane	52
AVODART	
see <i>dutasteride</i>	61
ayuna.....	52
AYVAKIT	21
<i>azacitidine</i>	19
AZACTAM	
see <i>aztreonam</i>	11
azathioprine	65
azelastine hcl.....	71
azelastine hcl (ophth).....	69
AZILECT	
see <i>rasagiline mesylate</i>	37
azithromycin	17
AZOPT	
see <i>brinzolamide</i>	69
AZOR	
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 10-20 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 10-40 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 5-20 mg</i>	27
see <i>amlodipine besylate-</i> <i>olmesartan medoxomil</i> <i>tab 5-40 mg</i>	27
aztreonam.....	11
AZULFIDINE	
see <i>sulfasalazine</i>	59
AZULFIDINE EN-TABS	
see <i>sulfasalazine</i>	60
azurette.....	52
B	
<i>bacitracin (ophthalmic)</i>	68
<i>bacitracin-polymyxin b</i> <i>ophth oint</i>	68
<i>bacitracin-polymyxin-</i> <i>neomycin-hc ophth oint</i> 1%.....	68
<i>baclofen</i>	47
BACTRIM	
see <i>sulfamethoxazole-</i> <i>trimethoprim tab 400-</i> <i>80 mg</i>	12
BACTRIM DS	
see <i>sulfamethoxazole-</i> <i>trimethoprim tab 800-</i> <i>160 mg</i>	12
BAFIERTAM	46
<i>balsalazide disodium</i>	59
BALVERSA.....	21
<i>balziva</i>	52
BANZEL	
see <i>rufinamide</i>	42
BARACLUDE	16
see <i>entecavir</i>	16
BASAGLAR KWIKPEN...50	
BCG VACCINE	66
BD ALCOHOL SWABS...50	
<i>benazepril &</i> hydrochlorothiazide tab 10-12.5 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 20-12.5 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 20-25 mg	26
<i>benazepril &</i> hydrochlorothiazide tab 5-6.25mg	26
<i>benazepril hcl</i>	27
BENDEKA	19
BENICAR	
see <i>olmesartan</i> <i>medoxomil</i>	29
BENICAR HCT	
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 20-12.5 mg	28
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 40-12.5 mg	28
see <i>olmesartan</i> <i>medoxomil-</i> hydrochlorothiazide tab 40-25 mg	28
BENLYSTA	65
BENZAMYCIN	
see <i>benzoyl peroxide-</i> <i>erythromycin gel 5-3%</i>	73
<i>benzoyl peroxide-</i> erythromycin gel 5-3% 73	
benztropine mesylate.....	36
BERINERT	62
BESIVANCE	68
BESREMI.....	20
<i>betaine powder for oral</i> <i>solution</i>	56
<i>betamethasone</i>	
<i>dipropionate (topical)</i> ...75	
<i>betamethasone</i>	
<i>dipropionate augmented</i>	75
<i>betamethasone valerate</i> .75	
BETAPACE	
see <i>sorine</i>	30
see <i>sotalol hcl</i>	30
BETAPACE AF	
see <i>sotalol hcl (afib/afl)</i> 30	
BETASERON.....	46
<i>betaxolol hcl</i>	31
<i>betaxolol hcl (ophth)</i>	69
<i>bethanechol chloride</i>	61
BETOPTIC-S	69
BEVESPI AER 9-4.8MCG	
.....	70
bexarotene.....	21
bexarotene (<i>topical</i>)	76
BEXSERO INJ	66
BIAXIN XL	
see <i>clarithromycin</i>	17
<i>bicalutamide</i>	20
BICILLIN L-A.....	18
BIKTARVY TAB 30-120-15	
MG	15
BIKTARVY TAB 50-200-25	
MG	15
BILTRICIDE	
see <i>praziquantel</i>	12
<i>bisoprolol &</i>	
<i>hydrochlorothiazide tab</i> 10-6.25 mg	31

<i>bisoprolol & hydrochlorothiazide tab</i>	2.5-6.25 mg.....31	<i>buprenorphine hcl-naloxone hcl sl film</i>	12-3 mg (base equiv) .....47	<i>candesartan cilexetil-hydrochlorothiazide tab</i>
<i>bisoprolol & hydrochlorothiazide tab</i>	5-6.25 mg.....31	<i>buprenorphine hcl-naloxone hcl sl film</i>	2-0.5 mg (base equiv) .....47	16-12.5 mg.....28
<i>bisoprolol fumarate</i>	31	<i>buprenorphine hcl-naloxone hcl sl film</i>	4-1 mg (base equiv) .....47	<i>candesartan cilexetil-hydrochlorothiazide tab</i>
BIVIGAM.....	65	<i>buprenorphine hcl-naloxone hcl sl film</i>	8-2 mg (base equiv) .....47	32-12.5 mg.....28
<i>blisovi 24 fe</i>	52	<i>buprenorphine hcl-naloxone hcl sl tab</i>	2-0.5 mg (base equiv) .....47	<i>candesartan cilexetil-hydrochlorothiazide tab</i>
<i>blisovi fe 1.5/30</i>	52	<i>buprenorphine hcl-naloxone hcl sl tab</i>	8-2 mg (base equiv) .....47	32-25 mg.....28
BOOSTRIX INJ.....	66	<i>buprenorphine hcl-naloxone hcl tab</i>	2-0.5 mg (base equiv) .....47	CAPLYTA
<i>bortezomib</i>	21	<i>bupropion hcl</i>	35	CAPRELSA.....21, 22
BORTEZOMIB.....	21	<i>bupropion hcl (smoking deterrent)</i>	47	<i>captopril</i>
<i>bosentan</i>	34	<i>buspirone hcl</i>	34	27
BOSULIF	21	<i>butorphanol tartrate</i>	10	<i>captopril & hydrochlorothiazide tab</i>
BRAFTOVI.....	21	BYDUREON BCISE.....48	25-15 mg.....26	
BREO ELLIPTA INH 100-25	73	BYETTA.....48	<i>captopril & hydrochlorothiazide tab</i>	
BREO ELLIPTA INH 200-25	73	BYSTOLIC	25-25 mg.....26	
BREO ELLIPTA INH 50-25MCG	73	see <i>nebivolol hcl</i>....31, 32	<i>captopril & hydrochlorothiazide tab</i>	
BREZTRI AERO AER SPHERE	70	C	50-15 mg.....26	
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	70	<i>cabergoline</i>	60	
<i>briellyn</i>	52	CABOMETYX	<i>carb/levo orally</i>	
BRILINTA	63	<i>calcipotriene</i>	disintegrating tab 10-	
<i>brimonidine tartrate</i>	69	74	100mg	
<i>brinzolamide</i>	69	<i>calcitonin (salmon) spray</i> 51	36	
BRIVIACT	40	<i>calcitrene</i>	<i>carb/levo orally</i>	
<i>bromfenac sodium (ophth)</i>	69	75	disintegrating tab 25-	
<i>bromocriptine mesylate</i> ..36		<i>calcitriol</i>	100mg	
BROMSITE	69	58	36	
BRONCHITOL	71	<i>calcium acetate (phosphate binder)</i>	<i>carb/levo orally</i>	
BRUKINSA	21	57	disintegrating tab 25-	
<i>budesonide</i>	59	CALQUENCE	250mg	
<i>budesonide (inhalation)</i> ..73		21	36	
<i>bumetanide</i>	32	<i>camila</i>	CARBAGLU	
BUMEX		52	see <i>carglumic acid</i> ..56	
see <i>bumetanide</i>.....32		CAMPTOSAR	carbamazepine	
BUPHENYL		see <i>irinotecan hcl</i>.....21	40	
see <i>sodium phenylbutyrate</i>.....57		camrese	<i>carbidopa & levodopa tab</i>	
<i>buprenorphine hcl</i>.....47		52	10-100 mg.....37	
		camrese lo	<i>carbidopa & levodopa tab</i>	
		52	25-100 mg.....37	
		CANASA	<i>carbidopa & levodopa tab</i>	
		see <i>mesalamine</i>	25-250 mg.....37	
		59	<i>carbidopa & levodopa tab</i>	
		CANCIDAS	er 25-100 mg.....37	
		see <i>caspofungin acetate</i>		
		.....13	
		candesartan cilexetil		
		29		

<i>carbidopa & levodopa tab er</i> 50-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 12.5-50-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 18.75-75-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 25-100-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 31.25-125-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 37.5-150-200 mg.....	37
<i>carbidopa-levodopa-entacapone tabs</i> 50-200-200 mg.....	37
<i>carboplatin</i>	19
CARDIZEM see <i>diltiazem hcl</i>	32
CARDIZEM CD see <i>cartia xt</i>	32
see <i>diltiazem hcl coated beads</i>	32
CARDURA see <i>doxazosin mesylate</i>	27
<i>carglumic acid</i>	56
<i>carisoprodol</i>	47
CARNITOR see <i>levocarnitine (metabolic modifiers)</i>	57
<i>carteolol hcl (ophth)</i>	69
<i>cartia xt</i>	32
<i>carvedilol</i>	31
CASODEX see <i>bicalutamide</i>	20
<i>caspofungin acetate</i>	13
CATAPRES-TTS-1 see <i>clonidine</i>	33
CATAPRES-TTS-2 see <i>clonidine</i>	33
CATAPRES-TTS-3 see <i>clonidine</i>	33
CAYSTON	11
<i>cefaclor</i>	16
CEFACLOR ER	16
<i>cefadroxil</i>	16
CEFAZOLIN	16
CEFAZOLIN INJ 1GM/50ML	16
<i>cefazolin sodium</i>	16
CEFAZOLIN SOLN 2GM/100ML-4%	16
<i>cefdinir</i>	16
<i>cefpeme hcl</i>	16
<i>cefixime</i>	16
<i>cefoxitin sodium</i>	16
<i>cefpodoxime proxetil</i>	17
<i>cefprozil</i>	17
<i>ceftazidime</i>	17
<i>ceftriaxone sodium</i>	17
<i>cefuroxime axetil</i>	17
<i>cefuroxime sodium</i>	17
CELEBREX see <i>celecoxib</i>	9
<i>celecoxib</i>	9
CELEXA see <i>citalopram hydrobromide</i>	35
CELLCEPT see <i>mycophenolate mofetil</i>	65
CELONTIN see <i>methsuximide</i>	42
<i>cephalexin</i>	17
CERDELGA	56
CEREZYME	56
<i>cetirizine hcl</i>	71
<i>cevimeline hcl</i>	77
<i>chateal</i>	52
CHEMET	52
<i>chlorhexidine gluconate (mouth-throat)</i>	77
<i>chloroquine phosphate</i> ..	13
<i>chlorpromazine hcl</i>	38
<i>chlorthalidone</i>	32
<i>cholestyramine</i>	30
<i>cholestyramine light</i>	30
<i>ciclopirox olamine</i>	74
<i>cilostazol</i>	62
CILOXAN	68
CIMDUO TAB 300-300 ..	15
<i>cinacalcet hcl</i>	56
CIPRO	17
see <i>ciprofloxacin hcl</i>	17
<i>ciprofloxacin 200 mg/100ml in d5w</i>	17
<i>ciprofloxacin 400 mg/200ml in d5w</i>	17
<i>ciprofloxacin hcl</i>	17
<i>ciprofloxacin hcl (ophth)</i> ..	69
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	70
<i>cisplatin</i>	19
<i>citalopram hydrobromide</i> 35	
<i>claravis</i>	73
<i>clarithromycin</i>	17
CLEOCIN see <i>clindamycin hcl</i>	11
see <i>clindamycin</i>	
..... <i>phosphate vaginal</i> ..	62
CLEOCIN PEDIATRIC GRANULE see <i>clindamycin palmitate hydrochloride</i>	11
CLEOCIN PHOSPHATE see <i>clindamycin phosphate</i>	11
CLEOCIN-T see <i>clindamycin phosphate (topical)</i> ..	74
CLIMARA see <i>estradiol</i>	55
<i>clindamycin hcl</i>	11
<i>clindamycin palmitate hydrochloride</i>	11
<i>clindamycin phosphate</i>	11
..... <i>(topical)</i>	73, 74
<i>clindamycin phosphate in d5w iv soln 300 mg/50ml</i>	11
<i>clindamycin phosphate in d5w iv soln 600 mg/50ml</i>	11
<i>clindamycin phosphate in d5w iv soln 900 mg/50ml</i>	11
<i>clindamycin phosphate vaginal</i>	62

CLINDMYC/NAC INJ	
300/50ML	11
CLINDMYC/NAC INJ	
600/50ML	11
CLINDMYC/NAC INJ	
900/50ML	11
CLINIMIX INJ 4.25/D10 ..	68
CLINIMIX INJ 4.25/D5W.	68
CLINIMIX INJ 5%/D15W.	68
CLINIMIX INJ 5%/D20W.	68
CLINIMIX INJ 6/5.....	68
CLINIMIX INJ 8/10.....	68
CLINIMIX INJ 8/14.....	68
clinisol sf 15%.....	68
CLINOLIPID EMU 20%...	68
clobazam	40
clobetasol propionate....	75
clobetasol propionate e...	75
clomipramine hcl.....	35
clonazepam	40
clonidine	33
clonidine hcl.....	33
clopidogrel bisulfate.....	63
clorazepate dipotassium.	40
clotrimazole	77
clotrimazole (topical)....	74
clotrimazole w/	
betamethasone cream 1-0.05%.....	74
clozapine	38
CLOZARIL	
see clozapine	38
COARTEM TAB 20-120MG	
.....	13
COLAZAL	
see balsalazide disodium	59
colchicine.....	9
colchicine w/ probenecid tab 0.5-500 mg.....	9
colesevelam hcl	30
COLESTID	
see colestipol hcl.....	30
colestipol hcl.....	30
colistimethate sodium	11
COLY-MYCIN M	
see colistimethate sodium.....	11
COMBIGAN SOL 0.2/0.5%	
.....	70
COMBIVENT AER 20-100	
.....	70
COMETRIQ (60MG DOSE)	
.....	22
COMETRIQ KIT 100MG	22
COMETRIQ KIT 140MG	22
COMPLERA TAB.....	15
compro.....	58
COMTAN	
see entacapone.....	37
constulose	60
COPAXONE	
see glatiramer acetate.	46
see glatopa.....	46
COPIKTRA	22
COREG	
see carvedilol	31
CORGARD	
see nadolol.....	31
CORLANOR	33
CORTEF	
see hydrocortisone.....	56
CORTENEMA	
see hydrocortisone (intrarectal)	59
COSOPT	
see dorzolamide hcl-timolol maleate ophth soln 2-0.5%.....	70
COTELLIC	22
COZAAR	
see losartan potassium	29
CREON CAP 12000UNT	60
CREON CAP 24000UNT	60
CREON CAP 3000UNIT	60
CREON CAP 36000UNT	60
CREON CAP 6000UNIT	60
CRESTOR	
see rosuvastatin calcium	30
cromolyn sodium.....	72
cromolyn sodium (mastocytosis).....	60
cromolyn sodium (ophth)	69
cryselle-28	52
cyclobenzaprine hcl.....	47
cyclophosphamide	19
CYCLOPHOSPHAMIDE	19
MONOHYDR	19
cycloserine.....	15
cyclosporine.....	65
cyclosporine modified (for microemulsion).....	65
CYKLOKAPRON	
see tranexamic acid ...	63
CYMBALTA	
see duloxetine hcl	35
cyproheptadine hcl.....	71
cyred eq.....	52
CYSTADANE	
see betaine powder for oral solution	56
CYSTADROPS	70
CYSTAGON.....	56
CYSTARAN	70
cytarabine	19
CYTOMEL	
see liothyronine sodium	58
CYTOTEC	
see misoprostol	60
D	
D10W/NACL INJ 0.2%....	66
D2.5W/NACL INJ 0.45%.	66
D5W/LYTES INJ #48	66
dabigatran etexilate mesylate.....	62
dalfampridine	46
DALIRESP	
see roflumilast	72
danazol	55
DANTRIUM	
see dantrolene sodium	47
dantrolene sodium	47
dapsone	11
DAPTACEL INJ	66
daptomycin	12
DAPTO MYCIN.....	11
see daptomycin	12
darunavir	14
dasetta 1/35	52
dasetta 7/7/7	52
DAURISMO	22
daysee	52

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

DIOVAN	
see <i>valsartan</i>	29
DIOVAN HCT	
see <i>valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>160-12.5 mg</i>	29
<i>see valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>160-25 mg</i>	29
<i>see valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>320-12.5 mg</i>	29
<i>see valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>320-25 mg</i>	29
<i>see valsartan-</i>	
<i>hydrochlorothiazide tab</i>	
<i>80-12.5 mg</i>	29
DIP/TET PED INJ 25-5LFU	.....66
diphenhydramine hcl.....	71
diphenoxylate w/ atropine	
<i>liq 2.5-0.025 mg/5ml</i>	60
diphenoxylate w/ atropine	
<i>tab 2.5-0.025 mg</i>	60
DIPROLENE	
<i>see betamethasone</i>	
<i>dipropionate</i>	
<i>augmented</i>	75
dipyridamole	63
disopyramide phosphate.....	30
disulfiram	48
divalproex sodium.....	41
docetaxel	21
DOCETAXEL.....	21
<i>see docetaxel</i>	21
dofetilide	30
donepezil hydrochloride..	34
DOPTELET.....	62
dorzolamide hcl.....	70
dorzolamide hcl-timolol	
<i>maleate ophth soln 2-0.5%</i>	70
dotti.....	55
DOVATO TAB 50-300MG	.....15
doxazosin mesylate	27
doxepin hcl	35
doxepin hcl (sleep).....	45
DOXIL	
<i>see doxorubicin hcl</i>	
<i>liposomal</i>	19
doxorubicin hcl.....	19
doxorubicin hcl <i>liposomal</i> 19	
doxy 100.....	18
doxycycline (<i>monohydrate</i>)	
.....18, 19	
doxycycline <i>hyclate</i>	19
dronabinol.....	58
drospirenone-ethinyl	
<i>estradiol tab 3-0.02 mg</i> 53	
drospirenone-ethinyl	
<i>estradiol tab 3-0.03 mg</i> 53	
drospirenone-ethinyl	
<i>estradi-levomefolate tab</i>	
<i>3-0.03-0.451 mg</i>	53
DROXIA.....	63
droxidopa	33
DULERA AER 100-5MCG	.....73
DULERA AER 200-5MCG	.....73
DULERA AER 50-5MCG	73
duloxetine hcl.....	35
DUPIXENT	63
DUREZOL	
<i>see difluprednate</i>	69
dutasteride.....	61
dutasteride-tamsulosin hcl	
<i>cap 0.5-0.4 mg</i>	61
E	
e.e.s. 400.....	17
EC-NAPROSYN	
<i>see ec-naproxen</i>	9
<i>see naproxen</i>	9
ec-naproxen.....	9
EDURANT	14
efavirenz.....	14
efavirenz-emtricitabine-	
<i>tenofovir df tab 600-200-300 mg</i>	15
efavirenz-lamivudine-	
<i>tenofovir df tab 400-300-300 mg</i>	15
efavirenz-lamivudine-	
<i>tenofovir df tab 600-300-300 mg</i>	15
EFFEXOR XR	
<i>see venlafaxine hcl</i>	36
EFFIENT	
<i>see prasugrel hcl</i>	63
EFUDEX	
<i>see fluorouracil (topical)</i>	
.....76	
ELIGARD	20
elinest	53
ELIQUIS	62
ELIQUIS STARTER PACK	.....62
ELLENCE	19
eluryng.....	53
EMCYT	20
EMEND	
<i>see aprepitant</i>	58
EMSAM	35
emtricitabine	14
emtricitabine-tenofovir	
<i>disoproxil fumarate tab</i>	
<i>100-150 mg</i>	15
emtricitabine-tenofovir	
<i>disoproxil fumarate tab</i>	
<i>133-200 mg</i>	15
emtricitabine-tenofovir	
<i>disoproxil fumarate tab</i>	
<i>167-250 mg</i>	15
emtricitabine-tenofovir	
<i>disoproxil fumarate tab</i>	
<i>200-300 mg</i>	15
EMTRIVA.....	14
<i>see emtricitabine</i>	14
EMVERM	12
enalapril maleate	27
enalapril maleate &	
<i>hydrochlorothiazide tab</i>	
<i>10-25 mg</i>	26
enalapril maleate &	
<i>hydrochlorothiazide tab</i>	
<i>5-12.5 mg</i>	26
ENBREL	63
ENBREL MINI.....	63
ENBREL SURECLICK....	63
ENDARI	63
endocet tab 10-325mg....	10
endocet tab 2.5-325mg...10	
endocet tab 5-325mg.....10	
endocet tab 7.5-325mg...10	
ENGERIX-B	66

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

FELBATOL	
see <i>felbamate</i>	41
FELDENE	
see <i>piroxicam</i>	9
felodipine	32
FEMARA	
see <i>letrozole</i>	20
fenofibrate	30
fenofibrate micronized	30
fentanyl	9
fentanyl citrate	10
fesoterodine fumarate	61
FETZIMA	35
FETZIMA CAP TITRATIO	35
FIASP	50
FIASP FLEXTOUCH	50
FIASP PENFILL	50
FIASP PUMPCART	50
finasteride	61
fingolimod hcl	46
FINTEPLA	41
finzala	53
FIRAZYR	
see <i>icatibant acetate</i> ...	63
see <i>sajazir</i>	63
FIRMAGON	20
flac	70
FLAREX	69
FLEBOGAMMA DIF	65
flecainide acetate	30
FLOMAX	
see <i>tamsulosin hcl</i>	61
fluconazole	13
fluconazole in nacl 0.9% inj	
200 mg/100ml	13
fluconazole in nacl 0.9% inj	
400 mg/200ml	13
flucytosine	13
fludrocortisone acetate	56
flunisolide (nasal)	72
fluocinolone acetonide	75
fluocinolone acetonide (otic)	70
fluocinonide	75
fluocinonide emulsified base	75
fluorometholone (ophth)	69
fluorouracil	19
fluorouracil (topical)	76
fluoxetine hcl	36
fluphenazine decanoate	38
fluphenazine hcl	38
flurbiprofen	9
flurbiprofen sodium	69
fluticasone propionate	75
(nasal).....	73
fluticasone-salmeterol aer powder ba 100-50 mcg/act	73
fluticasone-salmeterol aer powder ba 250-50 mcg/act	73
fluticasone-salmeterol aer powder ba 500-50 mcg/act	73
fluvoxamine maleate	34
FML LIQUIFILM	
see <i>fluorometholone (ophth)</i>	69
FOCALIN	
see <i>dexmethylphenidate hcl</i>	44
fondaparinux sodium	62
FOSAMAX	
see <i>alendronate sodium</i>	
.....	51
fosamprenavir calcium	14
fosinopril sodium	27
fosinopril sodium &	
hydrochlorothiazide tab 10-12.5 mg	27
fosinopril sodium &	
hydrochlorothiazide tab 20-12.5 mg	27
FOTIVDA	22
FRUZAQLA	22
fulvestrant	20
furosemide	32
furosemide inj	32
FUZEON	14
fyavolv tab 0.5mg-2.5mcg	55
.....	55
fyavolv tab 1mg-5mcg....	55
FYCOMPA	41
G	
gabapentin.....	41
galantamine hydrobromide	
.....	34
GAMASTAN INJ	65
GAMMAGARD LIQUID	65
GAMMAGARD S/D IGA LESS TH	65
GAMMAKED	65
GAMMAPLEX	65
GAMUNEX-C	65
ganciclovir sodium	16
GARDASIL 9 INJ	66
GASTROCROM	
see <i>cromolyn sodium (mastocytosis)</i>	60
gatifloxacin (ophth)	69
GATTEX	60
GAUZE PADS 2.....	50
gavilyte-c.....	60
gavilyte-g	60
GAVRETO	22
gefitinib	22
gemcitabine hcl.....	19
GEMCITABINE	
HYDROCHLORIDE	
see <i>gemcitabine hcl</i> ...	19
gemfibrozil	30
GEMTESA	61
generlac	60
gengraf	65
GENOTROPIN	57
GENOTROPIN MINIQUICK	57
gentamicin in saline inj 0.8 mg/ml	12
gentamicin in saline inj 1 mg/ml	12
gentamicin in saline inj 1.2 mg/ml	12
gentamicin in saline inj 1.6 mg/ml	12
gentamicin in saline inj 2 mg/ml	12
gentamicin sulfate.....	12
gentamicin sulfate (ophth)	69
gentamicin sulfate (topical)	74
GENVOYA TAB	15
GEODON	

see <i>ziprasidone hcl</i> ....40	HALDOL DECANOATE 100 see <i>haloperidol</i> <i>decanoate</i>.....38	HUMIRA PEN .....64
see <i>ziprasidone mesylate</i>.....40	HALDOL DECANOATE 50 see <i>haloperidol</i> <i>decanoate</i>.....38	HUMIRA PEN KIT PS/UV.....64
GILENYA see <i>fingolimod hcl</i> .....46	halobetasol propionate ...75	HUMIRA PEN-CD/UC/HS START .....64
GILOTrif .....22	haloette.....53	HUMIRA PEN-PEDIATRIC UC S .....64
<i>glatiramer acetate</i>.....46	haloperidol.....38	HUMIRA PEN-PS/UV STARTER .....64
<i>glatopa</i>.....46	haloperidol decanoate ...38	HUMULIN R U-500 (CONCENTR.....50
GLEEVEC see <i>imatinib mesylate</i> ..22	haloperidol lactate.....38	HUMULIN R U-500 KWIKPEN.....50
GLEOSTINE .....19	HARVONI PAK 33.75- 150MG .....16	hydralazine hcl.....33
<i>glimepiride</i> .....48	HARVONI PAK 45-200MG.....16	HYDREA see <i>hydroxyurea</i>.....21
<i>glipizide</i>.....48	HARVONI TAB 45-200MG.....16	hydrochlorothiazide.....33
<i>glipizide xl</i> .....48	HARVONI TAB 90-400MG.....16	hydrocodone bitartrate.....9
<i>glipizide-metformin hcl tab</i> 2.5-250 mg.....48	HAVRIX .....66	hydrocodone- acetaminophen soln 7.5- 325 mg/15ml .....10
<i>glipizide-metformin hcl tab</i> 2.5-500 mg.....48	heather .....53	hydrocodone- acetaminophen tab 10- 325 mg .....10
<i>glipizide-metformin hcl tab</i> 5-500 mg.....48	HEP SOD/D5W INJ 20000UNT .....62	hydrocodone- acetaminophen tab 5-325 mg .....10
GLUCOTROL XL see <i>glipizide</i> .....48	HEP SOD/D5W INJ 25000UNT .....62	hydrocodone- acetaminophen tab 7.5- 325 mg .....10
see <i>glipizide xl</i>.....48	HEP SOD/NACL INJ 12500UNT .....62	hydrocodone-ibuprofen tab 7.5-200 mg .....10
<i>glycopyrrolate</i> .....59	HEP SOD/NACL INJ 25000UNT .....62	hydrocortisone .....56
<i>glydo</i>.....76	heparin sodium (porcine) 62	hydrocortisone (intrarectal) .....59
GLYXAMBI TAB 10-5 MG.....48	HEPARIN/NACL INJ 25000UNT .....62	hydrocortisone (rectal)....76
GLYXAMBI TAB 25-5 MG.....49	HEPLISAV-B.....66	hydrocortisone (topical) ..76
GOLYTELY see <i>gavilyte-g</i>.....60	HERCEP HYLEC SOL 60- 10000 .....22	hydromorphone hcl.....10
see <i>peg 3350-kcl-na</i> <i>bicarb-nacl-na sulfate</i> <i>for soln 236 gm</i>.....60	HERCEPTIN .....22	hydroxychloroquine sulfate.....64
granisetron hcl .....58	HERZUMA .....22	hydroxyurea .....21
<i>griseofulvin microsize</i> ....13	HETLIOZ see <i>tasimelteon</i>.....45	hydroxyzine hcl.....71
<i>griseofulvin ultramicrosize</i>.....13	HIBERIX .....66	hydroxyzine pamoate.....71
guanfacine hcl .....33	HIPREX see <i>methenamine</i> <i>hippurate</i>.....12	HYSINGLA ER.....9
guanfacine hcl (adhd) ....44	HUMIRA .....63	HYZAAR see <i>losartan potassium &</i> <i>hydrochlorothiazide tab</i> 100-12.5 mg .....28
GVOKE HYPOOPEN 2- PACK .....56	HUMIRA PEDIA INJ CROHNS.....63	
GVOKE KIT .....56	HUMIRA PEDIATRIC CROHNS D .....63	
GVOKE PFS .....56		
H		
HAEGARDA .....63		
hailey 1.5/30 .....53		
hailey 24 fe .....53		

see <i>losartan potassium & hydrochlorothiazide tab</i> 100-25 mg	28
see <i>losartan potassium & hydrochlorothiazide tab</i> 50-12.5 mg	28
I	
<i>ibandronate sodium</i>	51
IBRANCE	22
<i>ibu</i>	9
<i>ibuprofen</i>	9
<i>icatibant acetate</i>	63
<i>iclevia</i>	53
ICLUSIG	22
IDACIO (2 PEN)	64
IDACIO (2 SYRINGE)	64
IDACIO CROHN INJ DISEASE	64
IDACIO PLAQU INJ PSORIASIS	64
IDHIFA	22
<i>imatinib mesylate</i>	22
IMBRUVICA	22, 23
<i>imipenem-cilastatin</i> <i>intravenous for soln</i> 250 mg	12
<i>imipenem-cilastatin</i> <i>intravenous for soln</i> 500 mg	12
<i>imipramine hcl</i>	36
<i>imiquimod</i>	76
IMITREX see <i>sumatriptan</i> <i>succinate</i>	46
IMITREX STATDOSE REFILL see <i>sumatriptan</i> <i>succinate</i>	46
IMITREX STATDOSE SYSTEM see <i>sumatriptan</i> <i>succinate</i>	46
IMOVAX RABIES (H.D.C.V.)	66
IMURAN see <i>azathioprine</i>	65
INBRIJA	37
<i>incassia</i>	53
INCRELEX	57
INCRUSE ELLIPTA	70
<i>indapamide</i>	33
INDERAL LA see <i>propranolol hcl</i>	32
INFANRIX INJ	66
INFLIXIMAB	64
INLYTA	23
INQOVI TAB 35-100MG	.19
INREBIC	23
INSPRA see <i>eplerenone</i>	27
INSULIN PEN NEEDLES: BD/NOVO	50
INSULIN SAFETY NEEDLES	50
INSULIN SYRINGES: BD	50
INTELENCE	14
see <i>etravirine</i>	14
INTRALIPID	68
<i>introvale</i>	53
INTUNIV see <i>guanfacine hcl</i> (<i>adhd</i>)	44
INVEGA see <i>paliperidone</i>	39
INVEGA HAFYERA	38
INVEGA SUSTENNA	38
INVEGA TRINZA	38
IPOL INJ INACTIVE	66
<i>ipratropium bromide</i>	71
<i>ipratropium bromide (nasal)</i>	71
<i>ipratropium-albuterol nebu</i> <i>soln</i> 0.5-2.5(3) mg/3ml	70
<i>irbesartan</i>	29
<i>irbesartan-</i> <i>hydrochlorothiazide tab</i> 150-12.5 mg	28
<i>irbesartan-</i> <i>hydrochlorothiazide tab</i> 300-12.5 mg	28
IRESSA see <i>gefitinib</i>	22
<i>irinotecan hcl</i>	21
ISENTRESS	14
ISENTRESS HD	14
<i>isibloom</i>	53
ISOLYTE-P INJ /D5W	67
ISOLYTE-S INJ	67
ISOLYTE-S INJ PH 7.4	67
<i>isoniazid</i>	15
ISORDIL TITRADOSE see <i>isosorbide dinitrate</i>	33
<i>isosorbide dinitrate</i>	33
<i>isosorbide mononitrate</i> ..	33
<i>isotretinoin</i>	74
<i>isradipine</i>	32
<i>itraconazole</i>	13
<i>ivermectin</i>	12
IXIARO INJ	66
J	
JADENU see <i>deferasirox</i>	52
JADENU SPRINKLE see <i>deferasirox</i>	52
JAKAFI	23
JALYN see <i>dutasteride</i> - <i>tamsulosin hcl cap</i> 0.5- 0.4 mg	61
jantoven	62
JANUMET TAB 50-1000	.49
JANUMET TAB 50-500MG	49
JANUMET XR TAB 100- 1000	49
JANUMET XR TAB 50- 1000	49
JANUMET XR TAB 50- 500MG	49
JANUVIA	49
JARDIANC E	49
<i>jasmiel</i>	53
<i>javygtor</i>	57
JAYPIRCA	23
JENTADUETO TAB 2.5- 1000	49
JENTADUETO TAB 2.5- 500	49
JENTADUETO TAB 2.5- 850	49
JENTADUETO TAB XR 2.5-1000MG	49
JENTADUETO TAB XR 5- 1000MG	49
<i>jinteli</i>	55

<i>jolessa</i>	53	<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	67	<i>klor-con m20</i>	68
<i>juleber</i>	53			<i>KORLYM</i>	57
JULUCA TAB 50-25MG	15			<i>KOSELUGO</i>	23
<i>junel 1.5/30</i>	53			<i>kourzeq</i>	77
<i>junel 1/20</i>	53			<i>KRAZATI</i>	23
<i>junel fe 1.5/30</i>	53			<i>K-TAB</i>	
<i>junel fe 1/20</i>	53			see <i>potassium chloride</i>	68
<i>junel fe 24</i>	53			<i>kurvelo</i>	53
JYNNEOS	66			<i>KUVAN</i>	
K				see <i>javygtor</i>	57
KADCYLA	23			see <i>sapropterin dihydrochloride</i>	57
<i>kaitlib fe</i>	53				
KALETRA				L	
<i>see lopinavir-ritonavir</i>				<i>labetalol hcl</i>	31
<i>soln 400-100 mg/5ml (80-20 mg/ml)</i>	15			<i>lacosamide</i>	41
<i>see lopinavir-ritonavir tab 100-25 mg</i>	15			<i>lacosamide oral</i>	41
<i>see lopinavir-ritonavir tab 200-50 mg</i>	15			<i>lactated ringer's solution</i>	67
KALYDECO	72			<i>lactic acid (ammonium lactate)</i>	76
KANJINTI	23			<i>lactulose</i>	60
<i>kariva</i>	53			<i>lactulose (encephalopathy)</i>	60
KCL 0.3%/D5W/NACL 0.9%					
<i>see kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj</i>	67			LAMICTAL	
<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	67			<i>see lamotrigine</i>	41
<i>kcl 20 meq/l (0.149%) in nacl 0.45% inj</i>	67			<i>see subvenite</i>	42
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	67			LAMICTAL CHEWABLE DISPERS	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	67			<i>see lamotrigine</i>	41
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	67			LAMICTAL XR	
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	67			<i>see lamotrigine</i>	41
<i>klayesta</i>	74			<i>lamivudine</i>	14
KLARON				<i>lamivudine (hbv)</i>	16
<i>see sulfacetamide sodium (acne)</i>	74			<i>lamivudine-zidovudine tab 150-300 mg</i>	15
KLONOPIN				<i>lamotrigine</i>	41
<i>see clonazepam</i>	40			LANOXIN	
<i>klor-con</i>	68			<i>see digoxin</i>	33
<i>klor-con 10</i>	68			<i>lansoprazole</i>	60, 61
<i>klor-con 8</i>	68			LANTUS	50
<i>klor-con m10</i>	68			<i>LANTUS SOLOSTAR</i>	50
<i>klor-con m15</i>	68			<i>lapatinib ditosylate</i>	23

LATUDA	
see <i>lurasidone hcl</i>.....38	
layolis fe.....53	
leena.....53	
leflunomide	65
lenalidomide	20
LENVIMA 10 MG DAILY	
DOSE	23
LENVIMA 12MG DAILY	
DOSE	23
LENVIMA 20 MG DAILY	
DOSE	23
LENVIMA 4 MG DAILY	
DOSE	23
LENVIMA 8 MG DAILY	
DOSE	23
LENVIMA CAP 14 MG....23	
LENVIMA CAP 18 MG....23	
LENVIMA CAP 24 MG....23	
<i>lessina</i>	53
LETAIRIS	
see <i>ambrisentan</i>.....34	
letrozole	20
leucovorin calcium	26
LEUKERAN	19
leuprolide acetate	20
levalbuterol hcl.....71	
levalbuterol tartrate.....71	
levetiracetam	41
LEVETIRACETAM	
see <i>levetiracetam in sodium chloride iv soln 1000 mg/100ml</i>.....42	
see <i>levetiracetam in sodium chloride iv soln 1500 mg/100ml</i>.....42	
see <i>levetiracetam in sodium chloride iv soln 500 mg/100ml</i>.....42	
levetiracetam in sodium chloride iv soln 1000 mg/100ml	42
levetiracetam in sodium chloride iv soln 1500 mg/100ml	42
levetiracetam in sodium chloride iv soln 500 mg/100ml	42
levobunolol hcl.....70	
levocarnitine (<i>metabolic modifiers</i>)	57
levocetirizine	
<i>dihydrochloride</i>.....71	
levofloxacin	17
levofloxacin <i>in d5w iv soln 250 mg/50ml</i>	17
levofloxacin <i>in d5w iv soln 500 mg/100ml</i>	17
levofloxacin <i>in d5w iv soln 750 mg/150ml</i>	17
levonest	53
levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg	53
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	53
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	53
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	53
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	53
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	53
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	53
levora 0.15/30-28.....53	
levo-t.....58	
levothyroxine sodium	58
levoxyl.....58	
LEXAPRO	
see <i>escitalopram oxalate</i>	35
LEXIVA	14
see <i>fosamprenavir calcium</i>	14
LIALDA	
see <i>mesalamine</i>	59
lidocaine	76
lidocaine hcl.....76	
lidocaine hcl (<i>local anesth.</i>)	11
lidocaine hcl (<i>mouth-throat</i>)	77
lidocaine-prilocaine cream 2.5-2.5%.....76	
LIDODERM	
see <i>lidocaine</i>	76
linezolid.....12	
LINEZOLID INJ 2MG/ML 12	
LINZESS.....60	
liothyronine sodium.....58	
LIPITOR	
see <i>atorvastatin calcium</i>	30
lisinopril.....27	
lisinopril &	
<i>hydrochlorothiazide tab 10-12.5 mg</i>	27
lisinopril &	
<i>hydrochlorothiazide tab 20-12.5 mg</i>	27
lisinopril &	
<i>hydrochlorothiazide tab 20-25 mg</i>	27
LITHIUM	46
lithium carbonate	46
LITHOBID	
see <i>lithium carbonate</i> ..46	
LODINE	
see <i>etodolac</i>.....9	
loestrin 1.5/30-21	53
loestrin 1/20-21.....53	
loestrin fe 1.5/30	53
loestrin fe 1/20	53
LOKELMA	52
LOMOTIL	
see <i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	60
LONSURF TAB 15-6.14 .19	
LONSURF TAB 20-8.19 .19	
loperamide hcl	60
LOPID	
see <i>gemfibrozil</i>	30
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	15
lopinavir-ritonavir tab 100-25 mg	15

<i>lopinavir-ritonavir tab 200-50 mg</i>.....15	<i>see omega-3-acid ethyl esters cap 1 gm</i>.....31	MAGNESIUM SULFATE IN D5W
LOPRESSOR	<i>LOVENOX</i>	<i>see magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>.....67
<i>see metoprolol tartrate</i> 31	<i>see enoxaparin sodium</i>	<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>.....67
<i>lorazepam</i>.....34	.....62	<i>MALARONE</i>
<i>lorazepam intensol</i>.....34	<i>low-ogestrel</i>.....54	<i>see atovaquone-proguanil hcl tab 250-100 mg</i>.....13
LORBRENA.....23	<i>loxapine succinate</i>.....38	<i>see atovaquone-proguanil hcl tab 62.5-25 mg</i>.....13
<i>loryna</i>.....53	<i>LUMAKRAS</i>.....23	<i>malathion</i>.....76
<i>losartan potassium</i>.....29	<i>LUMIGAN</i>.....70	<i>maraviroc</i>.....14
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>.....28	<i>LUMIZYME</i>.....57	<i>MARINOL</i>
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>.....28	<i>LUNESTA</i>	<i>see dronabinol</i>.....58
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>.....28	<i>see eszopiclone</i> .....45	<i>marlissa</i>.....54
LOTEMAX	<i>LUPRON DEPOT (1-MONTH)</i>.....20	<i>MARPLAN</i>.....36
LOTENSIN	<i>LUPRON DEPOT (3-MONTH)</i>.....20	<i>MATULANE</i>.....21
<i>see benazepril hcl</i> .....27	<i>LUPRON DEPOT-PED (1-MONTH)</i>.....57	<i>MAVYRET PAK 50-20MG</i>
LOTENSIN HCT	<i>LUPRON DEPOT-PED (3-MONTH)</i>.....57	.....16
<i>see benazepril & hydrochlorothiazide tab 10-12.5 mg</i> .....26	<i>lurasidone hcl</i>.....38	<i>MAVYRET TAB 100-40MG</i>
<i>see benazepril & hydrochlorothiazide tab 20-12.5 mg</i> .....26	<i>lutera</i>.....54	.....16
<i>see benazepril & hydrochlorothiazide tab 20-25 mg</i> .....26	<i>lyeq</i>.....54	<i>MAXALT</i>
LOTREL	<i>lyllana</i>.....55	<i>see rizatriptan benzoate</i>
<i>see amlodipine besylate-benazepril hcl cap 10-20 mg</i> .....26	<i>LYNPARZA</i>.....23	.....45
<i>see amlodipine besylate-benazepril hcl cap 10-40 mg</i> .....26	<i>LYRICA</i>	<i>MAXALT-MLT</i>
<i>see amlodipine besylate-benazepril hcl cap 5-10 mg</i> .....26	<i>see pregabalin</i>.....42	<i>see rizatriptan benzoate</i>
<i>see amlodipine besylate-benazepril hcl cap 5-20 mg</i> .....26	<i>LYSODREN</i>.....20	.....45
LOTRONEX	<i>LYTGOBI (12 MG DAILY DOSE)</i>.....23	<i>MAXITROL</i>
<i>see alosetron hcl</i>.....60	<i>LYTGOBI (16 MG DAILY DOSE)</i>.....23	<i>see neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>.....68
<i>lovastatin</i>.....30	<i>LYTGOBI (20 MG DAILY DOSE)</i>.....23	<i>see neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>.....68
LOVAZA	<i>lyza</i>.....54	<i>MAXZIDE</i>
	M	<i>see triamterene & hydrochlorothiazide tab 75-50 mg</i> .....33
	MACROBID	<i>MAXZIDE-25</i>
	<i>see nitrofurantoin monohyd macro</i>.....12	<i>see triamterene & hydrochlorothiazide tab 37.5-25 mg</i> .....33
	MACRODANTIN	<i>meclizine hcl</i> .....58
	<i>see nitrofurantoin macrocrystal</i>.....12	<i>MEDROL</i>
	<i>magnesium sulfate</i>.....67	
	MAGNESIUM SULFATE 67	
	<i>see magnesium sulfate</i>	
	.....67	

see <i>methylprednisolone</i>	.....56
MEDROL DOSEPAK	
<i>see methylprednisolone</i>	.....56
medroxyprogesterone	
acetate	57
medroxyprogesterone	
acetate (contraceptive).....54	
mefloquine hcl	13
megestrol acetate	20, 58
megestrol acetate	
(appetite).....58	
MEKINIST	23, 24
MEKTOVI	24
meloxicam	9
memantine hcl	34, 35
memantine hcl tab 28 x 5	
mg & 21 x 10 mg titration pack	35
MENACTRA INJ	66
MENQUADFI INJ	66
MENVEO INJ.....	66
MENVEO SOL.....	66
MEPRON	
<i>see atovaquone</i>.....11	
mercaptopurine.....	19
meropenem	12
mesalamine	59
mesalamine w/ cleanser ..59	
MESNEX	26
MESTINON	
<i>see pyridostigmine</i>	
bromide	46
metformin hcl.....	49
methadone hcl	10
methadone hydrochloride i	
.....10	
METHADOSE	
<i>see methadone</i>	
hydrochloride i	10
methazolamide	33
methenamine hippurate..	12
methimazole	58
methocarbamol.....	47
methotrexate sodium ..19, 65	
methsuximide	42
METHYLIN	
see <i>methylphenidate hcl</i>	
.....44	
<i>methylphenidate hcl</i>.....44	
<i>methylprednisolone</i>.....56	
<i>methylprednisolone acetate</i>	
.....56	
<i>methylprednisolone sod</i>	
succ.....56	
<i>methyltestosterone</i>	48
<i>metoclopramide hcl</i>.....59	
<i>metolazone</i>	33
<i>metoprolol &</i>	
<i>hydrochlorothiazide tab</i>	
100-25 mg.....31	
<i>metoprolol &</i>	
<i>hydrochlorothiazide tab</i>	
50-25 mg.....31	
<i>metoprolol succinate</i>.....31	
<i>metoprolol tartrate</i>.....31	
METROCREAM	
<i>see metronidazole</i>	
(<i>topical</i>).....76	
METROLOTION	
<i>see metronidazole</i>	
(<i>topical</i>).....76	
<i>metronidazole</i>	12
METRONIDAZOLE	
<i>see metronidazole</i>.....12	
<i>metronidazole (<i>topical</i>)</i> ..76	
<i>metronidazole vaginal</i>.....62	
<i>metyrosine</i>	33
MG SO4/D5W INJ	
10MG/ML	67
<i>mibelas 24 fe</i>	54
<i>micafungin sodium</i>.....13	
MICARDIS	
<i>see telmisartan</i>.....29	
MICARDIS HCT	
<i>see telmisartan-</i>	
<i>hydrochlorothiazide tab</i>	
40-12.5 mg	29
<i>see telmisartan-</i>	
<i>hydrochlorothiazide tab</i>	
80-12.5 mg	29
see <i>telmisartan-</i>	
<i>hydrochlorothiazide tab</i>	
80-25 mg	29
<i>microgestin 1.5/30</i>	54
<i>microgestin 1/20</i>	54
<i>microgestin 24 fe</i>	54
<i>microgestin fe 1.5/30</i>	54
<i>microgestin fe 1/20</i>	54
<i>midodrine hcl</i>	33
<i>miglustat</i>	57
MIGRAL	
<i>see dihydroergotamine</i>	
<i>mesylate</i>	45
<i>mihi</i>	54
<i>mimvey</i>	55
MINASTRIN 24 FE	
<i>see finzala</i>.....53	
<i>see mibelas 24 fe</i>.....54	
<i>see norethindrone ace-</i>	
<i>eth estradiol-fe chew</i>	
<i>tab 1 mg-20 mcg (24)</i>	
.....54	
MINIPRESS	
<i>see prazosin hcl</i>	27
MINIVELLE	
<i>see lyllana</i>	55
<i>minocycline hcl</i>	19
<i>minoxidil</i>	33
<i>mirtazapine</i>	36
<i>misoprostol</i>	60
MITIGARE	9
M-M-R II INJ	66
M-NATAL PLUS TAB.....	68
<i>modafinil</i>	47
<i>moexipril hcl</i>	27
<i>molindone hcl</i>	38
<i>mometasone furoate</i>	76
MONJUVI.....	24
<i>mono-linyah</i>	54
<i>montelukast sodium</i>	71
<i>morphine sulfate</i>	10
MORPHINE SULFATE ..10	
MORPHINE	
<i>SULFATE/SODIUM C.10</i>	
MOUNJARO	49
MOVANTIK	60
<i>moxifloxacin hcl</i>	17
<i>moxifloxacin hcl (ophth)</i> ..69	

<i>moxifloxacin hcl</i> 400 mg/250ml in sodium chloride 0.8% inj.....17	NAMZARIC CAP 7-10MG	35
MS CONTIN see <i>morphine sulfate</i> ...10	NAMZARIC CAP PACK..35	
MULTAQ.....30	NAPROSYN see <i>naproxen</i> .....9	
<i>multiple electrolytes ph</i> 5.5	naproxen.....9	
<i>multiple electrolytes ph</i> 7.4	naproxen sodium .....9	
<i>multiple electrolytes ph</i> 7.4	naratriptan hcl.....45	
<i>mupirocin</i> .....74	NARDIL see <i>phenelzine sulfate</i> 36	
MYAMBUTOL see <i>ethambutol hcl</i>.....15	NATACYN .....69	
MYCAMINE see <i>micafungin sodium</i> 13	nateglinide .....49	
MYCOBUTIN see <i>rifabutin</i> .....15	NATPARA.....52	
<i>mycophenolate mofetil</i>....65	NAYZILAM.....42	
<i>mycophenolate sodium</i> ...65	<i>nebivolol hcl</i>.....31, 32	
MYFORTIC see <i>mycophenolate sodium</i>.....65	NEBUPENT see <i>pentamidine isethionate inh</i> .....12	
MYRBETRIQ .....61	necon 0.5/35-28.....54	
mysoline see <i>primidone</i>.....42	nefazodone hcl .....36	
N	<i>neomycin sulfate</i>.....12	
<i>nabumetone</i>.....9	<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	69
<i>nadolol</i>.....31	<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>....69	
<i>nafcillin sodium</i>.....18	<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	68
NAGLAZYME .....57	<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	68
<i>nalbuphine hcl</i> .....11	<i>neomycin-polymyxin-hc ophth susp</i>.....68	
<i>naloxone hcl</i> .....48	<i>neomycin-polymyxin-hc otic soln 1%</i>	70
<i>naltrexone hcl</i> .....48	<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	70
NAMENDA see <i>memantine hcl</i>.....35	<i>neo-polycin 5(3.5)mg-400unt-10000unt op oin</i>	69
NAMENDA TITRATION PAK see <i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>.....35	<i>neo-polycin hc ophth oint 1%</i>.....68	
NAMENDA XR see <i>memantine hcl</i>.....34	NEORAL	
NAMZARIC CAP 14-10MG		
NAMZARIC CAP 21-10MG		
NAMZARIC CAP 28-10MG		
see cyclosporine modified (for microemulsion) .....65		
see gengraf.....65		
NERLYNX.....24		
NEUPRO .....37		
NEURONTIN see <i> gabapentin</i>.....41		
<i>nevirapine</i> .....14		
NEXAVAR.....24 see <i>sorafenib tosylate</i> .24		
NEXIUM see <i>esomeprazole magnesium</i>.....60		
<i>niacin (antihyperlipidemic)</i>		31
<i>nicardipine hcl</i>.....32		
NICOTROL INHALER....48		
NICOTROL NS .....48		
<i>nifedipine</i> .....32		
<i>nikki</i> .....54		
NILANDRON see <i>nilutamide</i>.....20		
<i>nilutamide</i>		20
<i>nimodipine</i>		32
NINLARO.....24		
<i>nitazoxanide</i>.....12		
<i>nitisinone</i>		57
NITRO-BID .....33		
<i>nitrofurantoin macrocrystal</i>		12
<i>nitrofurantoin monohyd macro</i>		12
<i>nitroglycerin</i> .....33, 34		
NITROLINGUAL see <i>nitroglycerin</i>.....34		
NITROSTAT see <i>nitroglycerin</i>.....34		
<i>nizatidine</i>		59
<i>nora-be</i>		54
<i>norelgestromin-ethinyl estradiol td ptwk</i> 150-35 mcg/24hr		54
<i>norethindrone & ethinyl estradiol-fe chew tab</i> 0.4 mg-35 mcg		54
<i>norethindrone & ethinyl estradiol-fe chew tab</i> 0.8 mg-25 mcg		54

<i>norethindrone</i>	see <i>amlodipine besylate</i>
(contraceptive)	54
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	54
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	54
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	54
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	54
<i>norethindrone acetate</i>	58
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	55
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	55
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	54
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	54
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	54
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	54
<i>norlyroc</i>	54
NORPACE	
<i>see disopyramide phosphate</i>	30
NORPACE CR	30
NORPRAMIN	
<i>see desipramine hcl</i>	35
NORTHERA	
<i>see droxidopa</i>	33
<i>nortrel 0.5/35 (28)</i>	54
<i>nortrel 1/35 (21)</i>	54
<i>nortrel 1/35 (28)</i>	54
<i>nortrel 7/7/7</i>	54
<i>nortriptyline hcl</i>	36
NORVASC	
	see <i>aurobindo</i>
	32
NORVIR	14
<i>see ritonavir</i>	14
NOVOLIN INJ 70/30	50
NOVOLIN INJ 70/30 FP	50
NOVOLIN N	50
NOVOLIN N FLEXPEN	50
NOVOLIN R	51
NOVOLIN R FLEXPEN	51
NOVOLOG	51
NOVOLOG FLEXPEN	51
NOVOLOG MIX INJ 70/30	51
NOVOLOG MIX INJ FLEXPEN	51
NOVOLOG PENFILL	51
NOXAFL	
<i>see posaconazole</i>	13
NUBEQA	20
NUDEXTA CAP 20-10MG	46
NULOJIX	65
NUPLAZID	38
NURTEC	45
NUTRILIPID	68
NUVARING	
<i>see eluryng</i>	53
<i>see enilloring</i>	53
<i>see etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	53
<i>see haloette</i>	53
NUVIGIL	
<i>see armodafinil</i>	47
NUZYRA	19
<i>nyamyc</i>	74
<i>nylia 1/35</i>	54
<i>nylia 7/7/7</i>	54
NYMALIZE	32
<i>nymyo</i>	54
<i>nystatin</i>	13
<i>nystatin (mouth-throat)</i>	77
<i>nystatin (topical)</i>	74
<i>nystop</i>	74
O	
<i>ocella</i>	54
OCTAGAM	65
<i>octreotide acetate</i>	57
OCUFLOX	
<i>see ofloxacin (ophth)</i>	69
ODEFSEY TAB	15
ODOMZO	24
OFEV	72
<i>ofloxacin (ophth)</i>	69
<i>ofloxacin (otic)</i>	70
OGIVRI	24
OGIVRI INJ 420MG	24
OGSIVEO	24
OJJAARA	24
<i>olanzapine</i>	38, 39
<i>olmesartan medoxomil</i>	29
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	28
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	28
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	29
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	28
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	28
<i>omega-3-acid ethyl esters cap 1 gm</i>	31
<i>omeprazole</i>	61
OMNIPOD 5 G6 KIT	
<i>INTRO</i>	51
OMNIPOD 5 G6 MIS PODS	
<i>INTRO</i>	51
OMNIPOD DASH KIT	
<i>INTRO</i>	51
OMNIPOD DASH MIS PODS	
<i>INTRO</i>	51

OMNIPOD GO KIT	
10UNT/DY.....	51
OMNIPOD GO KIT	
15UNT/DY.....	51
OMNIPOD GO KIT	
20UNT/DY.....	51
OMNIPOD GO KIT	
25UNT/DY.....	51
OMNIPOD GO KIT	
30UNT/DY.....	51
OMNIPOD GO KIT	
35UNT/DY.....	51
OMNIPOD MIS CLASSIC	
.....	51
ondansetron.....	59
ondansetron hcl.....	59
ONFI	
see clobazam.....	40
ONTRUZANT	24
ONUREG	19
OPSUMIT	34
ORFADIN	
see nitisinone.....	57
ORGOVYX	20
ORKAMBI GRA 100-125	72
ORKAMBI GRA 150-188	72
ORKAMBI GRA 75-94MG	
.....	72
ORKAMBI TAB 100-125	.72
ORKAMBI TAB 200-125	.72
ORSERDU.....	20
ORTHO TRI-CYCLEN LO	
see norgestimate-eth	
estradiol tab 0.18-	
25/0.215-25/0.25-25	
mg-mcg	54
see tri-lo-estarylla.....	55
see tri-lo-marzia	55
see tri-lo-mili.....	55
see tri-lo-sprintec.....	55
see tri-vylibra lo.....	55
oseltamivir phosphate.....	16
OTEZLA.....	64
OTEZLA TAB 10/20/30...	64
oxacillin sodium	18
oxaliplatin.....	19
oxcarbazepine	42
oxybutynin chloride	61
oxycodone hcl.....	11
oxycodone w/	
acetaminophen tab 10-	
325 mg	11
oxycodone w/	
acetaminophen tab 2.5-	
325 mg	11
oxycodone w/	
acetaminophen tab 5-325	
mg	11
oxycodone w/	
acetaminophen tab 7.5-	
325 mg	11
OZEMPIC (0.25 OR 0.5	
MG/DOSE)	49
OZEMPIC (0.25 OR	
0.5MG/DOSE)	49
OZEMPIC (1MG/DOSE) .49	
OZEMPIC (2MG/DOSE) .49	
P	
pacerone.....	30
paclitaxel.....	21
paclitaxel protein-bound	
particles for iv susp 100	
mg	21
paliperidone	39
PAMELOR	
see nortriptyline hcl	36
pamidronate disodium	52
PAMIDRONATE	
DISODIUM	52
PANRETIN	76
pantoprazole sodium	61
PANZYGA	65
paraplatin.....	19
paricalcitol.....	58
PARLODEL	
see bromocriptine	
mesylate	36
PARNATE	
see tranylcypromine	
sulfate.....	36
paromomycin sulfate.....	12
paroxetine hcl	36
PAXIL	
see paroxetine hcl.....	36
pazopanib hcl.....	24
PEDIAPRED	
see prednisolone sodium	
phosphate.....	56
PEDIARIX INJ 0.5ML.....	66
PEDVAX HIB	66
peg 3350-kcl-na bicarb-	
nacl-na sulfate for soln	
236 gm	60
peg 3350-kcl-sod bicarb-	
nacl for soln 420 gm....	60
PEGASYS.....	16
PEMAZYRE	24
pemetrexed disodium	19
PEN GK/DEXTR INJ	
40000/ML	18
PEN GK/DEXTR INJ	
60000/ML	18
PENBRAYA INJ.....	66
penicillamine	52
penicillin g potassium.....	18
penicillin g sodium	18
penicillin v potassium.....	18
PENTACEL INJ	66
PENTAM 300	
see pentamidine	
isethionate inj.....	12
pentamidine isethionate inh	
.....	12
pentamidine isethionate inj	
.....	12
pentoxifylline	63
PEPCID	
see famotidine.....	59
PERCOCET	
see endocet tab 10-	
325mg.....	10
see endocet tab 2.5-	
325mg.....	10
see endocet tab 5-325mg	
.....	10
see endocet tab 7.5-	
325mg.....	10
see oxycodone w/	
acetaminophen tab 10-	
325 mg	11
see oxycodone w/	
acetaminophen tab	
2.5-325 mg	11

see oxycodone w/ acetaminophen tab 5- 325 mg	11	piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm).....	18	potassium chloride 20 meq/l (0.15%) in dextrose 5% inj.....	68
see oxycodone w/ acetaminophen tab 7.5-325 mg	11	piperacillin sod-tazobactam sod for inj 40.5 gm (36- 4.5 gm).....	18	potassium chloride microencapsulated crystals er.....	68
PERIDEX		PIQRAY 200MG DAILY		POTASSIUM	
see chlorhexidine gluconate (mouth- throat).....	77	DOSE	24	CHLORIDE/SODIUM	
see periogard.....	77	PIQRAY 250MG TAB		see kcl 20 meq/l (0.15%)	
perindopril erbumine.....	27	DOSE	24	in nacl 0.45% inj	67
periogard	77	PIQRAY 300MG DAILY		see kcl 20 meq/l (0.15%)	
permethrin	76	DOSE	24	in nacl 0.9% inj	67
perphenazine.....	39	pirfenidone	72	see kcl 40 meq/l (0.3%)	
PERSERIS	39	piroxicam	9	in nacl 0.9% inj	67
pfizerpen.....	18	PLAQUENIL		potassium citrate	
phenelzine sulfate.....	36	see hydroxychloroquine sulfate.....	64	(alkalinizer).....	61
PHENERGAN		PLASMA-LYTE A		PRADAXA	62
see promethazine hcl..	59	see multiple electrolytes ph 7.4	67	see dabigatran etexilate mesylate	62
phenobarbital.....	42	PLASMA-LYTE INJ -148	67	pramipexole	
phenobarbital sodium	42	PLASMA-LYTE INJ -A	67	dihydrochloride.....	37
phenytek.....	42	PLASMA-LYTE-148		prasugrel hcl	63
phenytoin.....	42	see multiple electrolytes ph 5.5	67	pravastatin sodium	30
phenytoin sodium.....	42	PLAVIX		praziquantel	12
phenytoin sodium extended		see clopidogrel bisulfate	63	prazosin hcl	27
.....	42	plenamine	68	PRED FORTE	
PHESGO SOL	24	PLENUV SOL	60	see prednisolone acetate (ophth)	69
philith	54	podofilox	76	prednisolone	56
PIFELTRO	14	polycin ophth oint	69	prednisolone acetate (ophth)	69
pilocarpine hcl.....	70	polymyxin b-trimethoprim ophth soln 10000 unit/ml- 0.1%.....	69	PREDNISOLONE SODIUM	
pilocarpine hcl (oral)	77	POMALYST	20	PHOSP	69
pimozide	39	portia-28	54	prednisolone sodium phosphate	56
pimtrea.....	54	posaconazole	13	prednisone	56
pindolol	32	POT CHL 20MEQ/L IN		PREDNISONE INTENSOL	
pioglitazone hcl.....	49	NACL 0.45% INJ	67	.....	56
pioglitazone hcl-metformin		POT CHL 20MEQ/L IN		pregabalin	42
hcl tab 15-500 mg	49	NACL 0.9% INJ	67	PREHEVBARIO	66
pioglitazone hcl-metformin		POT CHL 40MEQ/L IN		PREMASOL SOL 10%	68
hcl tab 15-850 mg	49	NACL 0.9% INJ	67	PRENATAL TAB 27-1MG	
na for inj 3.375 gm (3- 0.375 gm).....	18	POTassium CHLORIDE		.....	68
piperacillin sod-tazobactam		.....	67	PRENATAL TAB PLUS	68
na for inj 13.5 gm (12- 1.5 gm).....	18	see potassium chloride 68		PREVACID	
piperacillin sod-tazobactam				see lansoprazole	61
sod for inj 2.25 gm (2- 0.25 gm).....	18			prevalite	31
				PREVYMIS	16

PREZCOBIX TAB 800-150	30
.....	15
PREZISTA	70
see darunavir	14
PRIFTIN	32
primaquine phosphate	58
PRIMAQUINE	66
PHOSPHATE	32
see primaquine	13
phosphate	14
PRIMAXIN IV	68
see imipenem-cilastatin	13
intravenous for soln	12
500 mg	42
primidone	42
PRIORIX INJ	66
PRISTIQ	71
see desvenlafaxine	13
succinate	35
PRIVIGEN	57
probencid	59
PROCARDIA XL	59
see nifedipine	32
prochlorperazine	59
prochlorperazine edisylate	59
prochlorperazine maleate	59
PROCRT	62
PROCTOCORT	62
see hydrocortisone	13
(rectal)	76
procto-med hc	76
proctosol hc	76
protozone-hc	76
progesterone	58
PROGLYCEM	58
see diazoxide	56
PROGRAF	56
see tacrolimus	66
PROLASTIN-C	66
PROLENSA	66
see bromfenac sodium	13
(ophth)	69
PROLIA	69
PROMACTA	69
promethazine hcl	59
PROMETRIUM	59
see progesterone	58
propafenone hcl	30
proparacaine hcl	70
propranolol hcl	32
propylthiouracil	58
PROQUAD INJ	66
PROSCAR	61
see finasteride	61
PROSOL INJ 20%	68
PROTONIX	61
see pantoprazole sodium	61
protriptyline hcl	36
PROVENTIL HFA	71
see albuterol sulfate	71
PROVERA	57
see	57
medroxyprogesterone	57
acetate	57
PROVIGIL	47
see modafinil	47
PROZAC	36
see fluoxetine hcl	36
PULMICORT	73
see budesonide	73
(inhalation)	73
PULMOZYME	72
PURIXAN	19
pyrazinamide	15
pyridostigmine bromide	46
Q	24
QINLOCK	24
QUADRACEL INJ	66
QUADRACEL INJ 0.5ML	66
QUALAQUIN	66
see quinine sulfate	14
QUESTRAN	30
see cholestyramine	30
QUESTRAN LIGHT	30
see cholestyramine light	30
see prevalite	31
quetiapine fumarate	39
quinapril hcl	27
quinidine sulfate	30
quinine sulfate	14
QULIPTA	45
R	66
RABAVERT INJ	66
rabeprozole sodium	61
raloxifene hcl	57
ramipril	27
ranolazine	33
RAPAMUNE	66
see sirolimus	66
rasagiline mesylate	37
RAYALDEE	58
RECLAST	52
see zoledronic acid	52
reclipsen	54
RECOMBIVAX HB	66
RECTIV	76
REGLAN	59
see metoclopramide hcl	59
REGRANEX	77
RELENZA DISKHALER	16
RELISTOR	60
REMERON	36
see mirtazapine	36
REMERON SOLTAB	36
see mirtazapine	36
REMICADE	64
RENFLEXIS	64
RENVELA	57
see sevelamer carbonate	57
repaglinide	49
REPATHA	31
REPATHA PUSHTRONEX	31
SYSTEM	31
REPATHA SURECLICK	31
RESTASIS	70
RESTASIS MULTIDOSE	70
RESTORIL	45
see temazepam	45
RETEVMO	24
RETIN-A	74
see tretinoin	74
RETROVIR	14
see zidovudine	14
REVATIO	34
see sildenafil citrate	34
(pulmonary	34
hypertension)	34
REVLIMID	20
REXULTI	39
REYATAZ	14
see atazanavir sulfate	14

REZLIDHIA	24
REZUROCK	65
RHOPRESSA	70
ribavirin (hepatitis c)	16
rifabutin	15
RIFADIN	
see rifampin	15
rifampin	15
RILUTEK	
see riluzole	46
riluzole	46
rimantadine hydrochloride	
.....	16
RINVOQ	64
risedronate sodium	52
RISPERDAL	
see risperidone	39
RISPERDAL CONSTA	39
risperidone	39
RITALIN	
see methylphenidate hcl	
.....	44
ritonavir	14
rivastigmine	35
rivastigmine tartrate	35
rivelsa	54
rizatriptan benzoate	45
ROBINUL	
see glycopyrrolate	59
ROBINUL FORTE	
see glycopyrrolate	59
ROCALTROL	
see calcitriol	58
see calcitriol (oral)	58
ROCKLATAN DRO	70
roflumilast	72
ropinirole hydrochloride	37
rosuvastatin calcium	30
ROTARIX SUS	66
ROTATEQ SOL	66
ROWASA	
see mesalamine w/ cleanser	59
roweepra	42
ROXICODONE	
see oxycodone hcl	11
ROZLYTREK	24
RUBRACA	24
rufinamide	42
RUKOBIA	14
RYBELSUS	49
RYDAPT	24
S	
SABRIL	
see vigabatrin	43
see vigadronе	43
SAFYRAL	
see drospirenone-ethynodiol estradiol-levomefolate	
tab 3-0.03-0.451 mg	53
see tydemy	55
sajazir	63
SALAGEN	
see pilocarpine hcl (oral)	
.....	77
SANDIMMUNE	65
see cyclosporine	65
SANDOSTATIN	
see octreotide acetate	57
SANTYL	77
SAPHRIS	
see asenapine maleate	
.....	37
sapropterin dihydrochloride	
.....	57
SCEMBLIX	24
scopolamine	59
SECUADO	39
selegiline hcl	37
selenium sulfide	75
SELZENTRY	14
see maraviroc	14
SENSIPAR	
see cinacalcet hcl	56
SEREVENT DISKUS	71
SEROQUEL	
see quetiapine fumarate	
.....	39
SEROQUEL XR	
see quetiapine fumarate	
.....	39
sertraline hcl	36
setlakin	54
sevelamer carbonate	57
sharobel	54
SHINGRIX	66
SIGNIFOR	57
<i>sildenafil citrate (pulmonary hypertension)</i>	34
SILENOR	
see doxepin hcl (sleep)	
.....	45
SILVADENE	
see silver sulfadiazine	74
see ssd	74
silver sulfadiazine	74
SIMBRINZA SUS 1-0.2%70	
simliya	54
simpesse	54
simvastatin	30
SINEMET	
see carbidopa & levodopa tab 10-100 mg	37
see carbidopa & levodopa tab 25-100 mg	37
SINGULAIR	
see montelukast sodium	
.....	71
sirolimus	66
SIRTURO	15
SIVEXTRO	12
SKYRIZI	64
SKYRIZI PEN	64
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	60
sodium chloride	68
sodium chloride (gu irrigant)	77
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	68
SODIUM OXYBATE	47
sodium phenylbutyrate	57
sodium polystyrene sulfonate powder	52
solifenacin succinate	61
SOLIQUA INJ 100/33	51
SOLTAMOX	20
SOLU-CORTEF	56
SOLU-MEDROL	
see methylprednisolone sod succ	56
SOMA	
see carisoprodol	47

SOMATULINE DEPOT	57
SOMAVERT	57
sorafenib tosylate	24
sorine	30
sotalol hcl	30
sotalol hcl (afib/afl)	30
spironolactone	27
spironolactone &	
hydrochlorothiazide tab	
25-25 mg	33
SPORANOX	
see itraconazole	13
sprintec	28
SPRITAM	42
SPRYCEL	24
sps	52
sronyx	54
ssd	74
STALEVO 100	
see carbidopa-levodopa-entacapone tabs 25-100-200 mg	37
STALEVO 125	
see carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	37
STALEVO 150	
see carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	37
STALEVO 200	
see carbidopa-levodopa-entacapone tabs 50-200-200 mg	37
STALEVO 50	
see carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	37
STALEVO 75	
see carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	37
STELARA	64
STIVARGA	24
STRATTERA	
see atomoxetine hcl	44
streptomycin sulfate	12
STRIBILD TAB	15
STROMECTOL	
see ivermectin	12
SUBOXONE	
see buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	47
see buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	47
see buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	47
see buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	47
subvenite	42
sucralfate	60
sulfacetamide sodium (acne)	74
sulfacetamide sodium (ophth)	69
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	68
sulfadiazine	12
sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml	12
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	12
sulfamethoxazole-trimethoprim tab 400-80 mg	12
sulfamethoxazole-trimethoprim tab 800-160 mg	12
SULFAMYLYON	74
sulfasalazine	59, 60
sulindac	9
sumatriptan	45
sumatriptan succinate	45, 46
sunitinib malate	24
SUNLENCA	14
SUPREP BOWEL PREP KIT	
see sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	60
SUSTIVA	
see efavirenz	14
SUTENT	
see sunitinib malate	24
syeda	54
SYMDEKO TAB 100-150	72
SYMDEKO TAB 50-75MG	
SYMF1	
see efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	15
SYMF1 LO	
see efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	15
SYMPAZAN	43
SYMTUZA TAB	15
SYNALAR	
see fluocinolone acetonide	75
SYNAREL	55
SYNJARDY TAB 12.5-1000MG	50
SYNJARDY TAB 12.5-500	50
SYNJARDY TAB 5-1000MG	50
SYNJARDY TAB 5-500MG	49
SYNJARDY XR TAB 10-1000	50
SYNJARDY XR TAB 12.5-1000	50
SYNJARDY XR TAB 25-1000	50
SYNJARDY XR TAB 5-1000MG	50
SYNTHROID	58
see euthyrox	58
see levo-t	58
see levothyroxine sodium	58
see levoxyl	58
see unithroid	58
SYPRINE	
see trientine hcl	52
T	
TABLOID	19

TABRECTA	24
tacrolimus	66
tacrolimus (topical).....	76
TAFINLAR	24
TAGRISSO	25
TALTZ.....	64
TALZENNA.....	25
TAMIFLU see oseltamivir	
phosphate.....	16
tamoxifen citrate	20
tamsulosin hcl.....	61
TARCEVA see erlotinib hcl.....	22
TARGETIN see bexarotene	21
see bexarotene (topical)	
.....	76
tarina 24 fe.....	54
tarina fe 1/20 eq.....	54
TASIGNA	25
tasimelteon	45
tazarotene.....	75
tazicef	17
TAZORAC	75
see tazarotene	75
taztia xt	32
TAZVERIK	25
TDVAX INJ 2-2 LF	66
TECENTRIQ	25
TEFLARO	17
TEGRETOL see carbamazepine....	40
see epitol.....	41
TEGRETOL-XR see carbamazepine....	40
TEKTURNA see aliskiren fumarate.	33
telmisartan	29
telmisartan-amlodipine tab 40-10 mg.....	29
telmisartan-amlodipine tab 40-5 mg.....	29
telmisartan-amlodipine tab 80-10 mg.....	29
telmisartan-amlodipine tab 80-5 mg.....	29
telmisartan- hydrochlorothiazide tab 40-12.5 mg.....	29
telmisartan- hydrochlorothiazide tab 80-12.5 mg.....	29
telmisartan- hydrochlorothiazide tab 80-25 mg.....	29
temazepam.....	45
TENIVAC INJ 5-2LF	66
tenofovir disoproxil fumarate.....	14
TENORETIC 100 see atenolol &	
chlorthalidone tab 100- 25 mg	31
TENORETIC 50 see atenolol &	
chlorthalidone tab 50- 25 mg	31
TENORMIN see atenolol.....	31
TEPMETKO	25
terazosin hcl.....	27
terbinafine hcl	13
terbutaline sulfate	71
terconazole vaginal.....	62
TERIPARATIDE.....	52
testosterone.....	48
testosterone cypionate....	48
testosterone enanthate	48
tetrabenazine	46
tetracycline hcl.....	19
THALOMID	20
THEO-24	72
theophylline	72
thioridazine hcl.....	39
thiothixene	39
tiadylt er.....	32
tiagabine hcl	43
TIAZAC see diltiazem hcl	
extended release	
beads.....	32
see taztia xt.....	32
see tiadylt er.....	32
TIBSOVO.....	25
TICOVAC.....	66
tigecycline	19
TIKOSYN see dofetilide.....	30
tilia fe	54
timolol maleate.....	32
timolol maleate (ophth) ..	70
tinidazole	13
TIVICAY	14
TIVICAY PD	14
tizanidine hcl.....	47
TOBRADEX OIN 0.3-0.1%	68
TOBRADEX ST SUS 0.3- 0.05	68
tobramycin	13
tobramycin (ophth).....	69
tobramycin sulfate.....	13
tobramycin-dexamethasone ophth susp 0.3-0.1% ..	68
tolterodine tartrate.....	61
TOPAMAX see topiramate	43
TOPAMAX SPRINKLE see topiramate	43
topiramate.....	43
TOPROL XL see metoprolol succinate	
.....	31
toremifene citrate	20
torsemide	33
TOUJEO MAX SOLOSTAR	51
TOUJEO SOLOSTAR.....	51
TOVIAZ see fesoterodine	
fumarate	61
TPN ELECTROL INJ	68
TRACLEER see bosentan.....	34
TRADJENTA	50
tramadol hcl	11
tramadol-acetaminophen tab 37.5-325 mg	11
trandolapril	27
tranexamic acid.....	63
TRANSDERM-SCOP see scopolamine	59
tranylcypromine sulfate... <td>36</td>	36
TRAVASOL INJ 10%	68

TRAZIMERA.....	25
trazodone hcl.....	36
TRECATOR.....	15
TRELEGY AER ELLIPTA 100-62.5-25 MCG	70
TRELEGY AER ELLIPTA 200-62.5-25 MCG	70
treprostinil.....	34
TRESIBA	51
TRESIBA FLEXTOUCH..	51
tretinoin.....	74
tretinoin (<i>chemotherapy</i>)	21
triamicinolone acetonide (mouth).....	77
triamicinolone acetonide (topical).....	76
triamterene & hydrochlorothiazide cap 37.5-25 mg.....	33
triamterene & hydrochlorothiazide tab 37.5-25 mg.....	33
TRIBENZOR see olmesartan- amlodipine- hydrochlorothiazide tab 20-5-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-10-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-10-25 mg	29
see olmesartan- amlodipine- hydrochlorothiazide tab 40-5-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-10-25 mg	29
see olmesartan- amlodipine- hydrochlorothiazide tab 40-5-12.5 mg	28
see olmesartan- amlodipine- hydrochlorothiazide tab 40-5-25 mg	28
TRICOR see fenofibrate	30
trientine hcl	52
tri-estarrylla	54
trifluoperazine hcl.....	39
trifluridine	69
trihexyphenidyl hcl	37
TRIJARDY XR TAB ER 24HR 10-5-1000MG....	50
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	50
TRIJARDY XR TAB ER 24HR 25-5-1000MG....	50
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG... <td>50</td>	50
TRIKAFTA PAK 59.5MG	72
TRIKAFTA PAK 75MG ...	72
TRIKAFTA TAB 100-50- 75MG & 150MG	72
TRIKAFTA TAB 50-25- 37.5MG & 75MG	72
tri-legest fe.....	54
TRILEPTAL see oxcarbazepine.....	42
tri-linyah	54
tri-lo-estarrylla	55
tri-lo-marzia.....	55
tri-lo-mili	55
tri-lo-sprintec.....	55
trimethoprim.....	13
tri-mili.....	55
trimipramine maleate	36
TRINTELLIX	36
tri-nymyo.....	55
tri-sprintec.....	55
TRIUMEQ PD TAB	15
TRIUMEQ TAB	15
trivora-28	55
tri-vylibra	55
tri-vylibra lo	55
TRIZIVIR TAB.....	15
TROGARZO	14
TROPHAMINE INJ 10% .	68
trospium chloride	61
TRULICITY	50
TRUMENBA INJ	66
TRUQAP.....	25
TRUVADA see emtricitabine- tenofovir disoproxil	
fumarate tab 100-150 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 133-200 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 167-250 mg	15
see emtricitabine- tenofovir disoproxil fumarate tab 200-300 mg	15
TRUXIMA.....	25
TUKYSA	25
TURALIO	25
turqoz.....	55
TWINRIX INJ	66
TYBOST	14
tydemy	55
TYGACIL see tigecycline.....	19
TYKERB see lapatinib ditosylate	23
TYPHIM VI.....	66
TYRVAYA	70
U	
UBRELVY	46
UCERIS see budesonide.....	59
UNASYN see ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm	18
see ampicillin & sulbactam sodium for inj 3 (2-1) gm	18
UNASYN BULK PACK see ampicillin & sulbactam sodium for iv soln 15 (10-5) gm.	18
unithroid.....	58
UROCIT-K 10 see potassium citrate (alkalinizer)	61
UROCIT-K 15 see potassium citrate (alkalinizer)	61

UROCIT-K 5	VANCOMYCIN INJ 500MG	V-GO 40 KIT
see <i>potassium citrate</i>	.....13	.....51
(<i>alkalinizer</i>).....61	VANCOMYCIN INJ 750MG	VIBRAMYCIN
UROXATRAL	.....13	see <i>doxycycline</i>
see <i>alfuzosin hcl</i>.....61	VANFLYTA	(<i>monohydrate</i>) .....19
URSO 250	.....25	see <i>doxycycline hyolate</i>
see <i>ursodiol</i>.....60	VAQTA	.....19
URSO FORTE	.....66	VIDAZA
see <i>ursodiol</i>.....60	varenicline tartrate	see <i>azacitidine</i> .....19
ursodiol	.....48	vienna
V	varenicline tartrate tab 11 x	.....55
VAGIFEM	0.5 mg & 42 x 1 mg start	vigabatrin
see <i>estradiol vaginal</i> ...55	pack	.....43
see <i>yuvafem</i>.....55	VARIVAX	vigadron
valacyclovir hcl	.....66	.....43
VALCHLOR	VASCEPA.....31	VIGAMOX
.....76	VASERETIC	see <i>moxifloxacin hcl</i>
VALCYTE	<i>hydrochlorothiazide tab</i>	(<i>ophth</i>) .....69
see <i>valganciclovir hcl</i> ..16	10-25 mg	VIIBRYD
valganciclovir hcl	.....26	see <i>vilazodone hcl</i>.....36
VALIUM	VASOTEC	vilazodone hcl.....36
see <i>diazepam</i>.....40	<i>enalapril maleate</i> ..27	VIMPAT
valproate sodium	VELCADE	<i>lacosamide</i> .....41
.....43	<i>bortezomib</i>.....21	<i>lacosamide oral</i> ...41
valproic acid	velivet	vincristine sulfate
.....43	.....55	.....21
valsartan	VELPHORO	vinorelbine tartrate
.....29	.....57	.....21
valsartan-	VELTASSA	viorele
<i>hydrochlorothiazide tab</i>	.....52	.....55
160-12.5 mg.....29	VEMLIDY	VIRACEPT
valsartan-	.....16	.....14
<i>hydrochlorothiazide tab</i>	VENCLEXTA	VIREAD
160-25 mg.....29	.....25	<i>tenofovir disoproxil</i>
valsartan-	VENCLEXTA TAB START	<i>fumarate</i> .....14
<i>hydrochlorothiazide tab</i>	PK	VISTARIL
320-12.5 mg.....29	.....25	<i>hydroxyzine</i>
valsartan-	venlafaxine hcl	<i>pamoate</i>.....71
<i>hydrochlorothiazide tab</i>	VENTAVIS	VITRAKVI
320-25 mg.....29	.....34	.....25
valsartan-	VENTOLIN HFA	VIVELLE-DOT
<i>hydrochlorothiazide tab</i>	.....71	<i>dotti</i>.....55
320-12.5 mg.....29	VENTOLIN HFA	<i>estradiol</i>.....55
VALTOCO 10 MG DOSE	(INSTITUTIONAL PACK)	VIVITROL
43	.....71	.....48
VALTOCO 15 MG DOSE	verapamil hcl	VIZIMPRO
43	.....32	.....25
VALTOCO 20 MG DOSE	VERELAN	VONJO
43	<i>see verapamil hcl</i>.....32	.....25
VALTOCO 5 MG DOSE	VERQUVO	voriconazole
..43	.....33	.....13
VALTREX	VERSACLOZ	VOSEVI TAB
<i>see valacyclovir hcl</i>....16	.....39	.....16
VANCOCIN	VERZENIO	VOTRIENT
<i>see vancomycin hcl</i>....13	.....25	<i>see pazopanib hcl</i> .....24
vancomycin hcl	VESICARE	VRAYLAR
.....13	<i>see solifenacin succinate</i>	.....39
VANCOMYCIN INJ 1 GM	.....61	VRAYLAR CAP 1.5-3MG
13	vestura	.....39
	VFEND	vyfemla
	<i>see voriconazole</i> .....13	.....55
	VFEND IV	vylibra
	<i>see voriconazole</i> .....13	.....55
	V-GO 20 KIT	VYTORIN
	.....51	<i>see ezetimibe-</i>
	V-GO 30 KIT	<i>simvastatin tab 10-10</i>
	.....51	<i>mg</i> .....30

see <i>ezetimibe-simvastatin tab</i>	10-20	XIFAXAN	60	see <i>drospirenone-ethinylestradiol tab</i>	3-0.02 mg
mg	31	XIGDUO XR TAB 10-1000	50	.....	53
see <i>ezetimibe-simvastatin tab</i>	10-40	XIGDUO XR TAB 10-	500MG	see <i>jasmiel</i>	53
mg	31	500MG	50	see <i>loryna</i>	53
see <i>ezetimibe-simvastatin tab</i>	10-80	XIGDUO XR TAB 2.5-1000	50	see <i>nikki</i>	54
mg	31	.....	50	see <i>vestura</i>	55
VYZULTA	70	XIGDUO XR TAB 5-	1000MG	YF-VAX INJ	66
W		500MG	50	yuvafem	55
<i>warfarin sodium</i>	62	XIGDUO XR TAB 5-500MG	50	Z	
<i>water for irrigation, sterile irrigation soln.</i>	77	.....	50	zafemy	55
WELCHOL		XIIDRA.....	70	zafirlukast	71
see <i>colesevelam hcl</i>	30	XOFLUZA	16	zaleplon	45
WELIREG	21	XOLAIR	72	ZANAFLEX	
WELLBUTRIN SR		XOSPATA.....	25	see <i>tizanidine hcl</i>	47
see <i>bupropion hcl</i>	35	XPOVIO 100 MG ONCE		ZARONTIN	
WELLBUTRIN XL		WEEKLY	26	see <i>ethosuximide</i>	41
see <i>bupropion hcl</i>	35	XPOVIO 40 MG ONCE		ZARXIO	62
wera.....	55	WEEKLY	25	ZAVESCA	
wixela inhub.....	73	XPOVIO 40 MG TWICE		see <i>miglustat</i>	57
wymzya fe.....	55	WEEKLY	25	see <i>yargesa</i>	57
X		XPOVIO 60 MG ONCE		ZEJULA	26
XALATAN		WEEKLY	25	ZELBORAF	26
see <i>latanoprost</i>	70	XPOVIO 60 MG TWICE		ZEMAIRA	72
XALKORI	25	WEEKLY	25	ZEMPLAR	
XANAX		XPOVIO 80 MG ONCE		see <i>paricalcitol</i>	58
see <i>alprazolam</i>	34	WEEKLY	25	zenatane	74
XARELTO	62	XPOVIO 80 MG TWICE		ZENPEP CAP 10000UNT	
XARELTO STAR TAB		WEEKLY	25	.....	60
15/20MG	62	XTANDI	20	ZENPEP CAP 15000UNT	
XATMEP	65	xulane	55	.....	60
XCOPRI	43	XULTOPHY INJ 100/3.6	51	ZENPEP CAP 20000UNT	
XCOPRI PAK 100-150....	43	XYLOCAINE		.....	60
XCOPRI PAK 12.5-25....	43	see <i>lidocaine hcl (local anesth.)</i>	11	ZENPEP CAP 25000UNT	
XCOPRI PAK 150-200MG (MAINTENANCE).....	43	XYLOCAINE-MPF		.....	60
XCOPRI PAK 150-200MG (TITRATION).....	43	see <i>lidocaine hcl (local anesth.)</i>	11	ZENPEP CAP 3000UNIT	60
XCOPRI PAK 50-100MG	43	Y		ZENPEP CAP 40000UNT	
XELJANZ	64	yargesa	57	.....	60
XELJANZ XR	64	YASMIN 28		ZENPEP CAP 5000UNIT	60
XENAZINE		see <i>drospirenone-ethinylestradiol tab</i> 3-0.03 mg		ZERVIATE	69
see <i>tetrabenazine</i>	46	.....	53	ZESTORETIC	
XERMELO	60	see <i>ocella</i>	54	see <i>lisinopril & hydrochlorothiazide tab</i> 10-12.5 mg	27
XGEVA	52	see <i>syeda</i>	54	see <i>lisinopril & hydrochlorothiazide tab</i> 20-12.5 mg	27
XHANCE.....	73	see <i>zumandimine</i>	55		
		YAZ			

<i>see lisinopril & hydrochlorothiazide tab 20-25 mg</i>	27	<i>zumandimine</i>	55
ZESTRIL		ZURZUVAE	36
<i>see lisinopril</i>	27	ZYDELIG	26
ZETIA		ZYKADIA	26
<i>see ezetimibe</i>	30	ZYLET SUS 0.5-0.3%	68
ZIAGEN		ZYPREXA	
<i>see abacavir sulfate</i>	14	<i>see olanzapine</i>	38
zidovudine	14	ZYPREXA RELPREVV	40
ZIEXTENZO	62	ZYPREXA ZYDIS	
ziprasidone hcl	40	<i>see olanzapine</i>	39
ziprasidone mesylate	40	ZYTIGA	
ZIRABEV	26	<i>see abiraterone acetate</i>	
ZIRGAN	69	.....	20
ZITHROMAX		ZYVOX	
<i>see azithromycin</i>	17	<i>see linezolid</i>	12
ZOCOR			
<i>see simvastatin</i>	30		
zoledronic acid	52		
ZOLINZA	26		
ZOLOFT			
<i>see sertraline hcl</i>	36		
zolpidem tartrate	45		
ZONEGRAN			
<i>see zonisamide</i>	43		
ZONISADE	43		
zonisamide	43		
ZORTRESS			
<i>see everolimus (immunosuppressant)</i>			
.....	65		
zovia 1/35	55		
ZTALMY	43		

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 03/01/2024. 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.