



**Aetna Better Health® of Illinois**  
**Preferred Drug List**  
**January 2024**

This Formulary is up to date through the date of publication. Please notify Aetna Better Health of Illinois at [ABHILPharmacy@AETNA.com](mailto:ABHILPharmacy@AETNA.com) or 1-866-329-4701 TTY: 711 with any mistakes in the formulary.

## Pharmacy Program

Aetna Better Health® of Illinois is committed to providing high quality drug coverage to our members. We work with the Department of Healthcare and Family Services to include medications that treat many conditions and diseases. Aetna Better Health covers prescription and certain over-the-counter (OTC) medications when ordered by a network provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and maximum quantities.

## Filling a Prescription

You can have your prescriptions filled at a network pharmacy. At the pharmacy, you will need to give the pharmacist your prescription and your ID card. You can find a pharmacy that is in the Aetna Better Health network by using the Find a Provider tool on **[AetnaBetterHealth.com/Illinois-Medicaid](https://www.aetna.com/illinois-medicaid)**. If you need help finding a pharmacy near you or if you have any questions about drug coverage, call us at **1-866-329-4701 TTY: 711**.

There is no cost for covered drugs.

If your medication is not on the preferred drug list or is on the preferred drug list but has limitations, you can:

1. Speak with your doctor about switching to a similar medication that is on the preferred drug list.
2. Request a prior authorization or speak to your doctor about submitting a prior authorization for you. You or your doctor may do this by submitting the medication prior authorization form, found on **[AetnaBetterHealth.com/Illinois-Medicaid](https://www.aetna.com/illinois-medicaid)**.

## Generic Drugs

Generic drugs have the same active ingredient and work the same as brand name drugs. When preferred generic drugs are available, the brand name drug will not be covered without prior authorization.

## Specialty Drugs

Specialty drugs are usually not available at retail pharmacies and require additional review and monitoring. These drugs are only covered when supplied by an Aetna Better Health network specialty pharmacy.

## Pharmacy Benefit Exclusions

The following drug categories are not part of the Aetna Better Health pharmacy benefit:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Durable Medical Equipment (DME) products and medical supplies (unless listed on the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth

- Erectile dysfunction drugs prescribed to treat impotence
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- OTC products (unless listed on the PDL)
- Drugs not included in the Medicaid Drug Rebate Program, drug product data file (unless listed on the PDL)

**Legend**

<b>P</b>	Preferred Drug	Drugs preferred by Aetna Better Health
<b>NP</b>	Non-Preferred	Drugs not preferred by Aetna Better Health
<b>AL</b>	Age Limit	Drug is limited to specific age
<b>PA</b>	Prior Authorization	Prior Authorization required before prescription can be filled.
-	Smart Edit	Prior Authorization required before prescription can be filled. Criteria may be met automatically
<b>QLL</b>	Quantity Level Limit	There is a limit on the amount of drug covered per prescription or within a specific time frame.
<b>ST</b>	Step Therapy	Requires trial and failure of one or more preferred products prior to coverage.
<b>OTC</b>	Over-the-Counter	Over-the-Counter (OTC) products eligible for coverage with a valid prescription written by a licensed physician/clinician.

# Aetna Better Health of Illinois Formulary Guide

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		Coverage Requirements and Limits
<b>lowercase italics</b> = Generic drugs	<b>Drug Tier</b>	<b>AL</b> = Age Restrictions
<b>UPPERCASE BOLD</b> = Brand name drugs	<b>Non – Preferred</b> = Non – Preferred	<b>OTC</b> = OTC Medications
	<b>Preferred</b> = Preferred	<b>PA</b> = Prior Authorization Applies
		<b>QL</b> = Quantity Limits
		<b>ST</b> = Step Therapy Applies
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiant* - Drugs For The Nervous System</b>		
<b>*Adhd Agent - Selective Alpha Adrenergic Agonists*** - Drugs For Attention Deficit Disorder</b>		
<i>clonidine hcl er tablet extended release 12 hour 0.1 mg oral</i>	Preferred	QL (120 EA per 30 days); AL (Min 6 Years)
<i>clonidine hcl er tablet extended release 12 hour 0.1 mg oral</i>	Preferred	QL (120 day per 1 day); AL (Min 6 Years)
<i>guanfacine hcl er</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>INTUNIV</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>*Adhd Agent - Selective Norepinephrine Reuptake Inhibitor*** - Drugs For Attention Deficit Disorder</b>		
<i>atomoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>QELBREE</b>	Non – Preferred	AL (Min 6 Years)
<b>STRATTERA</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Amphetamine Mixtures*** - Drugs For Attention Deficit Disorder</b>		
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 30 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 12.5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphetamine-dextroamphetamine tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>amphet-dextroamphetamine 3-bead er capsule extended release 24 hour 12.5 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>amphet-dextroamphetamine 3-bead er capsule extended release 24 hour 25 mg oral</i>	Non – Preferred	AL (Min 6 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 25 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 37.5 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 37.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 50 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>amphet-dextroamphet 3-bead er capsule extended release 24 hour 50 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 10 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 12.5 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 15 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 20 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 30 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL TABLET 5 MG ORAL</b>	Non – Preferred	AL (Min 6 Years)
<b>ADDERALL TABLET 7.5 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>MYDAYIS</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>*Amphetamines*** - Drugs For Attention Deficit Disorder</b>		
<i>amphetamine sulfate</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate oral solution</i>	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 10 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 10 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 15 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 20 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>dextroamphetamine sulfate tablet 5 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<i>lisdexamfetamine dimesylate</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methamphetamine hcl</i>	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
<b>ADZENYS XR-ODT</b>	Non – Preferred	AL (Min 6 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>DESOXYN</b>	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
<b>DEXEDRINE</b>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<b>DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE</b>	Preferred	PA; AL (Min 6 Years)
<b>DYANAVEL XR ORAL TABLET CHEWABLE EXTENDED RELEASE</b>	Non – Preferred	PA; AL (Min 6 Years)
<b>EVEKEO</b>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<b>EVEKEO ODT</b>	Non – Preferred	AL (Min 6 Years)
<b>PROCENTRA</b>	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
<b>VYVANSE</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>XELSTRYM</b>	Non – Preferred	AL (Min 6 Years)
<b>ZENZEDI TABLET 10 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 15 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 2.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 20 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 30 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 5 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
<b>ZENZEDI TABLET 7.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b><i>*Analeptics*** - Drugs For The Nervous System</i></b>		
<i>caffeine citrate</i>	Preferred	AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Dopamine And Norepinephrine Reuptake Inhibitors (Dnris)*** - Drugs For Sleep Disorder</i></b>		
SUNOSI	Non – Preferred	
<b><i>*Histamine H3-Receptor Antagonist/Inverse Agonists*** - Drugs For Sleep Disorder</i></b>		
WAKIX	Non – Preferred	AL (Min 18 Years)
<b><i>*Stimulant Combinations*** - Drugs For Attention Deficit Disorder</i></b>		
AZSTARYS	Non – Preferred	AL (Min 6 Years)
<b><i>*Stimulants - Misc.*** - Drugs For Attention Deficit Disorder</i></b>		
<i>armodafinil tablet 150 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 200 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 250 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<i>armodafinil tablet 50 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
<i>dexmethylphenidate hcl</i>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>dexmethylphenidate hcl er</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate</i>	Non – Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (cd)</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 18 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 36 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 45 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 54 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 63 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (osm) tablet extended release 72 mg oral</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl er (xr)</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	Non – Preferred	AL (Min 6 Years)
<i>methylphenidate hcl oral solution</i>	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl oral tablet</i>	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
<i>methylphenidate hcl oral tablet chewable</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
<i>modafinil</i>	Preferred	AL (Min 17 Years)

**Coverage Requirements and Limits**

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>APTENSIO XR</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL</b>	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<b>CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>COTEMPLA XR-ODT</b>	Non – Preferred	AL (Min 6 Years)
<b>DAYTRANA</b>	Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
<b>FOCALIN</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
<b>FOCALIN XR</b>	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>JORNAY PM</b>	Preferred	PA; AL (Min 6 Years)
<b>METHYLIN</b>	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
<b>NUVIGIL TABLET 150 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<b>NUVIGIL TABLET 200 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<b>NUVIGIL TABLET 250 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
<b>NUVIGIL TABLET 50 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
<b>PROVIGIL</b>	Non – Preferred	AL (Min 17 Years)
<b>QUILLICHEW ER</b>	Non – Preferred	AL (Min 6 Years)
<b>QUILLIVANT XR</b>	Non – Preferred	AL (Min 6 Years)
<b>RELEXXII TABLET EXTENDED RELEASE 18 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

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RELEXXII TABLET EXTENDED RELEASE 27 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 36 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 54 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL	Non – Preferred	AL (Min 6 Years)
RITALIN	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
<b>*Amebicides* - Drugs For Infections</b>		
<b><i>*Amebicides*** - Drugs For Parasites</i></b>		
SOLOSEC	Non – Preferred	
<b>*Aminoglycosides* - Drugs For Infections</b>		
<b><i>*Aminoglycosides*** - Antibiotics</i></b>		
<i>amikacin sulfate</i>	Preferred	
<i>gentamicin in saline</i>	Preferred	
<i>gentamicin sulfate</i>	Preferred	

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<i>neomycin sulfate</i>	Preferred	
<i>tobramycin nebulization solution 300 mg/4ml inhalation</i>	Non – Preferred	
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non – Preferred	QL (10 ML per 1 day)
<i>tobramycin sulfate</i>	Preferred	
<b>ARIKAYCE</b>	Non – Preferred	
<b>BETHKIS</b>	Non – Preferred	
<b>KITABIS PAK</b>	Preferred	QL (10 ML per 1 day)
<b>TOBI</b>	Non – Preferred	QL (10 ML per 1 day)
<b>TOBI PODHALER</b>	Non – Preferred	
<b>*Analgesics - Anti-Inflammatory* - Drugs For Pain And Fever</b>		
<b>*Antirheumatic - Janus Kinase (Jak) Inhibitors*** - Arthritis And Pain Drugs</b>		
<b>OLUMIANT</b>	Non – Preferred	
<b>RINVOQ</b>	Non – Preferred	
<b>XELJANZ ORAL TABLET</b>	Preferred	PA
<b>XELJANZ SOLUTION 1 MG/ML ORAL</b>	Non – Preferred	PA
<b>XELJANZ SOLUTION 1 MG/ML ORAL</b>	Preferred	PA
<b>XELJANZ XR</b>	Preferred	PA
<b>*Antirheumatic Antimetabolites*** - Arthritis And Pain Drugs</b>		
<b>OTREXUP</b>	Non – Preferred	
<b>RASUVO</b>	Non – Preferred	
<b>*Anti-Tnf-Alpha - Monoclonal Antibodies*** - Arthritis And Pain Drugs</b>		
<i>adalimumab-aacf</i>	Non – Preferred	

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<i>adalimumab-adaz</i>	Non – Preferred	
<i>adalimumab-adbm</i>	Non – Preferred	
<i>adalimumab-fkjp</i>	Non – Preferred	
<b>ABRILADA</b>	Non – Preferred	
<b>AMJEVITA</b>	Non – Preferred	
<b>AMJEVITA-PED 15KG TO &lt;30KG</b>	Non – Preferred	
<b>CYLTEZO</b>	Non – Preferred	
<b>CYLTEZO-CD/UC/HS STARTER</b>	Non – Preferred	
<b>CYLTEZO-PSORIASIS STARTER</b>	Non – Preferred	
<b>HADLIMA</b>	Non – Preferred	
<b>HADLIMA PUSHTOUCH</b>	Non – Preferred	
<b>HULIO</b>	Non – Preferred	
<b>HUMIRA</b>	Preferred	PA
<b>HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML &amp; 40MG/0.4ML SUBCUTANEOUS</b>	Preferred	PA
<b>HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS</b>	Preferred	PA; QL (3 EA per 180 days)
<b>HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS</b>	Preferred	PA
<b>HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS</b>	Preferred	PA
<b>HUMIRA PEN PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS</b>	Preferred	PA; QL (3 EA per 180 days)
<b>HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS</b>	Preferred	PA
<b>HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS</b>	Preferred	PA; QL (3 EA per 180 days)
<b>HUMIRA PEN-PEDIATRIC UC START</b>	Preferred	PA; QL (3 EA per 180 days)

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HUMIRA PEN-PS/UV/ADOL HS START	Preferred	PA
HUMIRA PEN-PSOR/UEIT STARTER	Preferred	PA
HYRIMOZ	Non – Preferred	
HYRIMOZ-CROHNS/UC STARTER	Non – Preferred	
HYRIMOZ-PED<40KG CROHN STARTER	Non – Preferred	
HYRIMOZ-PED>/=40KG CROHN START	Non – Preferred	
HYRIMOZ-PLAQUE PSORIASIS START	Non – Preferred	
IDACIO	Non – Preferred	
IDACIO FOR CROHNS DISEASE/UC	Non – Preferred	
IDACIO FOR PLAQUE PSORIASIS	Non – Preferred	
SIMPONI	Non – Preferred	
SIMPONI ARIA	Non – Preferred	
YUFLYMA	Non – Preferred	
YUFLYMA 1-PEN KIT	Non – Preferred	
YUFLYMA 2-PEN KIT	Non – Preferred	
YUFLYMA-CD/UC/HS STARTER	Non – Preferred	
YUSIMRY	Non – Preferred	
<b><i>*Cyclooxygenase 2 (Cox-2) Inhibitors*** - Arthritis And Pain Drugs</i></b>		
<i>celecoxib</i>	Preferred	QL (1 EA per 1 day)
CELEBREX	Non – Preferred	QL (1 EA per 1 day)
<b><i>*Gold Compounds*** - Arthritis And Pain Drugs</i></b>		
RIDAURA	Non – Preferred	
<b><i>*Interleukin-1 Blockers*** - Arthritis And Pain Drugs</i></b>		
ARCALYST	Non – Preferred	

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<b>*Interleukin-1 Receptor Antagonist (IL-1Ra)*** - Arthritis And Pain Drugs</b>		
KINERET	Non – Preferred	
<b>*Interleukin-1Beta Blockers*** - Arthritis And Pain Drugs</b>		
ILARIS	Non – Preferred	
<b>*Interleukin-6 Receptor Inhibitors*** - Arthritis And Pain Drugs</b>		
ACTEMRA	Non – Preferred	
ACTEMRA ACTPEN	Non – Preferred	
KEVZARA	Non – Preferred	
<b>*Nonsteroidal Anti-Inflammatory Agent Combinations*** - Arthritis And Pain Drugs</b>		
<i>diclofenac-misoprostol</i>	Non – Preferred	
<i>ibuprofen-famotidine tablet 800-26.6 mg oral</i>	Non – Preferred	
<i>ibuprofen-famotidine tablet 800-26.6 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>naproxen-esomeprazole mg</i>	Non – Preferred	
ARTHROTEC	Non – Preferred	
DUEXIS	Non – Preferred	
VIMOVO	Non – Preferred	
<b>*Nonsteroidal Anti-Inflammatory Agents (Nsaids)*** - Arthritis And Pain Drugs</b>		
<i>cvs ibuprofen infants</i>	Preferred	OTC
<i>diclofenac potassium oral capsule</i>	Non – Preferred	
<i>diclofenac potassium tablet 25 mg oral</i>	Non – Preferred	
<i>diclofenac potassium tablet 50 mg oral</i>	Preferred	
<i>diclofenac sodium</i>	Preferred	
<i>diclofenac sodium er</i>	Preferred	

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<i>ec-naproxen</i>	Preferred	
<i>etodolac</i>	Preferred	
<i>etodolac er</i>	Preferred	
<i>fenoprofen calcium</i>	Non – Preferred	
<i>flurbiprofen</i>	Preferred	
<i>ibuprofen oral capsule</i>	Preferred	OTC; QL (6 EA per 1 day)
<i>ibuprofen oral suspension</i>	Non – Preferred	
<i>ibuprofen oral tablet 200 mg</i>	Preferred	OTC; QL (6 EA per 1 day)
<i>ibuprofen tablet 400 mg oral</i>	Preferred	
<i>ibuprofen tablet 600 mg oral</i>	Preferred	
<i>ibuprofen tablet 800 mg oral</i>	Preferred	
<i>indomethacin</i>	Preferred	
<i>indomethacin er</i>	Preferred	
<i>ketoprofen</i>	Preferred	
<i>ketoprofen er</i>	Non – Preferred	
<i>ketorolac tromethamine tablet 10 mg oral</i>	Preferred	QL (5 EA Max Qty Per Fill Retail)
<i>ketorolac tromethamine tablet 10 mg oral</i>	Preferred	QL (20 EA per 30 days)
<i>ketorolac tromethamine tablet 10 mg oral</i>	Preferred	QL (5 days Max Qty Per Fill Retail)
<i>meclofenamate sodium</i>	Non – Preferred	
<i>mefenamic acid</i>	Non – Preferred	
<i>meloxicam oral capsule</i>	Non – Preferred	
<i>meloxicam oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>nabumetone</i>	Preferred	QL (4 EA per 1 day)
<i>naproxen</i>	Preferred	
<i>naproxen sodium</i>	Preferred	
<i>naproxen sodium er</i>	Non – Preferred	
<i>oxaprozin</i>	Non – Preferred	
<i>piroxicam</i>	Non – Preferred	

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<i>sulindac</i>	Preferred	
<i>tolmetin sodium</i>	Non – Preferred	
<b>DAYPRO</b>	Non – Preferred	
<b>FELDENE</b>	Non – Preferred	
<b>IBU</b>	Preferred	
<b>LOFENA</b>	Non – Preferred	
<b>MEDI-FIRST IBUPROFEN</b>	Preferred	OTC; QL (6 EA per 1 day)
<b>NALFON</b>	Non – Preferred	
<b>NAPRELAN</b>	Non – Preferred	
<b>RELAFEN DS</b>	Non – Preferred	
<b><i>*Phosphodiesterase 4 (Pde4) Inhibitors*** - Arthritis And Pain Drugs</i></b>		
<b>OTEZLA</b>	Non – Preferred	
<b><i>*Pyrimidine Synthesis Inhibitors*** - Arthritis And Pain Drugs</i></b>		
<i>leflunomide</i>	Preferred	QL (1 EA per 1 day)
<b>ARAVA</b>	Non – Preferred	QL (1 EA per 1 day)
<b><i>*Selective Costimulation Modulators*** - Arthritis And Pain Drugs</i></b>		
<b>ORENCIA</b>	Non – Preferred	
<b>ORENCIA CLICKJECT</b>	Non – Preferred	
<b><i>*Soluble Tumor Necrosis Factor Receptor Agents*** - Arthritis And Pain Drugs</i></b>		
<b>ENBREL MINI</b>	Preferred	PA; QL (4 PEN per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION</b>	Preferred	PA
<b>ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b>	Preferred	PA; QL (4 ML per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SURECLICK	Preferred	PA; QL (4 ML per 28 days)
<b>*Analgesics - Nonnarcotic* - Drugs For Pain And Fever</b>		
<b>*Analgesics Other*** - Arthritis And Pain Drugs</b>		
<i>acetaminophen</i>	Preferred	OTC
<i>acetaminophen childrens</i>	Preferred	OTC
<i>pain relief extra strength</i>	Preferred	OTC
<i>pain reliever</i>	Preferred	OTC
CHILDRENS MEDI-TABS	Preferred	OTC
<b>*Analgesics-Sedatives*** - Arthritis And Pain Drugs</b>		
<i>butalbital-acetaminophen oral capsule</i>	Non – Preferred	
<i>butalbital-acetaminophen tablet 50-300 mg oral</i>	Preferred	
<i>butalbital-acetaminophen tablet 50-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine capsule 50-300-40 mg oral</i>	Preferred	
<i>butalbital-apap-caffeine capsule 50-325-40 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine oral tablet</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine</i>	Preferred	QL (6 EA per 1 day)
<b>BAC</b>	Preferred	QL (6 EA per 1 day)
<b>BUPAP</b>	Preferred	
<b>ESGIC ORAL CAPSULE</b>	Preferred	QL (6 EA per 1 day)
<b>ESGIC ORAL TABLET</b>	Non – Preferred	QL (6 EA per 1 day)
<b>FIORICET</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Salicylate Combinations*** - Arthritis And Pain Drugs</b>		
<i>aspirin buf(cacarb-mgcarb-mgo)</i>	Preferred	OTC
<b>*Salicylates*** - Arthritis And Pain Drugs</b>		
<i>aspirin 81</i>	Preferred	OTC
<i>diflunisal</i>	Preferred	
<i>salsalate</i>	Preferred	
<b>*Analgesics - Opioid* - Drugs For Pain And Fever</b>		
<b>*Codeine Combinations*** - Arthritis And Pain Drugs</b>		
<i>acetaminophen-codeine oral tablet</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>acetaminophen-codeine solution 120-12 mg/5ml oral</i>	Preferred	AL (Min 18 Years)
<i>acetaminophen-codeine solution 120-12 mg/5ml oral</i>	Preferred	QL (20 ML per 1 day); AL (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-300-40-30 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>butalbital-apap-caff-cod capsule 50-325-40-30 mg oral</i>	Non – Preferred	AL (Min 18 Years)
<i>butalbital-asa-caff-codeine</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<b>ASCOMP-CODEINE</b>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<b>FIORICET/CODEINE</b>	Non – Preferred	
<b>*Dihydrocodeine Combinations*** - Arthritis And Pain Drugs</b>		
<i>apap-caff-dihydrocodeine</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Hydrocodone Combinations*** - Arthritis And Pain Drugs</b>		
<i>hydrocodone-acetaminophen solution 2.5-108 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>hydrocodone-acetaminophen solution 5-217 mg/10ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>hydrocodone-acetaminophen solution 7.5-325 mg/15ml oral</i>	Preferred	QL (40 ML per 1 day)
<i>hydrocodone-acetaminophen solution 7.5-325 mg/15ml oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 10-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 7.5-300 mg oral</i>	Preferred	
<i>hydrocodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 10-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 5-200 mg oral</i>	Preferred	
<i>hydrocodone-ibuprofen tablet 7.5-200 mg oral</i>	Preferred	QL (4 EA per 1 day)
<b>*Opioid Agonists*** - Arthritis And Pain Drugs</b>		
<i>codeine sulfate</i>	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)

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<i>fentanyl</i>	Non – Preferred	
<i>fentanyl citrate buccal lozenge on a handle</i>	Non – Preferred	QL (4 EA per 1 day)
<i>fentanyl citrate buccal tablet</i>	Non – Preferred	
<i>hydrocodone bitartrate er</i>	Non – Preferred	
<i>hydromorphone hcl er</i>	Non – Preferred	
<i>hydromorphone hcl oral liquid</i>	Preferred	
<i>hydromorphone hcl rectal</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>levorphanol tartrate</i>	Non – Preferred	
<i>meperidine hcl</i>	Non – Preferred	
<i>methadone hcl oral concentrate</i>	Non – Preferred	QL (3 EA per 1 day)
<i>methadone hcl oral tablet soluble</i>	Non – Preferred	
<i>methadone hcl solution 10 mg/5ml oral</i>	Non – Preferred	QL (15 ML per 1 day)
<i>methadone hcl solution 5 mg/5ml oral</i>	Non – Preferred	QL (30 ML per 1 day)
<i>methadone hcl tablet 10 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>methadone hcl tablet 5 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>morphine sulfate (concentrate) solution 10 mg/0.5ml oral</i>	Preferred	
<i>morphine sulfate (concentrate) solution 10 mg/0.5ml oral</i>	Preferred	QL (4.5 EA per 1 day)
<i>morphine sulfate (concentrate) solution 100 mg/5ml oral</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate (concentrate) solution 20 mg/ml oral</i>	Preferred	
<i>morphine sulfate (concentrate) solution 20 mg/ml oral</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate er beads</i>	Non – Preferred	
<i>morphine sulfate er oral capsule extended release 24 hour</i>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>morphine sulfate er tablet extended release 100 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 15 mg oral</i>	Preferred	PA; QL (6 EA per 1 day)
<i>morphine sulfate er tablet extended release 200 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 30 mg oral</i>	Preferred	PA
<i>morphine sulfate er tablet extended release 60 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate solution 10 mg/5ml oral</i>	Preferred	PA
<i>morphine sulfate solution 10 mg/5ml oral</i>	Preferred	QL (45 ML per 1 day)
<i>morphine sulfate solution 20 mg/5ml oral</i>	Preferred	QL (500 ML per 23 days)
<i>morphine sulfate suppository 10 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate suppository 20 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate suppository 30 mg rectal</i>	Preferred	QL (3 EA per 1 day)
<i>morphine sulfate suppository 5 mg rectal</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate tablet 15 mg oral</i>	Preferred	PA
<i>morphine sulfate tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>morphine sulfate tablet 30 mg oral</i>	Preferred	PA
<i>morphine sulfate tablet 30 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl er</i>	Non – Preferred	
<i>oxycodone hcl oral capsule</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl oral concentrate</i>	Preferred	QL (6 ML per 1 day)
<i>oxycodone hcl oral solution</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl tablet 30 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxymorphone hcl</i>	Non – Preferred	

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<i>oxymorphone hcl er</i>	Non – Preferred	QL (2 EA per 1 day)
<i>tramadol hcl (er biphasic)</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl er</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl oral solution</i>	Non – Preferred	AL (Min 18 Years)
<i>tramadol hcl tablet 100 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
<i>tramadol hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day); AL (Min 18 Years)
<b>CONZIP</b>	Non – Preferred	AL (Min 18 Years)
<b>DILAUDID ORAL LIQUID</b>	Non – Preferred	
<b>DILAUDID TABLET 2 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>DILAUDID TABLET 4 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>DILAUDID TABLET 8 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>FENTORA</b>	Non – Preferred	
<b>HYSINGLA ER</b>	Non – Preferred	
<b>METHADONE HCL INTENSOL</b>	Non – Preferred	QL (3 ML per 1 day)
<b>METHADOSE ORAL CONCENTRATE</b>	Non – Preferred	QL (3 ML per 1 day)
<b>METHADOSE ORAL TABLET SOLUBLE</b>	Non – Preferred	
<b>METHADOSE SUGAR-FREE</b>	Non – Preferred	QL (3 ML per 1 day)
<b>MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL</b>	Non – Preferred	PA; QL (1 EA per 1 day)
<b>MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL</b>	Non – Preferred	PA; QL (6 EA per 1 day)
<b>MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL</b>	Non – Preferred	PA; QL (1 EA per 1 day)
<b>MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL</b>	Non – Preferred	PA
<b>MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL</b>	Non – Preferred	PA; QL (1 EA per 1 day)
<b>NUCYNTA</b>	Non – Preferred	
<b>NUCYNTA ER</b>	Non – Preferred	

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<b>OXYCONTIN</b>	Non – Preferred	
<b>QDOLO</b>	Non – Preferred	AL (Min 18 Years)
<b>ROXICODONE</b>	Non – Preferred	QL (4 EA per 1 day)
<b>XTAMPZA ER</b>	Non – Preferred	
<b>*Opioid Combinations*** - Arthritis And Pain Drugs</b>		
<i>benzhydrocodone-acetaminophen</i>	Non – Preferred	
<i>nalocet</i>	Non – Preferred	
<i>oxycodone-acetaminophen oral solution</i>	Preferred	
<i>oxycodone-acetaminophen oral tablet</i>	Preferred	QL (4 EA per 1 day)
<b>APADAZ</b>	Non – Preferred	
<b>ENDOCET</b>	Preferred	QL (4 EA per 1 day)
<b>PERCOCET</b>	Non – Preferred	QL (4 EA per 1 day)
<b>PROLATE</b>	Non – Preferred	
<b>*Opioid Partial Agonists*** - Arthritis And Pain Drugs</b>		
<i>buprenorphine hcl</i>	Preferred	
<i>buprenorphine hcl-naloxone hcl</i>	Preferred	
<i>buprenorphine patch weekly 10 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 15 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 20 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 5 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>buprenorphine patch weekly 7.5 mcg/hr transdermal</i>	Non – Preferred	QL (4 EA per 28 days)
<i>butorphanol tartrate</i>	Non – Preferred	QL (2.5 ML per 30 days)
<i>pentazocine-naloxone hcl</i>	Non – Preferred	QL (4 EA per 1 day)
<b>BELBUCA</b>	Non – Preferred	

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<b>BRIXADI</b>	Preferred	
<b>BRIXADI (WEEKLY)</b>	Preferred	
<b>BUTRANS</b>	Non – Preferred	QL (4 EA per 28 days)
<b>SUBLOCADE</b>	Preferred	
<b>SUBOXONE</b>	Preferred	
<b>ZUBSOLV</b>	Preferred	
<b>*Tramadol Combinations*** - Arthritis And Pain Drugs</b>		
<i>tramadol-acetaminophen</i>	Non – Preferred	AL (Min 18 Years)
<b>SEGLENTIS TABLET 56-44 MG ORAL</b>	Non – Preferred	
<b>SEGLENTIS TABLET 56-44 MG ORAL</b>	Non – Preferred	AL (Min 18 Years)
<b>*Androgens-Anabolic* - Hormones</b>		
<b>*Androgens*** - Drugs For Men</b>		
<i>testosterone cypionate</i>	Preferred	PA; QL (10 ML per 90 days)
<i>testosterone enanthate</i>	Preferred	PA; QL (5 ML per 60 days)
<i>testosterone gel 1.62 % transdermal</i>	Preferred	PA; QL (5 GM per 1 day)
<i>testosterone gel 10 mg/act (2%) transdermal</i>	Preferred	PA; QL (120 GM per 30 days)
<i>testosterone gel 12.5 mg/act (1%) transdermal</i>	Preferred	PA; QL (300 GM per 30 days)
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	Preferred	PA; QL (5 GM per 1 day)
<i>testosterone gel 25 mg/2.5gm (1%) transdermal</i>	Preferred	PA; QL (2.5 GM per 1 day)
<i>testosterone gel 50 mg/5gm (1%) transdermal</i>	Preferred	PA; QL (10 GM per 1 day)
<i>testosterone transdermal solution</i>	Preferred	PA; QL (6 ML per 1 day)

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<b>*Anorectal And Related Products* - Rectal Preparations</b>		
<b><i>*Intrarectal Steroids*** - Rectal Preparations</i></b>		
<i>budesonide</i>	Non – Preferred	
<i>hydrocortisone</i>	Preferred	
<b>CORTENEMA</b>	Non – Preferred	
<b>CORTIFOAM</b>	Non – Preferred	
<b>UCERIS</b>	Non – Preferred	
<b><i>*Nitrate Vasodilating Agents*** - Rectal Preparations</i></b>		
<b>RECTIV</b>	Non – Preferred	
<b><i>*Rectal Anesthetic/Steroids*** - Rectal Preparations</i></b>		
<i>lidocaine-hydrocort (perianal)</i>	Non – Preferred	
<i>lidocaine-hydrocortisone ace</i>	Non – Preferred	
<b>ANA-LEX</b>	Non – Preferred	
<b>LIDOCORT</b>	Non – Preferred	
<b>PROCTOFOAM HC</b>	Non – Preferred	
<b><i>*Rectal Combinations - Misc.*** - Rectal Preparations</i></b>		
<i>hemorrhoidal</i>	Preferred	OTC
<b>PREPARATION H</b>	Preferred	OTC
<b><i>*Rectal Local Anesthetics*** - Rectal Preparations</i></b>		
<i>pramoxine hcl (perianal)</i>	Preferred	OTC
<b>PROCTOFOAM</b>	Preferred	OTC

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<b>*Rectal Steroids*** - Rectal Preparations</b>		
<i>hydrocortisone (perianal)</i>	Preferred	
<i>hydrocortisone acetate</i>	Non – Preferred	
<b>ANUSOL-HC</b>	Non – Preferred	
<b>PROCTO-MED HC</b>	Preferred	
<b>PROCTOSOL HC</b>	Preferred	
<b>PROCTOZONE-HC</b>	Preferred	
<b>*Antacids* - Drugs For The Stomach</b>		
<b>*Antacids - Aluminum Salts*** - Drugs For Ulcers And Stomach Acid</b>		
<i>aluminum hydroxide gel</i>	Preferred	OTC
<b>*Antacids - Bicarbonate*** - Drugs For Ulcers And Stomach Acid</b>		
<i>sodium bicarbonate</i>	Preferred	OTC
<b>*Antacids - Calcium Salts*** - Drugs For Ulcers And Stomach Acid</b>		
<i>calcium carbonate antacid</i>	Preferred	OTC
<b>*Antacids - Magnesium Salts*** - Drugs For Ulcers And Stomach Acid</b>		
<i>magnesium oxide</i>	Preferred	OTC
<b>*Anthelmintics* - Drugs For Infections</b>		
<b>*Anthelmintics*** - Drugs For Parasites</b>		
<i>albendazole</i>	Non – Preferred	
<i>benznidazole</i>	Non – Preferred	
<i>ivermectin</i>	Non – Preferred	
<i>praziquantel</i>	Preferred	

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<b>BILTRICIDE</b>	Non – Preferred	
<b>EGATEN</b>	Non – Preferred	
<b>EMVERM</b>	Non – Preferred	
<b>STROMEKTOL</b>	Non – Preferred	
<b>*Antianginal Agents* - Drugs For The Heart</b>		
<b>*Antianginals-Other*** - Drugs For Angina</b>		
<i>ranolazine er</i>	Non – Preferred	
<b>ASPRUZYO SPRINKLE</b>	Non – Preferred	
<b>*Nitrates*** - Drugs For Angina</b>		
<i>isosorbide dinitrate tablet 10 mg oral</i>	Preferred	
<i>isosorbide dinitrate tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>isosorbide dinitrate tablet 20 mg oral</i>	Preferred	
<i>isosorbide dinitrate tablet 30 mg oral</i>	Preferred	
<i>isosorbide dinitrate tablet 40 mg oral</i>	Preferred	
<i>isosorbide dinitrate tablet 5 mg oral</i>	Preferred	
<i>isosorbide mononitrate</i>	Preferred	
<i>isosorbide mononitrate er tablet extended release 24 hour 120 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>isosorbide mononitrate er tablet extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>isosorbide mononitrate er tablet extended release 24 hour 60 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>nitroglycerin sublingual</i>	Preferred	
<i>nitroglycerin transdermal</i>	Preferred	
<i>nitroglycerin translingual</i>	Non – Preferred	
<b>ISORDIL TITRADOSE</b>	Non – Preferred	
<b>NITRO-BID</b>	Preferred	
<b>NITRO-DUR</b>	Non – Preferred	

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<b>NITROLINGUAL</b>	Non – Preferred	
<b>NITROSTAT</b>	Non – Preferred	
<b>*Antianxiety Agents* - Drugs For The Nervous System</b>		
<b>*Antianxiety Agents - Misc.*** - Drugs For Anxiety</b>		
<i>bupirone hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>bupirone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bupirone hcl tablet 30 mg oral</i>	Preferred	
<i>bupirone hcl tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>bupirone hcl tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>bupirone hcl tablet 7.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine hcl oral syrup</i>	Preferred	
<i>hydroxyzine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine hcl tablet 50 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>hydroxyzine pamoate capsule 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine pamoate capsule 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>hydroxyzine pamoate capsule 50 mg oral</i>	Preferred	
<i>hydroxyzine pamoate capsule 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>meprobamate</i>	Non – Preferred	
<b>VISTARIL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>*Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<i>alprazolam er</i>	Non – Preferred	QL (2 EA per 1 day)
<i>alprazolam oral tablet dispersible</i>	Non – Preferred	
<i>alprazolam tablet 0.25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)

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<i>alprazolam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>alprazolam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>alprazolam xr</i>	Non – Preferred	QL (2 EA per 1 day)
<i>chlordiazepoxide hcl capsule 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlordiazepoxide hcl capsule 25 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>chlordiazepoxide hcl capsule 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>clorazepate dipotassium tablet 15 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>clorazepate dipotassium tablet 3.75 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>clorazepate dipotassium tablet 7.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diazepam oral concentrate</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral solution</i>	Preferred	QL (10 ML per 1 day)
<i>diazepam oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam oral concentrate</i>	Preferred	QL (2 ML per 1 day)
<i>lorazepam tablet 0.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lorazepam tablet 1 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lorazepam tablet 2 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>oxazepam</i>	Preferred	QL (4 EA per 1 day)
<b>ALPRAZOLAM INTENSOL</b>	Preferred	
<b>ATIVAN TABLET 0.5 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>ATIVAN TABLET 1 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>ATIVAN TABLET 2 MG ORAL</b>	Non – Preferred	QL (5 EA per 1 day)
<b>DIAZEPAM INTENSOL</b>	Preferred	QL (10 ML per 1 day)
<b>LORAZEPAM INTENSOL</b>	Preferred	QL (2 ML per 1 day)
<b>LOREEV XR</b>	Non – Preferred	
<b>XANAX TABLET 0.25 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>XANAX TABLET 0.5 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>XANAX TABLET 1 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>XANAX TABLET 2 MG ORAL</b>	Non – Preferred	QL (5 EA per 1 day)
<b>XANAX XR</b>	Non – Preferred	QL (2 EA per 1 day)

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<b>*Antiarrhythmics* - Drugs For The Heart</b>		
<b>*Antiarrhythmics Type I-A*** - Drugs For Abnormal Heart Rhythms</b>		
<i>disopyramide phosphate</i>	Preferred	
<i>quinidine gluconate er</i>	Preferred	
<i>quinidine sulfate</i>	Preferred	
<b>NORPACE</b>	Non – Preferred	
<b>NORPACE CR</b>	Preferred	
<b>*Antiarrhythmics Type I-B*** - Drugs For Abnormal Heart Rhythms</b>		
<i>mexiletine hcl</i>	Preferred	
<b>*Antiarrhythmics Type I-C*** - Drugs For Abnormal Heart Rhythms</b>		
<i>flecainide acetate</i>	Preferred	
<i>propafenone hcl</i>	Preferred	
<i>propafenone hcl er</i>	Non – Preferred	
<b>RYTHMOL SR</b>	Non – Preferred	
<b>*Antiarrhythmics Type Iii*** - Drugs For Abnormal Heart Rhythms</b>		
<i>amiodarone hcl</i>	Preferred	
<i>dofetilide</i>	Preferred	
<b>MULTAQ</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PACERONE</b>	Preferred	
<b>TIKOSYN</b>	Non – Preferred	

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<b>*Antiasthmatic And Bronchodilator Agents* - Drugs For The Lungs</b>		
<b>*5-Lipoxygenase Inhibitors*** - Drugs For Asthma/Copd</b>		
<i>zileuton er</i>	Non – Preferred	
<b>ZYFLO</b>	Non – Preferred	
<b>*Adrenergic Combinations*** - Drugs For Asthma/Copd</b>		
<i>budesonide-formoterol fumarate</i>	Non – Preferred	QL (10.3 GM per 20 days)
<i>fluticasone furoate-vilanterol aerosol powder breath activated 100-25 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone furoate-vilanterol aerosol powder breath activated 200-25 mcg/act inhalation</i>	Non – Preferred	QL (1 Pack per 30 days)
<i>fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation</i>	Non – Preferred	
<i>fluticasone-salmeterol inhalation aerosol</i>	Non – Preferred	
<i>ipratropium-albuterol</i>	Preferred	QL (18 ML per 1 day)
<b>ADVAIR DISKUS</b>	Preferred	
<b>ADVAIR HFA AEROSOL 115-21 MCG/ACT INHALATION</b>	Preferred	
<b>ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION</b>	Non – Preferred	

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ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION	Preferred	
ADVAIR HFA AEROSOL 45-21 MCG/ACT INHALATION	Preferred	
AIRDUO DIGIHALER	Preferred	
AIRDUO RESPICLICK 113/14	Preferred	
AIRDUO RESPICLICK 232/14	Preferred	
AIRDUO RESPICLICK 55/14	Preferred	
AIRSUPRA	Non – Preferred	
ANORO ELLIPTA	Preferred	
BEVESPI AEROSPHERE	Non – Preferred	QL (10.7 GM per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT INHALATION	Non – Preferred	QL (60 GM per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT INHALATION	Non – Preferred	QL (1 Pack per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH INHALATION	Non – Preferred	
BREYNA AEROSOL 160-4.5 MCG/ACT INHALATION	Non – Preferred	QL (10.3 GM per 20 days)
BREYNA AEROSOL 80-4.5 MCG/ACT INHALATION	Preferred	QL (10.3 GM per 20 days)
BREZTRI AEROSPHERE	Non – Preferred	
COMBIVENT RESPIMAT	Non – Preferred	QL (8 GM per 28 days)
DUAKLIR PRESSAIR	Non – Preferred	
DULERA AEROSOL 100-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 200-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 50-5 MCG/ACT INHALATION	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STIOLTO RESPIMAT	Non – Preferred	QL (1 CANISTER per 28 days)
SYMBICORT	Preferred	QL (10.3 GM per 20 days)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
<b><i>*Anti-Ige Monoclonal Antibodies*** - Drugs For Asthma/Copd</i></b>		
XOLAIR SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS	Non – Preferred	
XOLAIR SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS	Preferred	PA
XOLAIR SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS	Preferred	PA
XOLAIR SOLUTION RECONSTITUTED 150 MG SUBCUTANEOUS	Non – Preferred	
XOLAIR SOLUTION RECONSTITUTED 150 MG SUBCUTANEOUS	Preferred	PA
<b><i>*Anti-Inflammatory Agents*** - Drugs For Asthma/Copd</i></b>		
<i>cromolyn sodium</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Beta Adrenergics*** - Drugs For Asthma/Copd</b>		
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Non – Preferred	QL (36 GM per 30 days)
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	QL (36 GM per 30 days)
<i>albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 0.63 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 1.25 mg/3ml inhalation</i>	Preferred	QL (12 ML per 1 day)
<i>albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation</i>	Preferred	QL (2 EA per 1 day)
<i>albuterol sulfate oral</i>	Non – Preferred	
<i>arformoterol tartrate</i>	Non – Preferred	
<i>formoterol fumarate</i>	Non – Preferred	
<i>levalbuterol hcl</i>	Non – Preferred	
<i>levalbuterol tartrate</i>	Non – Preferred	QL (30 GM per 30 days)
<i>terbutaline sulfate</i>	Preferred	
<b>BROVANA</b>	Non – Preferred	
<b>PERFOROMIST</b>	Non – Preferred	
<b>PROAIR DIGIHALER</b>	Non – Preferred	
<b>PROAIR RESPICLICK</b>	Non – Preferred	
<b>PROVENTIL HFA</b>	Preferred	QL (36 GM per 30 days)
<b>SEREVENT DISKUS</b>	Preferred	QL (2 EA per 1 day)
<b>STRIVERDI RESPIMAT</b>	Non – Preferred	QL (4 GM per 28 days)
<b>VENTOLIN HFA</b>	Non – Preferred	QL (36 GM per 30 days)
<b>XOPENEX HFA AEROSOL 45 MCG/ACT INHALATION</b>	Non – Preferred	QL (30 GM per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Bronchodilators - Anticholinergics*** - Drugs For Asthma/Copd</b>		
<i>ipratropium bromide</i>	Preferred	
<i>tiotropium bromide monohydrate</i>	Preferred	
<b>ATROVENT HFA</b>	Preferred	QL (26 GM per 30 days)
<b>INCRUSE ELLIPTA</b>	Preferred	
<b>SPIRIVA HANDIHALER</b>	Preferred	
<b>SPIRIVA RESPIMAT</b>	Preferred	
<b>TUDORZA PRESSAIR</b>	Non – Preferred	
<b>YUPELRI</b>	Non – Preferred	
<b>*Interleukin-5 Antagonists (Igg1 Kappa)*** - Drugs For Asthma/Copd</b>		
<b>FASENRA</b>	Preferred	PA
<b>FASENRA PEN</b>	Preferred	PA
<b>NUCALA</b>	Preferred	PA
<b>*Interleukin-5 Antagonists (Igg4 Kappa)*** - Drugs For Asthma/Copd</b>		
<b>CINQAIR</b>	Non – Preferred	
<b>*Leukotriene Receptor Antagonists*** - Drugs For Asthma/Copd</b>		
<i>montelukast sodium</i>	Preferred	QL (1 EA per 1 day)
<i>zafirlukast tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>zafirlukast tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>zafirlukast tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day)
<b>ACCOLATE</b>	Non – Preferred	QL (2 EA per 1 day)
<b>SINGULAIR</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Selective Phosphodiesterase 4 (Pde4) Inhibitors*** - Drugs For Asthma/Copd</b>		
<i>roflumilast</i>	Non – Preferred	
<b>DALIRESP</b>	Non – Preferred	
<b>*Steroid Inhalants*** - Drugs For Asthma/Copd</b>		
<i>budesonide suspension 0.25 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>budesonide suspension 0.5 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>budesonide suspension 1 mg/2ml inhalation</i>	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
<i>fluticasone propionate diskus aerosol powder breath activated 100 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone propionate diskus aerosol powder breath activated 250 mcg/act inhalation</i>	Non – Preferred	QL (2 EA per 1 day)
<i>fluticasone propionate diskus aerosol powder breath activated 50 mcg/act inhalation</i>	Non – Preferred	QL (60 EA Max Qty Per Fill Retail)
<i>fluticasone propionate hfa</i>	Non – Preferred	
<b>ALVESCO</b>	Non – Preferred	
<b>ARMONAIR DIGIHALER</b>	Non – Preferred	
<b>ARNUITY ELLIPTA</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ASMANEX (120 METERED DOSES)</b>	Preferred	
<b>ASMANEX (14 METERED DOSES)</b>	Preferred	
<b>ASMANEX (30 METERED DOSES)</b>	Preferred	
<b>ASMANEX (60 METERED DOSES)</b>	Preferred	
<b>ASMANEX HFA</b>	Non – Preferred	
<b>FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION</b>	Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250 MCG/ACT INHALATION	Preferred	QL (2 EA per 1 day)
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION	Preferred	QL (60 EA Max Qty Per Fill Retail)
FLOVENT HFA AEROSOL 110 MCG/ACT INHALATION	Preferred	QL (0.4 GM per 1 day)
FLOVENT HFA AEROSOL 220 MCG/ACT INHALATION	Preferred	QL (0.4 GM per 1 day)
FLOVENT HFA AEROSOL 44 MCG/ACT INHALATION	Preferred	QL (0.3534 GM per 1 day)
PULMICORT	Non – Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
PULMICORT FLEXHALER	Non – Preferred	
QVAR REDHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION	Non – Preferred	QL (0.3533 GM per 1 day)
QVAR REDHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION	Non – Preferred	
<b><i>*Thymic Stromal Lymphopoietin (Tslp) Antagonists*** - Drugs For Asthma/Copd</i></b>		
TEZSPIRE	Non – Preferred	
<b><i>*Xanthines*** - Drugs For Asthma/Copd</i></b>		
<i>theophylline</i>	Preferred	
<i>theophylline er</i>	Preferred	
<b>THEO-24</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Anticoagulants* - Drugs For The Blood</b>		
<b>*Coumarin Anticoagulants*** - Drugs To Prevent Blood Clots</b>		
<i>warfarin sodium</i>	Preferred	
<b>JANTOVEN</b>	Preferred	
<b>*Direct Factor Xa Inhibitors*** - Drugs To Prevent Blood Clots</b>		
<b>ELIQUIS</b>	Preferred	QL (2 EA per 1 day)
<b>ELIQUIS DVT/PE STARTER PACK</b>	Preferred	QL (2 EA per 1 day)
<b>SAVAYSA</b>	Non – Preferred	
<b>XARELTO ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	
<b>XARELTO STARTER PACK</b>	Preferred	QL (51 EA per 30 days)
<b>XARELTO TABLET 10 MG ORAL</b>	Preferred	
<b>XARELTO TABLET 15 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>XARELTO TABLET 2.5 MG ORAL</b>	Preferred	
<b>XARELTO TABLET 20 MG ORAL</b>	Preferred	
<b>*Heparins And Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots</b>		
<i>heparin na (pork) lock flsh pf</i>	Preferred	
<i>heparin sod (pork) lock flush</i>	Preferred	
<i>heparin sodium (porcine) injection solution prefilled syringe</i>	Preferred	
<i>heparin sodium (porcine) pf</i>	Preferred	
<i>heparin sodium (porcine) solution 1000 unit/ml injection</i>	Preferred	QL (1 ML per 1 day)
<i>heparin sodium (porcine) solution 1000 unit/ml injection</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>heparin sodium (porcine) solution 10000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 20000 unit/ml injection</i>	Preferred	
<i>heparin sodium (porcine) solution 5000 unit/ml injection</i>	Preferred	
<b>*Low Molecular Weight Heparins*** - Drugs To Prevent Blood Clots</b>		
<i>enoxaparin sodium</i>	Preferred	
<b>FRAGMIN</b>	Preferred	
<b>LOVENOX</b>	Non – Preferred	
<b>*Synthetic Heparinoid-Like Agents*** - Drugs To Prevent Blood Clots</b>		
<i>fondaparinux sodium</i>	Preferred	
<b>ARIXTRA</b>	Non – Preferred	
<b>*Thrombin Inhibitors - Selective Direct &amp; Reversible*** - Drugs To Prevent Blood Clots</b>		
<i>dabigatran etexilate mesylate</i>	Non – Preferred	
<b>PRADAXA</b>	Non – Preferred	
<b>*Anticonvulsants* - Drugs For The Nervous System</b>		
<b>*Ampa Glutamate Receptor Antagonists*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<b>FYCOMPA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Anticonvulsants - Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<i>clobazam</i>	Non – Preferred	
<i>clonazepam oral tablet</i>	Preferred	
<i>clonazepam oral tablet dispersible</i>	Non – Preferred	
<i>diazepam</i>	Preferred	QL (2 EA Max Qty Per Fill Retail)
<b>DIASTAT ACUDIAL</b>	Preferred	QL (2 EA Max Qty Per Fill Retail)
<b>DIASTAT PEDIATRIC</b>	Preferred	QL (2 EA Max Qty Per Fill Retail)
<b>KLONOPIN</b>	Non – Preferred	
<b>NAYZILAM</b>	Non – Preferred	
<b>ONFI</b>	Non – Preferred	
<b>SYMPAZAN</b>	Non – Preferred	
<b>VALTOCO 10 MG DOSE</b>	Non – Preferred	
<b>VALTOCO 15 MG DOSE</b>	Non – Preferred	
<b>VALTOCO 20 MG DOSE</b>	Non – Preferred	
<b>VALTOCO 5 MG DOSE</b>	Non – Preferred	
<b>*Anticonvulsants - Misc.*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<i>carbamazepine</i>	Preferred	
<i>carbamazepine er oral capsule extended release 12 hour</i>	Non – Preferred	QL (4 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Preferred	QL (5 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>gabapentin capsule 100 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin capsule 300 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin capsule 400 mg oral</i>	Preferred	
<i>gabapentin capsule 400 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin oral solution</i>	Preferred	
<i>gabapentin tablet 600 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>gabapentin tablet 800 mg oral</i>	Preferred	QL (4.5 EA per 1 day)
<i>lacosamide</i>	Non – Preferred	
<i>lamotrigine er</i>	Non – Preferred	
<i>lamotrigine oral kit</i>	Non – Preferred	
<i>lamotrigine oral tablet dispersible</i>	Non – Preferred	
<i>lamotrigine starter kit-blue</i>	Non – Preferred	
<i>lamotrigine starter kit-green</i>	Non – Preferred	
<i>lamotrigine starter kit-orange</i>	Non – Preferred	
<i>lamotrigine tablet 100 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet 100 mg oral</i>	Preferred	
<i>lamotrigine tablet 150 mg oral</i>	Preferred	
<i>lamotrigine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamotrigine tablet 25 mg oral</i>	Preferred	
<i>lamotrigine tablet 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 25 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lamotrigine tablet chewable 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>levetiracetam er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>levetiracetam oral solution</i>	Preferred	
<i>levetiracetam tablet 1000 mg oral</i>	Preferred	QL (3 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>levetiracetam tablet 250 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>levetiracetam tablet 500 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>levetiracetam tablet 750 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxcarbazepine</i>	Preferred	
<i>pregabalin</i>	Preferred	
<i>primidone</i>	Preferred	
<i>rufinamide</i>	Non – Preferred	
<i>topiramate er</i>	Non – Preferred	
<i>topiramate oral capsule sprinkle</i>	Preferred	QL (4 EA per 1 day)
<i>topiramate tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>topiramate tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>topiramate tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>topiramate tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>zonisamide</i>	Preferred	QL (6 EA per 1 day)
<b>APTIOM</b>	Non – Preferred	
<b>BANZEL</b>	Non – Preferred	
<b>BRIVIACT</b>	Non – Preferred	
<b>CARBATROL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>DIACOMIT</b>	Non – Preferred	
<b>ELEPSIA XR</b>	Non – Preferred	
<b>EPIDIOLEX</b>	Non – Preferred	
<b>EPITOL</b>	Preferred	
<b>EPRONTIA</b>	Non – Preferred	
<b>FINTEPLA</b>	Non – Preferred	
<b>KEPPRA ORAL SOLUTION</b>	Non – Preferred	
<b>KEPPRA TABLET 1000 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day)
<b>KEPPRA TABLET 250 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>KEPPRA TABLET 500 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>KEPPRA TABLET 750 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>LAMICTAL ODT</b>	Non – Preferred	
<b>LAMICTAL STARTER</b>	Non – Preferred	
<b>LAMICTAL TABLET 100 MG ORAL</b>	Non – Preferred	
<b>LAMICTAL TABLET 150 MG ORAL</b>	Non – Preferred	
<b>LAMICTAL TABLET 200 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>LAMICTAL TABLET 25 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>LAMICTAL TABLET CHEWABLE 25 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>LAMICTAL TABLET CHEWABLE 5 MG ORAL</b>	Non – Preferred	QL (8 EA per 1 day)
<b>LAMICTAL XR</b>	Non – Preferred	
<b>LYRICA</b>	Non – Preferred	
<b>MOTPOLY XR</b>	Non – Preferred	
<b>MYSOLINE</b>	Non – Preferred	
<b>NEURONTIN ORAL CAPSULE</b>	Non – Preferred	QL (6 EA per 1 day)
<b>NEURONTIN ORAL SOLUTION</b>	Non – Preferred	
<b>NEURONTIN TABLET 600 MG ORAL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>NEURONTIN TABLET 800 MG ORAL</b>	Non – Preferred	QL (4.5 EA per 1 day)
<b>OXTELLAR XR</b>	Non – Preferred	
<b>QUDEXY XR</b>	Non – Preferred	
<b>ROWEEPRA</b>	Preferred	QL (6 EA per 1 day)
<b>SPRITAM</b>	Non – Preferred	
<b>SUBVENITE STARTER KIT-BLUE</b>	Non – Preferred	
<b>SUBVENITE STARTER KIT-GREEN</b>	Non – Preferred	
<b>SUBVENITE STARTER KIT-ORANGE</b>	Non – Preferred	
<b>SUBVENITE TABLET 100 MG ORAL</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUBVENITE TABLET 150 MG ORAL	Preferred	
SUBVENITE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
SUBVENITE TABLET 25 MG ORAL	Preferred	QL (6 EA per 1 day)
TEGRETOL	Non – Preferred	
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	QL (10 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX SPRINKLE	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 100 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX TABLET 25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 50 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TRILEPTAL	Non – Preferred	
TROKENDI XR	Non – Preferred	
VIMPAT	Non – Preferred	
ZONISADE	Non – Preferred	
<b><i>*Carbamates*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i></b>		
<i>felbamate</i>	Non – Preferred	
FELBATOL	Non – Preferred	
XCOPRI	Preferred	
XCOPRI (250 MG DAILY DOSE)	Preferred	
XCOPRI (350 MG DAILY DOSE)	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Gaba Modulators*** - Drugs For Seizures / Personality Disorder / Nerve Pain</b>		
<i>tiagabine hcl tablet 12 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>tiagabine hcl tablet 16 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>tiagabine hcl tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>tiagabine hcl tablet 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>vigabatrin</i>	Non – Preferred	
<b>SABRIL</b>	Non – Preferred	
<b>VIGADRONE</b>	Non – Preferred	
<b>*Hydantoins*** - Drugs For Seizures / Personality Disorder / Nerve Pain</b>		
<i>phenytoin</i>	Preferred	
<i>phenytoin sodium extended</i>	Preferred	
<b>DILANTIN</b>	Non – Preferred	
<b>DILANTIN INFATABS</b>	Non – Preferred	
<b>PHENYTEK</b>	Preferred	
<b>PHENYTOIN INFATABS</b>	Preferred	
<b>*Succinimides*** - Drugs For Seizures / Personality Disorder / Nerve Pain</b>		
<i>ethosuximide</i>	Preferred	
<i>methsuximide</i>	Non – Preferred	
<b>CELONTIN</b>	Non – Preferred	
<b>ZARONTIN</b>	Non – Preferred	
<b>*Valproic Acid*** - Drugs For Seizures / Personality Disorder / Nerve Pain</b>		
<i>divalproex sodium</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>divalproex sodium er</i>	Preferred	
<i>valproic acid</i>	Preferred	
<b>DEPAKOTE</b>	Non – Preferred	
<b>DEPAKOTE ER</b>	Non – Preferred	
<b>DEPAKOTE SPRINKLES</b>	Non – Preferred	
<b>*Antidepressants* - Drugs For The Nervous System</b>		
<b>*Alpha-2 Receptor Antagonists (Tetracyclics)*** - Drugs For Depression</b>		
<i>mirtazapine</i>	Preferred	QL (1 EA per 1 day)
<b>REMERON</b>	Non – Preferred	QL (1 EA per 1 day)
<b>REMERON SOLTAB</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Antidepressants - Misc.*** - Drugs For Depression</b>		
<i>bupropion hcl</i>	Preferred	QL (3 EA per 1 day)
<i>bupropion hcl er (smoking det)</i>	Preferred	QL (2 EA per 1 day)
<i>bupropion hcl er (sr)</i>	Preferred	QL (2 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral</i>	Preferred	
<b>APLENZIN</b>	Non – Preferred	
<b>FORFIVO XL</b>	Non – Preferred	
<b>WELLBUTRIN SR</b>	Non – Preferred	QL (2 EA per 1 day)
<b>WELLBUTRIN XL</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Monoamine Oxidase Inhibitors (Maois)*** - Drugs For Depression</b>		
<i>phenelzine sulfate</i>	Preferred	
<i>tranylcypromine sulfate</i>	Preferred	
<b>EMSAM</b>	Non – Preferred	
<b>MARPLAN</b>	Non – Preferred	
<b>NARDIL</b>	Non – Preferred	
<b>*N-Methyl-D-Aspartic Acid (Nmda) Receptor Antagonists*** - Drugs For Depression</b>		
<b>SPRAVATO (56 MG DOSE)</b>	Non – Preferred	
<b>SPRAVATO (84 MG DOSE)</b>	Non – Preferred	
<b>*Selective Serotonin Reuptake Inhibitors (Ssris)*** - Drugs For Depression</b>		
<i>citalopram hydrobromide oral capsule</i>	Non – Preferred	
<i>citalopram hydrobromide oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>citalopram hydrobromide tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>citalopram hydrobromide tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>escitalopram oxalate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>escitalopram oxalate oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fluoxetine hcl capsule 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluoxetine hcl oral capsule delayed release</i>	Non – Preferred	
<i>fluoxetine hcl oral tablet</i>	Preferred	
<i>fluoxetine hcl solution 20 mg/5ml oral</i>	Preferred	QL (150 ML per 30 days)
<i>fluvoxamine maleate er</i>	Non – Preferred	
<i>fluvoxamine maleate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>fluvoxamine maleate tablet 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fluvoxamine maleate tablet 50 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl er</i>	Non – Preferred	
<i>paroxetine hcl oral suspension</i>	Preferred	
<i>paroxetine hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>paroxetine hcl tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>paroxetine hcl tablet 40 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>sertraline hcl concentrate 20 mg/ml oral</i>	Preferred	
<i>sertraline hcl concentrate 20 mg/ml oral</i>	Preferred	QL (120 ML per 30 days)
<i>sertraline hcl oral capsule</i>	Non – Preferred	
<i>sertraline hcl oral tablet</i>	Preferred	QL (2 EA per 1 day)
<b>CELEXA TABLET 10 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>CELEXA TABLET 20 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>CELEXA TABLET 40 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>LEXAPRO</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PAXIL CR</b>	Non – Preferred	
<b>PAXIL ORAL SUSPENSION</b>	Non – Preferred	
<b>PAXIL TABLET 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PAXIL TABLET 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PAXIL TABLET 30 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PAXIL TABLET 40 MG ORAL</b>	Non – Preferred	QL (1.5 EA per 1 day)
<b>PROZAC CAPSULE 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PROZAC CAPSULE 20 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PROZAC CAPSULE 40 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>ZOLOFT ORAL CONCENTRATE</b>	Non – Preferred	QL (120 ML per 30 days)
<b>ZOLOFT ORAL TABLET</b>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Serotonin Modulators*** - Drugs For Depression</b>		
<i>nefazodone hcl</i>	Non – Preferred	
<i>trazodone hcl</i>	Preferred	
<i>vilazodone hcl</i>	Non – Preferred	
<b>TRINTELLIX</b>	Non – Preferred	
<b>VIIBRYD</b>	Non – Preferred	
<b>VIIBRYD STARTER PACK</b>	Non – Preferred	
<b>*Serotonin-Norepinephrine Reuptake Inhibitors (Snrts)*** - Drugs For Depression</b>		
<i>desvenlafaxine er</i>	Non – Preferred	
<i>desvenlafaxine succinate er</i>	Non – Preferred	
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>venlafaxine hcl</i>	Preferred	
<i>venlafaxine hcl er oral capsule extended release 24 hour</i>	Preferred	QL (1 EA per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour</i>	Non – Preferred	
<b>CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EFFEXOR XR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>FETZIMA</b>	Non – Preferred	
<b>FETZIMA TITRATION</b>	Non – Preferred	
<b>PRISTIQ</b>	Non – Preferred	
<b>*Tricyclic Agents*** - Drugs For Depression</b>		
<i>amitriptyline hcl</i>	Preferred	
<i>amoxapine</i>	Non – Preferred	
<i>clomipramine hcl</i>	Preferred	
<i>desipramine hcl tablet 10 mg oral</i>	Preferred	
<i>desipramine hcl tablet 100 mg oral</i>	Preferred	
<i>desipramine hcl tablet 150 mg oral</i>	Preferred	
<i>desipramine hcl tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>desipramine hcl tablet 50 mg oral</i>	Preferred	
<i>desipramine hcl tablet 75 mg oral</i>	Preferred	
<i>doxepin hcl</i>	Preferred	
<i>imipramine hcl</i>	Preferred	
<i>imipramine pamoate</i>	Non – Preferred	
<i>nortriptyline hcl</i>	Preferred	
<i>protriptyline hcl</i>	Preferred	
<i>trimipramine maleate</i>	Non – Preferred	
<b>ANAFRANIL</b>	Non – Preferred	
<b>NORPRAMIN TABLET 10 MG ORAL</b>	Non – Preferred	
<b>NORPRAMIN TABLET 25 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PAMELOR</b>	Non – Preferred	
<b>*Antidiabetics* - Hormones</b>		
<b>*Alpha-Glucosidase Inhibitors*** - Drugs For Diabetes</b>		
<i>acarbose</i>	Preferred	QL (3 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>miglitol</i>	Preferred	
<b>*Antidiabetic - Amylin Analogs*** - Drugs For Diabetes</b>		
<b>SYMLINPEN 120</b>	Non – Preferred	
<b>SYMLINPEN 60</b>	Non – Preferred	
<b>*Biguanides*** - Drugs For Diabetes</b>		
<i>metformin hcl er (mod)</i>	Non – Preferred	
<i>metformin hcl er (osm)</i>	Non – Preferred	
<i>metformin hcl er tablet extended release 24 hour 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metformin hcl er tablet extended release 24 hour 750 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metformin hcl oral solution</i>	Non – Preferred	
<i>metformin hcl tablet 1000 mg oral</i>	Preferred	
<i>metformin hcl tablet 500 mg oral</i>	Preferred	
<i>metformin hcl tablet 625 mg oral</i>	Non – Preferred	
<i>metformin hcl tablet 850 mg oral</i>	Preferred	
<b>GLUMETZA</b>	Non – Preferred	
<b>RIOMET</b>	Non – Preferred	
<b>*Diabetic Other*** - Drugs For Diabetes</b>		
<i>diazoxide</i>	Preferred	
<i>glucagon emergency</i>	Non – Preferred	
<b>BAQSIMI ONE PACK</b>	Preferred	
<b>BAQSIMI TWO PACK</b>	Preferred	
<b>GLUCAGEN HYPOKIT</b>	Non – Preferred	
<b>GVOKE HYPOPEN 1-PACK</b>	Preferred	
<b>GVOKE HYPOPEN 2-PACK</b>	Preferred	
<b>GVOKE KIT</b>	Preferred	
<b>GVOKE PFS</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGLYCEM	Preferred	
ZEGALOGUE	Preferred	
<b>*Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors*** - Drugs For Diabetes</b>		
<i>alogliptin benzoate</i>	Non – Preferred	QL (1 EA per 1 day)
<i>saxagliptin hcl</i>	Non – Preferred	
<b>JANUVIA</b>	Preferred	QL (1 EA per 1 day)
<b>NESINA</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ONGLYZA</b>	Non – Preferred	
<b>TRADJENTA</b>	Preferred	QL (1 EA per 1 day)
<b>*Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations*** - Drugs For Diabetes</b>		
<i>alogliptin-metformin hcl</i>	Non – Preferred	
<i>saxagliptin-metformin er</i>	Non – Preferred	
<b>JANUMET</b>	Non – Preferred	QL (2 EA per 1 day)
<b>JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL</b>	Non – Preferred	
<b>JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>JENTADUETO</b>	Non – Preferred	
<b>JENTADUETO XR</b>	Non – Preferred	
<b>KAZANO</b>	Non – Preferred	
<b>KOMBIGLYZE XR</b>	Non – Preferred	
<b>*Dopamine Receptor Agonists - Ergot Derivatives*** - Drugs For Diabetes</b>		
<b>CYCLOSET</b>	Non – Preferred	

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<b>*Dpp-4 Inhibitor-Thiazolidinedione Combinations*** - Drugs For Diabetes</b>		
<i>alogliptin-pioglitazone</i>	Non – Preferred	QL (1 EA per 1 day)
<b>OSENI</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Human Insulin*** - Drugs For Diabetes</b>		
<i>insulin asp prot &amp; asp flexpen</i>	Non – Preferred	
<i>insulin aspart</i>	Non – Preferred	
<i>insulin aspart flexpen</i>	Non – Preferred	
<i>insulin aspart penfill</i>	Non – Preferred	
<i>insulin aspart prot &amp; aspart</i>	Non – Preferred	
<i>insulin degludec</i>	Non – Preferred	
<i>insulin degludec flextouch</i>	Non – Preferred	
<i>insulin glargine</i>	Non – Preferred	
<i>insulin glargine solostar</i>	Non – Preferred	
<i>insulin glargine-yfgn</i>	Non – Preferred	
<i>insulin lispro</i>	Preferred	
<i>insulin lispro (1 unit dial)</i>	Preferred	
<i>insulin lispro junior kwikpen</i>	Preferred	QL (1 ML per 1 day)
<i>insulin lispro prot &amp; lispro</i>	Preferred	
<b>ADMELOG</b>	Non – Preferred	
<b>ADMELOG SOLOSTAR</b>	Non – Preferred	
<b>AFREZZA</b>	Non – Preferred	
<b>APIDRA</b>	Non – Preferred	
<b>APIDRA SOLOSTAR</b>	Non – Preferred	
<b>BASAGLAR KWIKPEN</b>	Non – Preferred	
<b>BASAGLAR TEMPO PEN</b>	Non – Preferred	
<b>FIASP</b>	Non – Preferred	
<b>FIASP FLEXTOUCH</b>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>FIASP PENFILL</b>	Non – Preferred	
<b>FIASP PUMPCART</b>	Non – Preferred	
<b>HUMALOG</b>	Preferred	
<b>HUMALOG JUNIOR KWIKPEN</b>	Preferred	QL (1 ML per 1 day)
<b>HUMALOG KWIKPEN</b>	Preferred	
<b>HUMALOG MIX 50/50</b>	Preferred	
<b>HUMALOG MIX 50/50 KWIKPEN</b>	Preferred	
<b>HUMALOG MIX 75/25</b>	Preferred	
<b>HUMALOG MIX 75/25 KWIKPEN</b>	Preferred	
<b>HUMALOG TEMPO PEN</b>	Non – Preferred	
<b>HUMULIN 70/30</b>	Preferred	OTC
<b>HUMULIN 70/30 KWIKPEN</b>	Preferred	OTC
<b>HUMULIN N</b>	Preferred	OTC
<b>HUMULIN N KWIKPEN</b>	Preferred	OTC
<b>HUMULIN R</b>	Preferred	OTC
<b>HUMULIN R U-500 (CONCENTRATED)</b>	Preferred	
<b>HUMULIN R U-500 KWIKPEN</b>	Preferred	
<b>LANTUS</b>	Preferred	
<b>LANTUS SOLOSTAR</b>	Preferred	
<b>LEVEMIR</b>	Preferred	
<b>LEVEMIR FLEXPEN</b>	Preferred	
<b>LYUMJEV</b>	Non – Preferred	
<b>LYUMJEV KWIKPEN</b>	Non – Preferred	
<b>LYUMJEV TEMPO PEN</b>	Non – Preferred	
<b>NOVOLIN 70/30</b>	Non – Preferred	OTC
<b>NOVOLIN 70/30 FLEXPEN</b>	Non – Preferred	OTC
<b>NOVOLIN 70/30 FLEXPEN RELION</b>	Non – Preferred	OTC
<b>NOVOLIN 70/30 RELION</b>	Non – Preferred	OTC
<b>NOVOLIN N</b>	Non – Preferred	OTC

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NOVOLIN N FLEXPEN	Non – Preferred	
NOVOLIN N FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN N RELION	Non – Preferred	OTC
NOVOLIN R	Non – Preferred	OTC
NOVOLIN R FLEXPEN	Non – Preferred	OTC
NOVOLIN R FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN R RELION	Non – Preferred	OTC
NOVOLOG	Non – Preferred	
NOVOLOG 70/30 FLEXPEN RELION	Non – Preferred	
NOVOLOG FLEXPEN	Non – Preferred	
NOVOLOG FLEXPEN RELION	Non – Preferred	
NOVOLOG MIX 70/30	Non – Preferred	
NOVOLOG MIX 70/30 FLEXPEN	Non – Preferred	
NOVOLOG MIX 70/30 RELION	Non – Preferred	
NOVOLOG PENFILL	Non – Preferred	
NOVOLOG RELION	Non – Preferred	
SEMGLEE	Non – Preferred	
SEMGLEE (YFGN)	Non – Preferred	
TOUJEO MAX SOLOSTAR	Non – Preferred	
TOUJEO SOLOSTAR	Non – Preferred	
TRESIBA	Non – Preferred	
TRESIBA FLEXTOUCH	Non – Preferred	
<b><i>*Incretin Mimetic Agents (Gip &amp; Glp-1 Receptor Agonists)*** - Drugs For Diabetes</i></b>		
MOUNJARO	Non – Preferred	
<b><i>*Incretin Mimetic Agents (Glp-1 Receptor Agonists)*** - Drugs For Diabetes</i></b>		
BYDUREON BCISE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BYETTA 10 MCG PEN	Non – Preferred	
BYETTA 5 MCG PEN	Non – Preferred	
OZEMPIC (0.25 OR 0.5 MG/DOSE)	Non – Preferred	
OZEMPIC (1 MG/DOSE)	Non – Preferred	
OZEMPIC (2 MG/DOSE)	Non – Preferred	
RYBELSUS	Preferred	PA
TRULICITY	Preferred	
VICTOZA	Preferred	QL (0.6 ML per 1 day)
<b><i>*Insulin-Incretin Mimetic Combinations*** - Drugs For Diabetes</i></b>		
SOLIQUA	Non – Preferred	
XULTOPHY	Non – Preferred	
<b><i>*Meglitinide Analogues*** - Drugs For Diabetes</i></b>		
<i>nateglinide</i>	Preferred	QL (3 EA per 1 day)
<i>repaglinide tablet 0.5 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>repaglinide tablet 1 mg oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>repaglinide tablet 2 mg oral</i>	Non – Preferred	QL (8 EA per 1 day)
<b><i>*Progesterone Receptor Antagonists*** - Drugs For Diabetes</i></b>		
KORLYM	Non – Preferred	
<b><i>*SglT2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb*** - Drugs For Diabetes</i></b>		
TRIJARDY XR	Non – Preferred	
<b><i>*SglT2 Inhibitor - Dpp-4 Inhibitor Combinations*** - Drugs For Diabetes</i></b>		
GLYXAMBI	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QTERN	Non – Preferred	
STEGLUJAN	Non – Preferred	
<b>*Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors*** - Drugs For Diabetes</b>		
FARXIGA	Preferred	
INVOKANA	Preferred	
JARDIANCE	Preferred	QL (1 EA per 1 day)
STEGLATRO	Non – Preferred	
<b>*Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb*** - Drugs For Diabetes</b>		
INVOKAMET	Non – Preferred	
INVOKAMET XR	Non – Preferred	
SEGLUROMET	Non – Preferred	
SYNJARDY	Non – Preferred	
SYNJARDY XR	Non – Preferred	
XIGDUO XR	Non – Preferred	
<b>*Sulfonylurea-Biguanide Combinations*** - Drugs For Diabetes</b>		
<i>glipizide-metformin hcl tablet 2.5-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide-metformin hcl tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>glyburide-metformin tablet 1.25-250 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 2.5-500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glyburide-metformin tablet 5-500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<b>*Sulfonylureas*** - Drugs For Diabetes</b>		
<i>glimepiride tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>glimepiride tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glimepiride tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide</i>	Preferred	
<i>glipizide er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 2.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glipizide xl tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide</i>	Preferred	
<i>glyburide micronized tablet 1.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 3 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>glyburide micronized tablet 6 mg oral</i>	Preferred	
<b>GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 2.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>GLYNASE</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Sulfonylurea-Thiazolidinedione Combinations*** - Drugs For Diabetes</b>		
<i>pioglitazone hcl-glimepiride</i>	Non – Preferred	
<b>DUETACT</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Thiazolidinedione-Biguanide Combinations*** - Drugs For Diabetes</b>		
<i>pioglitazone hcl-metformin hcl</i>	Non – Preferred	
<b>ACTOPLUS MET</b>	Non – Preferred	
<b>*Thiazolidinediones*** - Drugs For Diabetes</b>		
<i>pioglitazone hcl tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>pioglitazone hcl tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>pioglitazone hcl tablet 45 mg oral</i>	Preferred	
<i>pioglitazone hcl tablet 45 mg oral</i>	Preferred	QL (1 EA per 1 day)
<b>ACTOS</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Antidiarrheal/Probiotic Agents* - Drugs For The Stomach</b>		
<b>*Antidiarrheal/Probiotic Agents - Misc.*** - Drugs For Diarrhea</b>		
<i>bismuth subsalicylate</i>	Preferred	OTC
<i>stomach relief extra strength</i>	Preferred	OTC
<b>*Antiperistaltic Agents*** - Drugs For Diarrhea</b>		
<i>diphenoxylate-atropine</i>	Preferred	
<i>loperamide hcl oral capsule</i>	Preferred	
<i>loperamide hcl oral tablet</i>	Preferred	OTC
<b>*Antidotes And Specific Antagonists* - Drugs For Overdose Or Poisoning</b>		
<b>*Antidotes - Chelating Agents*** - Drugs For Overdose Or Poisoning</b>		
<i>deferasirox</i>	Non – Preferred	
<i>deferasirox granules</i>	Non – Preferred	

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<i>deferiprone</i>	Non – Preferred	
<b>CHEMET</b>	Preferred	
<b>EXJADE</b>	Non – Preferred	
<b>FERRIPROX</b>	Non – Preferred	
<b>FERRIPROX TWICE-A-DAY</b>	Non – Preferred	
<b>JADENU</b>	Non – Preferred	
<b>JADENU SPRINKLE</b>	Non – Preferred	
<b>*Opioid Antagonists*** - Drugs For Overdose Or Poisoning</b>		
<i>nalmefene hcl</i>	Preferred	
<i>naloxone hcl</i>	Preferred	
<i>naltrexone hcl</i>	Preferred	
<b>KLOXXADO</b>	Preferred	
<b>NARCAN</b>	Preferred	
<b>OPVEE</b>	Preferred	
<b>VIVITROL</b>	Preferred	
<b>ZIMHI</b>	Preferred	
<b>*Antiemetics* - Drugs For The Stomach</b>		
<b>*5-Ht3 Receptor Antagonists*** - Drugs For Vomiting And Nausea</b>		
<i>granisetron hcl tablet 1 mg oral</i>	Non – Preferred	QL (8 EA per 28 days)
<i>ondansetron</i>	Preferred	QL (3 EA per 1 day)
<i>ondansetron hcl oral tablet</i>	Preferred	QL (3 EA per 1 day)
<i>ondansetron hcl solution 4 mg/5ml oral</i>	Preferred	QL (50 ML per 1 day)
<i>ondansetron hcl solution 4 mg/5ml oral</i>	Preferred	QL (50 ML Max Qty Per Fill Retail)
<b>ANZEMET</b>	Non – Preferred	
<b>SANCUSO</b>	Non – Preferred	

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<b>*Antiemetic Combinations*** - Drugs For Vomiting And Nausea</b>		
<i>doxylamine-pyridoxine</i>	Non – Preferred	
<b>AKYNZEO</b>	Non – Preferred	
<b>BONJESTA</b>	Non – Preferred	
<b>DICLEGIS</b>	Non – Preferred	
<b>*Antiemetics - Anticholinergic*** - Drugs For Vomiting And Nausea</b>		
<i>meclizine hcl</i>	Preferred	
<i>scopolamine</i>	Preferred	
<i>trimethobenzamide hcl</i>	Non – Preferred	
<b>ANTIVERT</b>	Non – Preferred	
<b>TRANSDERM-SCOP</b>	Preferred	
<b>*Antiemetics - Miscellaneous*** - Drugs For Vomiting And Nausea</b>		
<i>dronabinol</i>	Non – Preferred	
<b>MARINOL</b>	Non – Preferred	
<b>*Substance P/Neurokinin 1 (Nk1) Receptor Antagonists*** - Drugs For Vomiting And Nausea</b>		
<i>aprepitant capsule 125 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant capsule 40 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant capsule 80 &amp; 125 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant capsule 80 mg oral</i>	Preferred	QL (3 EA per 30 days)
<i>aprepitant oral</i>	Preferred	QL (3 EA per 30 days)
<b>EMEND ORAL CAPSULE</b>	Non – Preferred	QL (3 EA per 30 days)
<b>EMEND ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	
<b>EMEND TRI-PACK</b>	Non – Preferred	QL (3 EA per 30 days)

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<b>*Antifungals* - Drugs For Infections</b>		
<b>*Antifungal - Glucan Synthesis Inhibitors (Echinocandins)*** - Drugs For Fungus</b>		
<i>micafungin sodium</i>	Preferred	
<b>*Antifungal - Glucan Synthesis Inhibitors (Triterpenoids)*** - Antibiotics</b>		
<b>BREXAFEMME</b>	Non – Preferred	
<b>*Antifungals*** - Drugs For Fungus</b>		
<i>flucytosine</i>	Non – Preferred	
<i>griseofulvin microsize</i>	Preferred	
<i>griseofulvin ultramicrosize</i>	Preferred	
<i>nystatin</i>	Preferred	QL (6 EA per 1 day)
<i>terbinafine hcl</i>	Preferred	QL (1 EA per 1 day)
<b>ANCOBON</b>	Non – Preferred	
<b>*Imidazoles*** - Drugs For Fungus</b>		
<i>ketoconazole</i>	Preferred	QL (1 EA per 1 day)
<b>*Tetrazoles*** - Drugs For Fungus</b>		
<b>VIVJOA</b>	Non – Preferred	
<b>*Triazoles*** - Drugs For Fungus</b>		
<i>fluconazole in sodium chloride</i>	Preferred	
<i>fluconazole oral suspension reconstituted</i>	Preferred	
<i>fluconazole tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 150 mg oral</i>	Preferred	QL (14 EA per 28 days)
<i>fluconazole tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>fluconazole tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>itraconazole oral capsule</i>	Preferred	QL (4 EA per 1 day)
<i>itraconazole oral solution</i>	Non – Preferred	

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<i>posaconazole</i>	Non – Preferred	
<i>tolsura</i>	Non – Preferred	
<i>voriconazole</i>	Non – Preferred	
<b>CRESEMBA</b>	Non – Preferred	
<b>DIFLUCAN ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	
<b>DIFLUCAN ORAL TABLET</b>	Non – Preferred	QL (2 EA per 1 day)
<b>NOXAFIL</b>	Non – Preferred	
<b>SPORANOX ORAL CAPSULE</b>	Non – Preferred	QL (4 EA per 1 day)
<b>SPORANOX ORAL SOLUTION</b>	Non – Preferred	
<b>VFEND</b>	Non – Preferred	
<b>*Antihistamines* - Drugs For The Lungs</b>		
<b>*Antihistamines - Alkylamines*** - Drugs For Allergies</b>		
<i>aller-chlor</i>	Preferred	OTC
<i>allergy</i>	Preferred	OTC
<i>allergy relief</i>	Preferred	OTC
<i>chlorpheniramine maleate</i>	Preferred	OTC
<b>WAL-FINATE</b>	Preferred	OTC
<b>*Antihistamines - Ethanolamines*** - Drugs For Allergies</b>		
<i>clemastine fumarate</i>	Preferred	OTC
<i>diphenhydramine hcl oral capsule</i>	Preferred	
<i>diphenhydramine hcl oral liquid</i>	Preferred	OTC; QL (20 ML per 1 day)
<i>diphenhydramine hcl oral tablet</i>	Preferred	OTC
<b>*Antihistamines - Non-Sedating*** - Drugs For Allergies</b>		
<i>cetirizine hcl oral solution</i>	Preferred	
<i>cetirizine hcl oral tablet</i>	Preferred	OTC; QL (1 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>cetirizine hcl oral tablet chewable</i>	Preferred	OTC
<i>fexofenadine hcl oral tablet 180 mg</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>fexofenadine hcl oral tablet 60 mg</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>levocetirizine dihydrochloride</i>	Preferred	QL (1 EA per 1 day)
<i>loratadine oral solution</i>	Preferred	OTC; QL (240 ML Max Qty Per Fill Retail)
<i>loratadine oral tablet</i>	Preferred	OTC; QL (1 EA per 1 day)
<b>*Antihistamines - Phenothiazines*** - Drugs For Allergies</b>		
<i>promethazine hcl oral syrup</i>	Preferred	QL (80 ML per 1 day); AL (Min 2 Years)
<i>promethazine hcl oral tablet</i>	Preferred	AL (Min 2 Years)
<i>promethazine hcl rectal</i>	Preferred	AL (Min 2 Years)
<b>*Antihistamines - Piperidines*** - Drugs For Allergies</b>		
<i>cyproheptadine hcl</i>	Preferred	
<b>*Antihyperlipidemics* - Drugs For The Heart</b>		
<b>*Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For Cholesterol</b>		
<b>NEXLIZET</b>	Non – Preferred	
<b>*Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For Cholesterol</b>		
<b>NEXLETOL</b>	Non – Preferred	
<b>*Antihyperlipidemics - Misc.*** - Drugs For Cholesterol</b>		
<i>icosapent ethyl</i>	Non – Preferred	
<i>omega-3-acid ethyl esters</i>	Non – Preferred	QL (4 EA per 1 day)

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<b>LOVAZA</b>	Non – Preferred	QL (4 EA per 1 day)
<b>VASCEPA</b>	Non – Preferred	
<b>*Bile Acid Sequestrants*** - Drugs For Cholesterol</b>		
<i>cholestyramine</i>	Preferred	
<i>cholestyramine light</i>	Preferred	
<i>colesevelam hcl</i>	Non – Preferred	
<i>colestipol hcl</i>	Non – Preferred	
<b>COLESTID</b>	Non – Preferred	
<b>COLESTID FLAVORED</b>	Non – Preferred	
<b>PREVALITE</b>	Preferred	
<b>QUESTRAN</b>	Non – Preferred	
<b>QUESTRAN LIGHT</b>	Non – Preferred	
<b>WELCHOL</b>	Non – Preferred	
<b>*Fibric Acid Derivatives*** - Drugs For Cholesterol</b>		
<i>fenofibrate</i>	Preferred	
<i>fenofibrate micronized</i>	Preferred	
<i>fenofibric acid oral capsule delayed release</i>	Preferred	
<i>fenofibric acid oral tablet</i>	Non – Preferred	
<i>gemfibrozil</i>	Preferred	QL (2 EA per 1 day)
<b>FENOGLIDE</b>	Non – Preferred	
<b>LIPOFEN</b>	Non – Preferred	
<b>LOPID</b>	Non – Preferred	QL (2 EA per 1 day)
<b>TRICOR</b>	Non – Preferred	
<b>TRILIPIX</b>	Non – Preferred	
<b>*Hmg Coa Reductase Inhibitors*** - Drugs For Cholesterol</b>		
<i>atorvastatin calcium</i>	Preferred	QL (1 EA per 1 day)

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<i>fluvastatin sodium</i>	Non – Preferred	QL (1 EA per 1 day)
<i>fluvastatin sodium er</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lovastatin tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>pitavastatin calcium</i>	Non – Preferred	
<i>pravastatin sodium</i>	Preferred	QL (1 EA per 1 day)
<i>rosuvastatin calcium</i>	Preferred	QL (1 EA per 1 day)
<i>simvastatin</i>	Preferred	QL (1 EA per 1 day)
<b>ALTOPREV</b>	Non – Preferred	
<b>ATORVALIQ</b>	Non – Preferred	
<b>CRESTOR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>EZALLOR SPRINKLE</b>	Non – Preferred	
<b>LESCOL XL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>LIPITOR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>LIVALO</b>	Non – Preferred	
<b>ZOCOR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZYPITAMAG</b>	Non – Preferred	
<b><i>*Intest Cholest Absorp Inhib-Hmg Coa Reductase Inhib Comb*** - Drugs For Cholesterol</i></b>		
<i>ezetimibe-simvastatin</i>	Non – Preferred	
<b>VYTORIN</b>	Non – Preferred	
<b><i>*Intestinal Cholesterol Absorption Inhibitors*** - Drugs For Cholesterol</i></b>		
<i>ezetimibe</i>	Preferred	QL (1 EA per 1 day)
<b>ZETIA</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Microsomal Triglyceride Transfer Protein Inhibitors*** - Drugs For Cholesterol</b>		
JUXTAPID	Non – Preferred	
<b>*Nicotinic Acid Derivatives*** - Drugs For Cholesterol</b>		
<i>niacin er (antihyperlipidemic)</i>	Non – Preferred	
<b>*Pcsk9 Inhibitors*** - Drugs For Cholesterol</b>		
PRALUENT	Non – Preferred	
REPATHA	Non – Preferred	
REPATHA PUSHTRONEX SYSTEM	Non – Preferred	
REPATHA SURECLICK	Non – Preferred	
<b>*Small Interfering Rna (Sirna) Pcsk9 Inhibitors*** - Drugs For Cholesterol</b>		
LEQVIO	Non – Preferred	
<b>*Antihypertensives* - Drugs For The Heart</b>		
<b>*Ace Inhibitor &amp; Calcium Channel Blocker Combinations*** - Drugs For High Blood Pressure</b>		
<i>amlodipine besy-benazepril hcl</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril-verapamil hcl er</i>	Preferred	
LOTREL	Non – Preferred	QL (1 EA per 1 day)
<b>*Ace Inhibitors &amp; Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure</b>		
<i>benazepril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>enalapril-hydrochlorothiazide tablet 10-25 mg oral</i>	Preferred	QL (2 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>enalapril-hydrochlorothiazide tablet 5-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>fosinopril sodium-hctz</i>	Preferred	
<i>lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lisinopril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>quinapril-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<b>ACCURETIC</b>	Non – Preferred	QL (1 EA per 1 day)
<b>LOTENSIN HCT</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VASERETIC</b>	Non – Preferred	QL (2 EA per 1 day)
<b>ZESTORETIC TABLET 10-12.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZESTORETIC TABLET 20-12.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZESTORETIC TABLET 20-25 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b><i>*Ace Inhibitors*** - Drugs For High Blood Pressure</i></b>		
<i>benazepril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>captopril</i>	Preferred	QL (3 EA per 1 day)
<i>enalapril maleate oral solution</i>	Non – Preferred	
<i>enalapril maleate oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>fosinopril sodium</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 40 mg oral</i>	Preferred	
<i>lisinopril tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lisinopril tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>moexipril hcl</i>	Preferred	
<i>perindopril erbumine tablet 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 4 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>perindopril erbumine tablet 8 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>quinapril hcl</i>	Preferred	QL (2 EA per 1 day)
<i>ramipril</i>	Preferred	QL (2 EA per 1 day)
<i>trandolapril tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>trandolapril tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>ACCUPRIL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>ALTACE</b>	Non – Preferred	QL (2 EA per 1 day)
<b>EPANED</b>	Non – Preferred	
<b>LOTENSIN</b>	Non – Preferred	QL (2 EA per 1 day)
<b>QBRELIS</b>	Non – Preferred	
<b>VASOTEC</b>	Non – Preferred	QL (2 EA per 1 day)
<b>ZESTRIL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>*Agents For Pheochromocytoma*** - Drugs For High Blood Pressure</b>		
<i>metyrosine</i>	Preferred	
<i>phenoxybenzamine hcl</i>	Non – Preferred	
<b>DEMSEER</b>	Preferred	
<b>*Angiotensin II Receptor Antag &amp; Ca Channel Blocker Comb*** - Drugs For High Blood Pressure</b>		
<i>amlodipine besylate-valsartan</i>	Non – Preferred	QL (1 EA per 1 day)
<i>amlodipine-olmesartan</i>	Non – Preferred	
<i>telmisartan-amlodipine</i>	Non – Preferred	
<b>AZOR</b>	Non – Preferred	
<b>EXFORGE</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Angiotensin II Receptor Antag &amp; Thiazide/Thiazide-Like*** - Drugs For High Blood Pressure</b>		
<i>candesartan cilexetil-hctz</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium-hctz</i>	Preferred	QL (1 EA per 1 day)
<i>olmesartan medoxomil-hctz</i>	Non – Preferred	
<i>telmisartan-hctz</i>	Non – Preferred	
<i>valsartan-hydrochlorothiazide</i>	Preferred	QL (1 EA per 1 day)
<b>ATACAND HCT</b>	Non – Preferred	QL (1 EA per 1 day)
<b>AVALIDE</b>	Non – Preferred	QL (1 EA per 1 day)
<b>BENICAR HCT</b>	Non – Preferred	
<b>DIOVAN HCT</b>	Non – Preferred	QL (1 EA per 1 day)
<b>EDARBYCLOR</b>	Non – Preferred	
<b>HYZAAR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>MICARDIS HCT</b>	Non – Preferred	
<b>*Angiotensin II Receptor Antagonists*** - Drugs For High Blood Pressure</b>		
<i>candesartan cilexetil</i>	Non – Preferred	QL (1 EA per 1 day)
<i>irbesartan</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 100 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>losartan potassium tablet 25 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>losartan potassium tablet 50 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>olmesartan medoxomil</i>	Non – Preferred	
<i>telmisartan</i>	Non – Preferred	
<i>valsartan oral solution</i>	Preferred	
<i>valsartan oral tablet</i>	Preferred	QL (1 EA per 1 day)
<b>ATACAND</b>	Non – Preferred	QL (1 EA per 1 day)
<b>AVAPRO</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BENICAR</b>	Non – Preferred	
<b>COZAAR TABLET 100 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>COZAAR TABLET 25 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>COZAAR TABLET 50 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>DIOVAN</b>	Non – Preferred	QL (1 EA per 1 day)
<b>EDARBI</b>	Non – Preferred	
<b>MICARDIS</b>	Non – Preferred	
<b>*Angiotensin li Receptor Ant-Ca Channel Blocker-Thiazides*** - Drugs For High Blood Pressure</b>		
<i>amlodipine-valsartan-hctz</i>	Non – Preferred	
<i>olmesartan-amlodipine-hctz</i>	Non – Preferred	
<b>EXFORGE HCT</b>	Non – Preferred	
<b>TRIBENZOR</b>	Non – Preferred	
<b>*Antiadrenergics - Centrally Acting*** - Drugs For High Blood Pressure</b>		
<i>clonidine</i>	Preferred	
<i>clonidine hcl</i>	Preferred	
<i>guanfacine hcl tablet 1 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>guanfacine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>methyldopa</i>	Preferred	
<b>CATAPRES-TTS-1</b>	Non – Preferred	
<b>CATAPRES-TTS-2</b>	Non – Preferred	
<b>CATAPRES-TTS-3</b>	Non – Preferred	
<b>*Antiadrenergics - Peripherally Acting*** - Drugs For High Blood Pressure</b>		
<i>doxazosin mesylate tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>doxazosin mesylate tablet 4 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>doxazosin mesylate tablet 8 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>prazosin hcl</i>	Preferred	QL (4 EA per 1 day)
<i>terazosin hcl capsule 1 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>terazosin hcl capsule 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 2 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>terazosin hcl capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<b>CARDURA TABLET 1 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CARDURA TABLET 2 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CARDURA TABLET 4 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CARDURA TABLET 8 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>MINIPRESS</b>	Non – Preferred	QL (4 EA per 1 day)
<b><i>*Beta Blocker &amp; Diuretic Combinations*** - Drugs For High Blood Pressure</i></b>		
<i>atenolol-chlorthalidone</i>	Preferred	
<i>bisoprolol-hydrochlorothiazide</i>	Preferred	
<i>metoprolol-hydrochlorothiazide</i>	Preferred	
<b>TENORETIC 100</b>	Non – Preferred	
<b>TENORETIC 50</b>	Non – Preferred	
<b><i>*Direct Renin Inhibitors*** - Drugs For High Blood Pressure</i></b>		
<i>aliskiren fumarate</i>	Non – Preferred	
<b>TEKTURNA</b>	Non – Preferred	
<b><i>*Selective Aldosterone Receptor Antagonists (Saras)*** - Drugs For High Blood Pressure</i></b>		
<i>eplerenone</i>	Non – Preferred	
<b>INSPRA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Vasodilators*** - Drugs For High Blood Pressure</b>		
<i>hydralazine hcl</i>	Preferred	
<i>minoxidil</i>	Preferred	
<b>*Anti-Infective Agents - Misc.* - Drugs For Infections</b>		
<b>*Anti-Infective Agents - Misc.*** - Drugs For Infections</b>		
<i>metronidazole intravenous</i>	Preferred	
<i>metronidazole oral capsule</i>	Non – Preferred	
<i>metronidazole oral tablet</i>	Preferred	
<i>pentamidine isethionate</i>	Preferred	
<i>tinidazole</i>	Non – Preferred	
<i>trimethoprim</i>	Preferred	
<b>AEMCOLO</b>	Non – Preferred	
<b>FLAGYL</b>	Non – Preferred	
<b>NEBUPENT</b>	Preferred	
<b>XIFAXAN</b>	Non – Preferred	
<b>*Anti-Infective Misc. - Combinations*** - Antibiotics</b>		
<i>sulfamethoxazole-trimethoprim</i>	Preferred	
<b>BACTRIM</b>	Non – Preferred	
<b>BACTRIM DS</b>	Non – Preferred	
<b>SULFATRIM PEDIATRIC</b>	Preferred	
<b>*Antiprotozoal Agents*** - Drugs For Parasites</b>		
<i>atovaquone</i>	Preferred	
<i>nitazoxanide</i>	Non – Preferred	
<b>LAMPIT</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEPRON	Non – Preferred	
<b>*Carbapenem Combinations*** - Antibiotics</b>		
<i>imipenem-cilastatin</i>	Preferred	
<b>*Carbapenems*** - Antibiotics</b>		
<i>ertapenem sodium</i>	Preferred	
<i>meropenem</i>	Preferred	
<i>meropenem-sodium chloride</i>	Preferred	
<b>*Glycopeptides*** - Antibiotics</b>		
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>vancomycin hcl capsule 250 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>vancomycin hcl in dextrose</i>	Preferred	
<i>vancomycin hcl in nacl</i>	Preferred	
<i>vancomycin hcl intravenous</i>	Preferred	
<i>vancomycin hcl oral solution reconstituted</i>	Preferred	
FIRVANQ	Non – Preferred	
VANCOCIN CAPSULE 125 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
VANCOCIN CAPSULE 250 MG ORAL	Non – Preferred	QL (8 EA per 1 day)
<b>*Leprostotics*** - Antibiotics</b>		
<i>dapsone</i>	Preferred	
<b>*Lincosamides*** - Antibiotics</b>		
<i>clindamycin hcl</i>	Preferred	
<i>clindamycin palmitate hcl</i>	Preferred	
<i>clindamycin phosphate</i>	Preferred	
<i>clindamycin phosphate in d5w</i>	Preferred	
<i>clindamycin phosphate in nacl</i>	Preferred	
CLEOCIN	Non – Preferred	
<b>*Monobactams*** - Antibiotics</b>		
<i>aztreonam</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CAYSTON</b>	Non – Preferred	
<b>*Oxazolidinones*** - Antibiotics</b>		
<i>linezolid</i>	Non – Preferred	
<b>SIVEXTRO</b>	Non – Preferred	
<b>ZYVOX</b>	Non – Preferred	
<b>*Urinary Anti-Infectives*** - Antibiotics</b>		
<i>fosfomycin tromethamine</i>	Preferred	
<i>methenamine hippurate</i>	Preferred	
<i>methenamine mandelate</i>	Preferred	
<i>nitrofurantoin macrocrystal</i>	Preferred	
<i>nitrofurantoin monohyd macro</i>	Preferred	
<i>nitrofurantoin suspension 25 mg/5ml oral</i>	Preferred	
<i>nitrofurantoin suspension 50 mg/5ml oral</i>	Preferred	QL (1 ML per 1 day)
<b>HIPREX</b>	Non – Preferred	
<b>MACROBID</b>	Non – Preferred	
<b>MACRODANTIN</b>	Non – Preferred	
<b>*Urinary Antiseptic-Antispasmodic &amp;/Or Analgesics*** - Drugs For Infections</b>		
<i>me/naphos/mb/hyo1</i>	Non – Preferred	
<i>uro-mp</i>	Non – Preferred	
<b>URIBEL</b>	Non – Preferred	
<b>URIMAR-T</b>	Non – Preferred	
<b>UROGESIC-BLUE</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antimalarials* - Drugs For Infections</b>		
<b>*Antimalarial Combinations*** - Drugs For Parasites</b>		
<i>atovaquone-proguanil hcl tablet 250-100 mg oral</i>	Preferred	QL (12 EA Max Qty Per Fill Retail)
<i>atovaquone-proguanil hcl tablet 62.5-25 mg oral</i>	Preferred	QL (9 EA Max Qty Per Fill Retail)
<b>COARTEM</b>	Non – Preferred	
<b>MALARONE TABLET 250-100 MG ORAL</b>	Non – Preferred	QL (12 EA Max Qty Per Fill Retail)
<b>MALARONE TABLET 62.5-25 MG ORAL</b>	Non – Preferred	QL (9 EA Max Qty Per Fill Retail)
<b>*Antimalarials*** - Drugs For Parasites</b>		
<i>chloroquine phosphate</i>	Preferred	
<i>hydroxychloroquine sulfate</i>	Preferred	
<i>mefloquine hcl</i>	Preferred	
<i>primaquine phosphate</i>	Preferred	QL (28 EA Max Qty Per Fill Retail)
<i>pyrimethamine</i>	Non – Preferred	
<i>quinine sulfate</i>	Non – Preferred	
<b>DARAPRIM</b>	Non – Preferred	
<b>KRINTAFEL</b>	Non – Preferred	
<b>QUALAQUIN</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antimyasthenic/Cholinergic Agents* - Drugs For Nerves And Muscles</b>		
<b>*Antimyasthenic/Cholinergic Agents*** - Drugs For Nerves And Muscles</b>		
<i>pyridostigmine bromide</i>	Preferred	
<i>pyridostigmine bromide er</i>	Preferred	
<b>FIRDAPSE</b>	Non – Preferred	
<b>MESTINON</b>	Non – Preferred	
<b>*Antimycobacterial Agents* - Drugs For Infections</b>		
<b>*Antimycobacterial Agents*** - Antibiotics</b>		
<i>cycloserine</i>	Preferred	
<i>ethambutol hcl</i>	Preferred	
<i>isoniazid</i>	Preferred	
<i>pretomanid</i>	Non – Preferred	
<i>pyrazinamide</i>	Preferred	
<i>rifabutin</i>	Preferred	
<i>rifampin</i>	Preferred	
<b>MYAMBUTOL</b>	Non – Preferred	
<b>MYCOBUTIN</b>	Non – Preferred	
<b>PRIFTIN</b>	Preferred	
<b>SIRTURO</b>	Non – Preferred	
<b>TRECTOR</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antineoplastics And Adjunctive Therapies* - Drugs For Cancer</b>		
<b><i>*Alkylating Agents*** - Drugs For Cancer</i></b>		
MYLERAN	Preferred	
<b><i>*Androgen Biosynthesis Inhibitors*** - Drugs For Cancer</i></b>		
<i>abiraterone acetate</i>	Preferred	
YONSA	Non – Preferred	
ZYTIGA	Non – Preferred	
<b><i>*Antiadrenals*** - Drugs For Cancer</i></b>		
LYSODREN	Preferred	
<b><i>*Antiandrogens*** - Drugs For Cancer</i></b>		
<i>bicalutamide</i>	Preferred	QL (1 EA per 1 day)
<i>nilutamide</i>	Preferred	
CASODEX	Non – Preferred	QL (1 EA per 1 day)
ERLEADA	Non – Preferred	
NUBEQA	Non – Preferred	
XTANDI	Non – Preferred	
<b><i>*Antiestrogens*** - Drugs For Cancer</i></b>		
<i>tamoxifen citrate</i>	Preferred	
<i>toremifene citrate</i>	Preferred	
FARESTON	Non – Preferred	
SOLTAMOX	Preferred	
<b><i>*Antimetabolites*** - Drugs For Cancer</i></b>		
<i>capecitabine tablet 150 mg oral</i>	Non – Preferred	QL (140 EA per 21 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>capecitabine tablet 500 mg oral</i>	Non – Preferred	
<i>capecitabine tablet 500 mg oral</i>	Non – Preferred	QL (154 EA per 21 days)
<i>mercaptopurine</i>	Preferred	
<i>methotrexate sodium (pf)</i>	Preferred	
<i>methotrexate sodium oral</i>	Preferred	
<i>methotrexate sodium solution 250 mg/10ml injection</i>	Preferred	QL (10 VIAL per 28 days)
<i>methotrexate sodium solution 50 mg/2ml injection</i>	Preferred	QL (4 VIAL per 28 days)
<b>JYLAMVO</b>	Non – Preferred	
<b>ONUREG</b>	Non – Preferred	
<b>PURIXAN</b>	Non – Preferred	
<b>TABLOID</b>	Preferred	
<b>TREXALL</b>	Preferred	
<b>XATMEP</b>	Non – Preferred	
<b>XELODA TABLET 150 MG ORAL</b>	Non – Preferred	QL (140 EA per 21 days)
<b>XELODA TABLET 500 MG ORAL</b>	Non – Preferred	QL (154 EA per 21 days)
<b><i>*Antineoplastic - Akt Inhibitors*** - Drugs For Cancer</i></b>		
<b>TRUQAP</b>	Non – Preferred	
<b><i>*Antineoplastic - Alk Inhibitors*** - Drugs For Cancer</i></b>		
<b>ALECENSA</b>	Non – Preferred	
<b>ALUNBRIG</b>	Non – Preferred	
<b>LORBRENA</b>	Non – Preferred	
<b>XALKORI</b>	Non – Preferred	
<b>ZYKADIA</b>	Non – Preferred	
<b><i>*Antineoplastic - Anti-Her2 Agents*** - Drugs For Cancer</i></b>		
<b>TUKYSA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antineoplastic - Bcl-2 Inhibitors*** - Drugs For Cancer</b>		
VENCLEXTA	Non – Preferred	
VENCLEXTA STARTING PACK	Non – Preferred	
<b>*Antineoplastic - Bcr-Abl Kinase Inhibitors*** - Drugs For Cancer</b>		
<i>imatinib mesylate tablet 100 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>imatinib mesylate tablet 400 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
BOSULIF	Non – Preferred	
GLEEVEC TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
GLEEVEC TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ICLUSIG	Non – Preferred	
SCEMBLIX	Non – Preferred	
SPRYCEL	Non – Preferred	QL (1 EA per 1 day)
TASIGNA	Non – Preferred	QL (4 EA per 1 day)
<b>*Antineoplastic - Braf Kinase Inhibitors*** - Drugs For Cancer</b>		
BRAFTOVI	Non – Preferred	
TAFINLAR	Non – Preferred	
ZELBORAF	Non – Preferred	
<b>*Antineoplastic - Btk Inhibitors*** - Drugs For Cancer</b>		
BRUKINSA	Non – Preferred	
CALQUENCE	Non – Preferred	
IMBRUVICA CAPSULE 140 MG ORAL	Non – Preferred	
IMBRUVICA CAPSULE 70 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
IMBRUVICA TABLET 140 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
IMBRUVICA TABLET 280 MG ORAL	Non – Preferred	
IMBRUVICA TABLET 420 MG ORAL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JAYPIRCA	Non – Preferred	
<b>*Antineoplastic - Egfr Inhibitors*** - Drugs For Cancer</b>		
<i>erlotinib hcl</i>	Preferred	QL (1 EA per 1 day)
<i>gefitinib</i>	Preferred	
<b>EXKIVITY</b>	Non – Preferred	
<b>GILOTRIF</b>	Non – Preferred	
<b>IRESSA</b>	Preferred	
<b>TAGRISSO</b>	Non – Preferred	
<b>TARCEVA</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VIZIMPRO</b>	Non – Preferred	
<b>*Antineoplastic - Fgfr Kinase Inhibitors*** - Drugs For Cancer</b>		
<b>BALVERSA</b>	Non – Preferred	
<b>LYTGOBI (12 MG DAILY DOSE)</b>	Non – Preferred	
<b>LYTGOBI (16 MG DAILY DOSE)</b>	Non – Preferred	
<b>LYTGOBI (20 MG DAILY DOSE)</b>	Non – Preferred	
<b>PEMAZYRE</b>	Non – Preferred	
<b>*Antineoplastic - Hedgehog Pathway Inhibitors*** - Drugs For Cancer</b>		
<b>DAURISMO</b>	Non – Preferred	
<b>ERIVEDGE</b>	Preferred	
<b>ODOMZO</b>	Non – Preferred	
<b>*Antineoplastic - Histone Deacetylase Inhibitors*** - Drugs For Cancer</b>		
<b>ZOLINZA</b>	Non – Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antineoplastic - Hormonal And Related Agent Combinations*** - Drugs For Cancer</b>		
AKEEGA	Non – Preferred	
<b>*Antineoplastic - Immunomodulators*** - Drugs For Cancer</b>		
POMALYST	Non – Preferred	
<b>*Antineoplastic - Kras Inhibitors*** - Drugs For Cancer</b>		
KRAZATI	Non – Preferred	
LUMAKRAS	Non – Preferred	
<b>*Antineoplastic - Mek Inhibitors*** - Drugs For Cancer</b>		
COTELLIC	Non – Preferred	
KOSELUGO	Non – Preferred	
MEKINIST	Non – Preferred	
MEKTOVI	Non – Preferred	
<b>*Antineoplastic - Met Inhibitors*** - Drugs For Cancer</b>		
TABRECTA	Non – Preferred	
TEPMETKO	Non – Preferred	
<b>*Antineoplastic - Methyltransferase Inhibitors*** - Drugs For Cancer</b>		
TAZVERIK	Non – Preferred	
<b>*Antineoplastic - Mtor Kinase Inhibitors*** - Drugs For Cancer</b>		
<i>everolimus oral tablet soluble</i>	Non – Preferred	
<i>everolimus tablet 10 mg oral</i>	Non – Preferred	
<i>everolimus tablet 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>everolimus tablet 2.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>everolimus tablet 5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>everolimus tablet 7.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<b>AFINITOR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>AFINITOR DISPERZ</b>	Non – Preferred	
<b>*Antineoplastic - Multikinase Inhibitors*** - Drugs For Cancer</b>		
<i>lapatinib ditosylate</i>	Non – Preferred	
<i>pazopanib hcl</i>	Preferred	QL (4 EA per 1 day)
<i>sorafenib tosylate</i>	Preferred	QL (4 EA per 1 day)
<i>sunitinib malate capsule 12.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 37.5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>sunitinib malate capsule 50 mg oral</i>	Preferred	QL (28 EA per 42 days)
<b>CABOMETYX</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CAPRELSA</b>	Preferred	
<b>COMETRIQ (100 MG DAILY DOSE)</b>	Non – Preferred	
<b>COMETRIQ (140 MG DAILY DOSE)</b>	Non – Preferred	
<b>COMETRIQ (60 MG DAILY DOSE)</b>	Non – Preferred	
<b>FOTIVDA</b>	Non – Preferred	
<b>NERLYNX</b>	Non – Preferred	
<b>NEXAVAR</b>	Preferred	QL (4 EA per 1 day)
<b>QINLOCK</b>	Non – Preferred	
<b>RYDAPT</b>	Non – Preferred	
<b>STIVARGA</b>	Non – Preferred	
<b>SUTENT CAPSULE 12.5 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>SUTENT CAPSULE 25 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>SUTENT CAPSULE 37.5 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>SUTENT CAPSULE 50 MG ORAL</b>	Preferred	QL (28 EA per 42 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYKERB	Non – Preferred	QL (6 EA per 1 day)
VANFLYTA	Non – Preferred	
VOTRIENT	Preferred	QL (4 EA per 1 day)
XOSPATA	Non – Preferred	
<b><i>*Antineoplastic - Pdgfr-Alpha Inhibitors*** - Drugs For Cancer</i></b>		
AYVAKIT	Non – Preferred	
<b><i>*Antineoplastic - Proteasome Inhibitors*** - Drugs For Cancer</i></b>		
NINLARO	Non – Preferred	
<b><i>*Antineoplastic - Ret Inhibitors*** - Drugs For Cancer</i></b>		
GAVRETO	Non – Preferred	
RETEVMO	Non – Preferred	
<b><i>*Antineoplastic - Tropomyosin Receptor Kinase Inhibitors*** - Drugs For Cancer</i></b>		
ROZLYTREK	Non – Preferred	
VITRAKVI	Non – Preferred	
<b><i>*Antineoplastic - Xpo1 Inhibitors*** - Drugs For Cancer</i></b>		
XPOVIO (100 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (60 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (60 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (80 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (80 MG TWICE WEEKLY)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Antineoplastic Combinations*** - Drugs For Cancer</i></b>		
INQOVI	Non – Preferred	
KISQALI FEMARA (200 MG DOSE)	Non – Preferred	
KISQALI FEMARA (400 MG DOSE)	Non – Preferred	
KISQALI FEMARA (600 MG DOSE)	Non – Preferred	
LONSURF	Non – Preferred	
<b><i>*Antineoplastics Misc.*** - Drugs For Cancer</i></b>		
<i>hydroxyurea</i>	Preferred	
HYDREA	Non – Preferred	
MATULANE	Preferred	
<b><i>*Aromatase Inhibitors*** - Drugs For Cancer</i></b>		
<i>anastrozole</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
<i>exemestane</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
<i>letrozole</i>	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
ARIMIDEX	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
AROMASIN	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
FEMARA	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
<b><i>*Cyclin-Dependent Kinases (Cdk) Inhibitors*** - Drugs For Cancer</i></b>		
IBRANCE ORAL CAPSULE	Non – Preferred	QL (1 EA per 1 day)
IBRANCE ORAL TABLET	Non – Preferred	
KISQALI (200 MG DOSE)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KISQALI (400 MG DOSE)	Non – Preferred	
KISQALI (600 MG DOSE)	Non – Preferred	
VERZENIO	Non – Preferred	QL (2 EA per 1 day)
<b><i>*Estrogens-Antineoplastic*** - Drugs For Cancer</i></b>		
EMCYT	Preferred	
<b><i>*Folic Acid Antagonists Rescue Agents*** - Drugs For Cancer</i></b>		
<i>leucovorin calcium</i>	Preferred	
<b><i>*Gonadotropin Releasing Hormone (Gnrh) Antagonists*** - Drugs For Cancer</i></b>		
ORGOVYX	Non – Preferred	
<b><i>*Imidazotetrazines*** - Drugs For Cancer</i></b>		
<i>temozolomide</i>	Preferred	
<b><i>*Isocitrate Dehydrogenase-1 (Idh1) Inhibitors*** - Drugs For Cancer</i></b>		
REZLIDHIA	Non – Preferred	
TIBSOVO	Non – Preferred	
<b><i>*Isocitrate Dehydrogenase-2 (Idh2) Inhibitors*** - Drugs For Cancer</i></b>		
IDHIFA	Non – Preferred	
<b><i>*Janus Associated Kinase (Jak) Inhibitors*** - Drugs For Cancer</i></b>		
INREBIC	Non – Preferred	
JAKAFI	Preferred	
VONJO	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Mitotic Inhibitors*** - Drugs For Cancer</i></b>		
<i>etoposide</i>	Preferred	
<b><i>*Nitrogen Mustards And Related Analogues*** - Drugs For Cancer</i></b>		
<i>cyclophosphamide</i>	Preferred	
<i>melphalan</i>	Preferred	
<b>LEUKERAN</b>	Preferred	
<b><i>*Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors*** - Drugs For Cancer</i></b>		
<b>COPIKTRA</b>	Non – Preferred	
<b>PIQRAY (200 MG DAILY DOSE)</b>	Non – Preferred	
<b>PIQRAY (250 MG DAILY DOSE)</b>	Non – Preferred	
<b>PIQRAY (300 MG DAILY DOSE)</b>	Non – Preferred	
<b>ZYDELIG</b>	Non – Preferred	
<b><i>*Poly (Adp-Ribose) Polymerase (Parp) Inhibitors*** - Drugs For Cancer</i></b>		
<b>LYNPARZA</b>	Non – Preferred	
<b>RUBRACA</b>	Non – Preferred	
<b>TALZENNA</b>	Non – Preferred	
<b>ZEJULA</b>	Non – Preferred	
<b><i>*Progestins-Antineoplastic*** - Drugs For Cancer</i></b>		
<i>megestrol acetate</i>	Preferred	
<b><i>*Retinoids*** - Drugs For Cancer</i></b>		
<i>tretinoin</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Selective Estrogen Receptor Degradors*** - Drugs For Cancer</i></b>		
ORSERDU	Preferred	
<b><i>*Selective Retinoid X Receptor Agonists*** - Drugs For Cancer</i></b>		
<i>bexarotene</i>	Preferred	
TARGRETIN	Non – Preferred	
<b><i>*Topoisomerase I Inhibitors*** - Drugs For Cancer</i></b>		
HYCAMTIN	Preferred	
<b><i>*Urinary Tract Protective Agents*** - Drugs For Cancer</i></b>		
MESNEX	Preferred	
<b><i>*Vascular Endothelial Growth Factor (Vegf) Inhibitors*** - Drugs For Cancer</i></b>		
FRUZAQLA	Non – Preferred	
INLYTA	Non – Preferred	
LENVIMA (10 MG DAILY DOSE)	Non – Preferred	
LENVIMA (12 MG DAILY DOSE)	Non – Preferred	
LENVIMA (14 MG DAILY DOSE)	Non – Preferred	
LENVIMA (18 MG DAILY DOSE)	Non – Preferred	
LENVIMA (20 MG DAILY DOSE)	Non – Preferred	
LENVIMA (24 MG DAILY DOSE)	Non – Preferred	
LENVIMA (4 MG DAILY DOSE)	Non – Preferred	
LENVIMA (8 MG DAILY DOSE)	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antiparkinson And Related Therapy Agents* - Drugs For The Nervous System</b>		
<b>*Adenosine Receptor Antagonist*** - Drugs For Parkinson</b>		
NOURIANZ	Non – Preferred	
<b>*Antiparkinson Anticholinergics*** - Drugs For Parkinson</b>		
<i>benztropine mesylate</i>	Preferred	
<i>trihexyphenidyl hcl</i>	Preferred	
<b>*Antiparkinson Dopaminergics*** - Drugs For Parkinson</b>		
<i>amantadine hcl</i>	Preferred	
<i>bromocriptine mesylate</i>	Preferred	
GOCOVRI	Non – Preferred	
INBRIJA	Non – Preferred	
OSMOLEX ER	Non – Preferred	
PARLODEL	Non – Preferred	
<b>*Antiparkinson Monoamine Oxidase Inhibitors*** - Drugs For Parkinson</b>		
<i>rasagiline mesylate</i>	Non – Preferred	
<i>selegiline hcl</i>	Preferred	
AZILECT	Non – Preferred	
XADAGO	Non – Preferred	
ZELAPAR	Non – Preferred	
<b>*Central/Peripheral Comt Inhibitors*** - Drugs For Parkinson</b>		
<i>tolcapone</i>	Non – Preferred	
TASMAR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Decarboxylase Inhibitors*** - Drugs For Parkinson</b>		
<i>carbidopa</i>	Preferred	
<b>LODOSYN</b>	Non – Preferred	
<b>*Levodopa Combinations*** - Drugs For Parkinson</b>		
<i>carbidopa-levodopa er</i>	Preferred	
<i>carbidopa-levodopa oral tablet</i>	Preferred	
<i>carbidopa-levodopa oral tablet dispersible</i>	Non – Preferred	
<i>carbidopa-levodopa-entacapone</i>	Non – Preferred	
<b>DHIVY</b>	Non – Preferred	
<b>RYTARY</b>	Non – Preferred	
<b>SINEMET</b>	Non – Preferred	
<b>STALEVO 100</b>	Non – Preferred	QL (9 EA per 1 day)
<b>STALEVO 125</b>	Non – Preferred	QL (9 EA per 1 day)
<b>STALEVO 150</b>	Non – Preferred	QL (9 EA per 1 day)
<b>STALEVO 200</b>	Non – Preferred	QL (9 EA per 1 day)
<b>STALEVO 50</b>	Non – Preferred	QL (9 EA per 1 day)
<b>STALEVO 75</b>	Non – Preferred	QL (9 EA per 1 day)
<b>*Nonergoline Dopamine Receptor Agonists*** - Drugs For Parkinson</b>		
<i>apomorphine hcl</i>	Non – Preferred	
<i>pramipexole dihydrochloride</i>	Preferred	
<i>pramipexole dihydrochloride er</i>	Non – Preferred	
<i>ropinirole hcl er tablet extended release 24 hour 12 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 2 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 4 mg oral</i>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>ropinirole hcl er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl er tablet extended release 24 hour 8 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>ropinirole hcl tablet 0.25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 0.25 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 0.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 0.5 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 1 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 1 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 2 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 3 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 3 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 4 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 4 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>ropinirole hcl tablet 5 mg oral</i>	Preferred	
<b>APOKYN</b>	Non – Preferred	
<b>MIRAPEX ER</b>	Non – Preferred	
<b>NEUPRO</b>	Non – Preferred	
<b>*Peripheral Comt Inhibitors*** - Drugs For Parkinson</b>		
<i>entacapone</i>	Preferred	
<b>COMTAN</b>	Non – Preferred	QL (4 EA per 1 day)
<b>ONGENTYS</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antipsychotics/Antimanic Agents* - Drugs For The Nervous System</b>		
<b>*Antimanic Agents*** - Drugs For Severe Mental Disorders</b>		
<i>lithium</i>	Preferred	
<i>lithium carbonate capsule 150 mg oral</i>	Preferred	QL (16 EA per 1 day)
<i>lithium carbonate capsule 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate capsule 600 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>lithium carbonate er tablet extended release 300 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>lithium carbonate er tablet extended release 450 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>lithium carbonate oral tablet</i>	Preferred	QL (8 EA per 1 day)
<b>LITHOBID</b>	Non – Preferred	QL (8 EA per 1 day)
<b>*Antipsychotics - Misc.*** - Drugs For Severe Mental Disorders</b>		
<i>lurasidone hcl tablet 120 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 60 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>lurasidone hcl tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>ziprasidone hcl</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>ziprasidone mesylate solution reconstituted 20 mg intramuscular</i>	Non – Preferred	AL (Min 18 Years)
<i>ziprasidone mesylate solution reconstituted 20 mg intramuscular</i>	Non – Preferred	AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CAPLYTA</b>	Non – Preferred	AL (Min 8 Years)
<b>EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL</b>	Non – Preferred	AL (Min 8 Years)
<b>EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL</b>	Non – Preferred	QL (8 EA per 1 day); AL (Min 8 Years)
<b>EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL</b>	Non – Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<b>GEODON INTRAMUSCULAR</b>	Non – Preferred	AL (Min 8 Years)
<b>GEODON ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>LATUDA TABLET 120 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>LATUDA TABLET 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>LATUDA TABLET 40 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>LATUDA TABLET 60 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>LATUDA TABLET 80 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>NUPLAZID</b>	Non – Preferred	AL (Min 8 Years)
<b>VRAYLAR ORAL CAPSULE</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>VRAYLAR ORAL CAPSULE THERAPY PACK</b>	Non – Preferred	QL (7 EA per 1 day); AL (Min 8 Years)
<b><i>*Benzisoxazoles*** - Drugs For Severe Mental Disorders</i></b>		
<i>paliperidone er tablet extended release 24 hour 1.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 3 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>paliperidone er tablet extended release 24 hour 6 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>paliperidone er tablet extended release 24 hour 9 mg oral</i>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>risperidone oral solution</i>	Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 2 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 3 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet 4 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 0.25 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 0.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 1 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 2 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>risperidone tablet dispersible 3 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>risperidone tablet dispersible 4 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TABLET 1 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TABLET 10 MG ORAL</b>	Non – Preferred	AL (Min 8 Years)
<b>FANAPT TABLET 12 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TABLET 2 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TABLET 4 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>FANAPT TABLET 6 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TABLET 8 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>FANAPT TITRATION PACK</b>	Non – Preferred	QL (1 PACK per 90 days); AL (Min 8 Years)
<b>INVEGA HAFYERA</b>	Preferred	ST; AL (Min 18 Years)
<b>INVEGA SUSTENNA</b>	Preferred	AL (Min 18 Years)
<b>INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>INVEGA TRINZA</b>	Preferred	AL (Min 18 Years)
<b>PERSERIS</b>	Non – Preferred	AL (Min 8 Years)
<b>RISPERDAL CONSTA</b>	Non – Preferred	AL (Min 8 Years)
<b>RISPERDAL ORAL SOLUTION</b>	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
<b>RISPERDAL TABLET 0.5 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>RISPERDAL TABLET 1 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>RISPERDAL TABLET 2 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>RISPERDAL TABLET 3 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>RISPERDAL TABLET 4 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<b>UZEDY</b>	Non – Preferred	AL (Min 18 Years)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Butyrophenones*** - Drugs For Severe Mental Disorders</b>		
<i>haloperidol decanoate</i>	Preferred	AL (Min 18 Years)
<i>haloperidol lactate injection</i>	Preferred	QL (4 ML per 1 day); AL (Min 3 Years)
<i>haloperidol lactate oral</i>	Preferred	QL (50 ML per 1 day)
<i>haloperidol tablet 0.5 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 1 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 10 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 2 mg oral</i>	Preferred	QL (10 EA per 1 day)
<i>haloperidol tablet 20 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>haloperidol tablet 5 mg oral</i>	Preferred	QL (5 EA per 1 day)
<b>*Dibenzodiazepines*** - Drugs For Severe Mental Disorders</b>		
<i>clozapine tablet 100 mg oral</i>	Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 200 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 100 mg oral</i>	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 12.5 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>clozapine tablet dispersible 150 mg oral</i>	Non – Preferred	QL (6 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 200 mg oral</i>	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
<i>clozapine tablet dispersible 25 mg oral</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>CLOZARIL TABLET 100 MG ORAL</b>	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
<b>CLOZARIL TABLET 25 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>VERSACLOZ</b>	Non – Preferred	AL (Min 8 Years)
<b><i>*Dibenzo-Oxepino Pyrroles*** - Drugs For Severe Mental Disorders</i></b>		
<i>asenapine maleate</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SAPHRIS</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SECUADO</b>	Non – Preferred	AL (Min 8 Years)
<b><i>*Dibenzothiazepines*** - Drugs For Severe Mental Disorders</i></b>		
<i>quetiapine fumarate er tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 300 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 100 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 150 mg oral</i>	Preferred	AL (Min 8 Years)
<i>quetiapine fumarate tablet 200 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>quetiapine fumarate tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 400 mg oral</i>	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<i>quetiapine fumarate tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 100 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 200 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 25 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 300 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 400 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL TABLET 50 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b>SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
<b><i>*Dibenzoxazepines*** - Drugs For Severe Mental Disorders</i></b>		
<i>loxapine succinate capsule 10 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>loxapine succinate capsule 25 mg oral</i>	Preferred	QL (10 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 5 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<i>loxapine succinate capsule 50 mg oral</i>	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
<b>ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION</b>	Non – Preferred	AL (Min 18 Years)
<b>ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION</b>	Preferred	AL (Min 18 Years)
<b>*Dihydroindolones*** - Drugs For Severe Mental Disorders</b>		
<i>molindone hcl</i>	Non – Preferred	
<b>*Phenothiazines*** - Drugs For Severe Mental Disorders</b>		
<i>chlorpromazine hcl injection</i>	Preferred	QL (2 ML per 1 day)
<i>chlorpromazine hcl oral concentrate</i>	Preferred	
<i>chlorpromazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 100 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>chlorpromazine hcl tablet 25 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorpromazine hcl tablet 50 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine decanoate</i>	Preferred	AL (Min 18 Years)
<i>fluphenazine hcl injection</i>	Preferred	QL (4 ML per 1 day)
<i>fluphenazine hcl oral concentrate</i>	Preferred	QL (8 ML per 1 day)
<i>fluphenazine hcl oral elixir</i>	Preferred	QL (80 ML per 1 day)
<i>fluphenazine hcl tablet 1 mg oral</i>	Preferred	
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>fluphenazine hcl tablet 2.5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>fluphenazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>perphenazine tablet 16 mg oral</i>	Preferred	QL (4 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>perphenazine tablet 2 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>perphenazine tablet 8 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>prochlorperazine</i>	Preferred	QL (2 EA per 1 day)
<i>prochlorperazine maleate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>prochlorperazine maleate tablet 5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>thioridazine hcl tablet 100 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>thioridazine hcl tablet 25 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>thioridazine hcl tablet 50 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>trifluoperazine hcl tablet 1 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 2 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>trifluoperazine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)
<b>COMPRO</b>	Preferred	QL (2 EA per 1 day)
<b>*Quinolinone Derivatives*** - Drugs For Severe Mental Disorders</b>		
<i>aripiprazole oral solution</i>	Non – Preferred	AL (Min 8 Years)
<i>aripiprazole oral tablet</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<i>aripiprazole tablet dispersible 10 mg oral</i>	Non – Preferred	
<i>aripiprazole tablet dispersible 10 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<i>aripiprazole tablet dispersible 15 mg oral</i>	Non – Preferred	
<i>aripiprazole tablet dispersible 15 mg oral</i>	Non – Preferred	AL (Min 8 Years)
<b>ABILIFY</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE</b>	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
<b>ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER</b>	Preferred	QL (1 VIAL per 28 days); AL (Min 18 Years)

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<b>ABILIFY MYCITE MAINTENANCE KIT</b>	Non – Preferred	AL (Min 8 Years)
<b>ABILIFY MYCITE STARTER KIT</b>	Non – Preferred	AL (Min 8 Years)
<b>ARISTADA INITIO</b>	Preferred	QL (1 SYRINGE per 365 days); AL (Min 18 Years)
<b>ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR</b>	Preferred	QL (1 SYRINGE per 56 days); AL (Min 18 Years)
<b>ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR</b>	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
<b>ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR</b>	Preferred	QL (2.4 ML per 28 days); AL (Min 18 Years)
<b>ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR</b>	Preferred	QL (3.2 ML per 28 days); AL (Min 18 Years)
<b>REXULTI</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b><i>*Thienbenzodiazepines*** - Drugs For Severe Mental Disorders</i></b>		
<i>olanzapine intramuscular</i>	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
<i>olanzapine oral</i>	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>ZYPREXA INTRAMUSCULAR</b>	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
<b>ZYPREXA RELPREVV</b>	Non – Preferred	AL (Min 18 Years)
<b>ZYPREXA TABLET 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZYPREXA TABLET 15 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZYPREXA TABLET 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
<b>ZYPREXA TABLET 5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZYPREXA TABLET 7.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ZYPREXA ZYDIS</b>	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Thioxanthenes*** - Drugs For Severe Mental Disorders</b>		
<i>thiothixene</i>	Preferred	QL (6 EA per 1 day)
<b>*Antiseptics &amp; Disinfectants* - Antiseptics And Disinfectants</b>		
<b>*Chlorine Antiseptics*** - Antiseptics And Disinfectants</b>		
<i>antiseptic skin cleanser</i>	Preferred	OTC
<i>sm antiseptic skin cleanser</i>	Preferred	OTC
<b>DYNA-HEX 4</b>	Preferred	OTC
<b>*Antivirals* - Drugs For Infections</b>		
<b>*Antiretroviral Combinations*** - Drugs For Viral Infections</b>		
<i>abacavir sulfate-lamivudine</i>	Preferred	QL (1 EA per 1 day)
<i>cabenuva</i>	Preferred	PA
<i>efavirenz-emtricitab-tenofo df</i>	Preferred	
<i>efavirenz-lamivudine-tenofovir</i>	Non – Preferred	QL (1 EA per 1 day)
<i>emtricitabine-tenofovir df tablet 100-150 mg oral</i>	Preferred	
<i>emtricitabine-tenofovir df tablet 133-200 mg oral</i>	Preferred	
<i>emtricitabine-tenofovir df tablet 167-250 mg oral</i>	Preferred	
<i>emtricitabine-tenofovir df tablet 200-300 mg oral</i>	Preferred	
<i>emtricitabine-tenofovir df tablet 200-300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine-zidovudine</i>	Preferred	QL (2 EA per 1 day)
<i>lopinavir-ritonavir oral solution</i>	Preferred	QL (10 ML per 1 day)
<i>lopinavir-ritonavir oral tablet</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ATRIPLA	Preferred	QL (1 EA per 1 day)
BIKTARVY TABLET 30-120-15 MG ORAL	Preferred	
BIKTARVY TABLET 50-200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
CIMDUO	Non – Preferred	QL (1 EA per 1 day)
COMBIVIR	Non – Preferred	QL (2 EA per 1 day)
COMPLERA	Preferred	QL (1 EA per 1 day)
DELSTRIGO	Preferred	QL (1 EA per 1 day)
DESCOVY TABLET 120-15 MG ORAL	Preferred	
DESCOVY TABLET 200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
DOVATO	Preferred	QL (1 EA per 1 day)
EPZICOM	Non – Preferred	QL (1 EA per 1 day)
EVOTAZ	Non – Preferred	
GENVOYA	Preferred	QL (1 EA per 1 day)
JULUCA	Non – Preferred	
KALETRA ORAL SOLUTION	Non – Preferred	QL (10 ML per 1 day)
KALETRA ORAL TABLET	Preferred	QL (4 EA per 1 day)
ODEFSEY	Preferred	QL (1 EA per 1 day)
PREZCOBIX	Non – Preferred	
STRIBILD	Non – Preferred	
SYMFI	Preferred	QL (1 EA per 1 day)
SYMFI LO	Preferred	QL (1 EA per 1 day)
SYMTUZA	Preferred	
TRIUMEQ	Preferred	QL (1 EA per 1 day)
TRUVADA	Preferred	QL (1 EA per 1 day)
<b><i>*Antiretrovirals - Capsid Inhibitors*** - Drugs For Viral Infections</i></b>		
SUNLENCA	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antiretrovirals - Ccr5 Antagonists (Entry Inhibitor)*** - Drugs For Viral Infections</b>		
<i>maraviroc</i>	Non – Preferred	
<b>SELZENTRY</b>	Non – Preferred	
<b>*Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor*** - Drugs For Viral Infections</b>		
<b>TROGARZO</b>	Preferred	PA
<b>*Antiretrovirals - Fusion Inhibitors*** - Drugs For Viral Infections</b>		
<b>FUZEON</b>	Non – Preferred	QL (2 EA per 1 day)
<b>*Antiretrovirals - Gp120-Directed Attachment Inhibitor*** - Drugs For Viral Infections</b>		
<b>RUKOBIA</b>	Non – Preferred	
<b>*Antiretrovirals - Integrase Inhibitors*** - Drugs For Viral Infections</b>		
<b>APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML</b>	Preferred	
<b>APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR</b>	Non – Preferred	
<b>ISENTRESS HD</b>	Preferred	QL (2 EA per 1 day)
<b>ISENTRESS ORAL PACKET</b>	Preferred	QL (2 EA per 1 day)
<b>ISENTRESS ORAL TABLET</b>	Preferred	QL (2 EA per 1 day)
<b>ISENTRESS ORAL TABLET CHEWABLE</b>	Preferred	QL (6 EA per 1 day)
<b>TIVICAY</b>	Preferred	QL (2 EA per 1 day)
<b>TIVICAY PD</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antiretrovirals - Protease Inhibitors*** - Drugs For Viral Infections</b>		
<i>atazanavir sulfate capsule 150 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>atazanavir sulfate capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>atazanavir sulfate capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>darunavir</i>	Preferred	
<i>fosamprenavir calcium</i>	Preferred	QL (4 EA per 1 day)
<i>ritonavir</i>	Preferred	QL (12 EA per 1 day)
<b>APTIVUS</b>	Preferred	QL (4 EA per 1 day)
<b>LEXIVA ORAL SUSPENSION</b>	Preferred	QL (56 ML per 1 day)
<b>LEXIVA ORAL TABLET</b>	Preferred	QL (4 EA per 1 day)
<b>NORVIR ORAL PACKET</b>	Preferred	
<b>NORVIR ORAL TABLET</b>	Preferred	QL (12 EA per 1 day)
<b>PREZISTA</b>	Preferred	
<b>REYATAZ CAPSULE 200 MG ORAL</b>	Preferred	QL (2 EA per 1 day)
<b>REYATAZ CAPSULE 300 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>REYATAZ ORAL PACKET</b>	Preferred	QL (6 EA per 1 day)
<b>VIRACEPT TABLET 250 MG ORAL</b>	Preferred	QL (10 EA per 1 day)
<b>VIRACEPT TABLET 625 MG ORAL</b>	Preferred	QL (4 EA per 1 day)
<b>*Antiretrovirals - Rti-Non-Nucleoside Analogues*** - Drugs For Viral Infections</b>		
<i>efavirenz</i>	Preferred	QL (1 EA per 1 day)
<i>etravirine</i>	Preferred	
<i>nevirapine er</i>	Preferred	QL (1 EA per 1 day)
<i>nevirapine oral suspension</i>	Preferred	QL (40 ML per 1 day)
<i>nevirapine oral tablet</i>	Preferred	QL (2 EA per 1 day)
<b>EDURANT</b>	Preferred	QL (1 EA per 1 day)
<b>INTELENCE TABLET 100 MG ORAL</b>	Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTELENCE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
INTELENCE TABLET 25 MG ORAL	Preferred	QL (4 EA per 1 day)
PIFELTRO	Non – Preferred	
SUSTIVA	Preferred	QL (1 EA per 1 day)
<b>*Antiretrovirals - Rti-Nucleoside Analogues-Purines*** - Drugs For Viral Infections</b>		
<i>abacavir sulfate oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>abacavir sulfate oral tablet</i>	Preferred	QL (2 EA per 1 day)
ZIAGEN	Preferred	QL (30 ML per 1 day)
<b>*Antiretrovirals - Rti-Nucleoside Analogues-Pyrimidines*** - Drugs For Viral Infections</b>		
<i>emtricitabine</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine oral solution</i>	Preferred	QL (30 ML per 1 day)
<i>lamivudine tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lamivudine tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL CAPSULE	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION	Preferred	QL (24 ML per 1 day)
EPIVIR ORAL SOLUTION	Non – Preferred	QL (30 ML per 1 day)
EPIVIR TABLET 150 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
EPIVIR TABLET 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
<b>*Antiretrovirals - Rti-Nucleoside Analogues-Thymidines*** - Drugs For Viral Infections</b>		
<i>zidovudine oral capsule</i>	Preferred	QL (2 EA per 1 day)
<i>zidovudine oral syrup</i>	Preferred	QL (60 ML per 1 day)
<i>zidovudine oral tablet</i>	Preferred	QL (2 EA per 1 day)
RETROVIR ORAL CAPSULE	Non – Preferred	QL (2 EA per 1 day)
RETROVIR ORAL SYRUP	Non – Preferred	QL (60 ML per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antiretrovirals - Rti-Nucleotide Analogues*** - Drugs For Viral Infections</b>		
<i>tenofovir disoproxil fumarate</i>	Preferred	QL (1 EA per 1 day)
<b>VIREAD ORAL POWDER</b>	Preferred	QL (8 GM per 1 day)
<b>VIREAD ORAL TABLET</b>	Preferred	QL (1 EA per 1 day)
<b>*Antiretrovirals Adjuvants*** - Drugs For Viral Infections</b>		
<b>TYBOST</b>	Non – Preferred	
<b>*Antiviral Combinations*** - Drugs For Infections</b>		
<b>PAXLOVID (150/100)</b>	Preferred	AL (Min 12 Years)
<b>PAXLOVID (300/100)</b>	Preferred	AL (Min 12 Years)
<b>*Cmv Agents*** - Drugs For Viral Infections</b>		
<i>valganciclovir hcl oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>valganciclovir hcl solution reconstituted 50 mg/ml oral</i>	Non – Preferred	
<i>valganciclovir hcl solution reconstituted 50 mg/ml oral</i>	Non – Preferred	QL (2 ML per 1 day)
<b>LIVTENCITY</b>	Preferred	PA
<b>PREVYMIS</b>	Non – Preferred	
<b>VALCYTE ORAL SOLUTION RECONSTITUTED</b>	Non – Preferred	
<b>VALCYTE TABLET 450 MG ORAL</b>	Non – Preferred	
<b>VALCYTE TABLET 450 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>*Hepatitis B Agents*** - Drugs For Viral Infections</b>		
<i>adefovir dipivoxil</i>	Non – Preferred	
<i>entecavir</i>	Preferred	QL (1 EA per 1 day)

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<i>lamivudine</i>	Non – Preferred	QL (1 EA per 1 day)
<b>BARACLUDE ORAL SOLUTION</b>	Non – Preferred	
<b>BARACLUDE ORAL TABLET</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VEMLIDY</b>	Non – Preferred	QL (1 EA per 1 day)
<b><i>*Hepatitis C Agent - Combinations*** - Drugs For Viral Infections</i></b>		
<i>ledipasvir-sofosbuvir</i>	Non – Preferred	
<i>sofosbuvir-velpatasvir</i>	Preferred	QL (1 EA per 1 day)
<b>EPCLUSA ORAL PACKET</b>	Non – Preferred	
<b>EPCLUSA TABLET 200-50 MG ORAL</b>	Non – Preferred	
<b>EPCLUSA TABLET 400-100 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>HARVONI</b>	Non – Preferred	
<b>MAVYRET ORAL PACKET</b>	Preferred	QL (5 EA per 1 day)
<b>MAVYRET ORAL TABLET</b>	Preferred	QL (3 EA per 1 day)
<b>VOSEVI</b>	Non – Preferred	
<b>ZEPATIER</b>	Non – Preferred	
<b><i>*Hepatitis C Agents*** - Drugs For Viral Infections</i></b>		
<i>ribavirin</i>	Preferred	
<b>PEGASYS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (2 ML per 28 days)
<b>PEGASYS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (2 UNIT per 28 days)
<b>PEGASYS SUBCUTANEOUS SOLUTION</b>	Non – Preferred	QL (4 UNIT per 28 days)
<b>SOVALDI</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Herpes Agents - Purine Analogues*** - Drugs For Viral Infections</b>		
<i>acyclovir capsule 200 mg oral</i>	Preferred	QL (30 EA per 50 days)
<i>acyclovir capsule 200 mg oral</i>	Preferred	QL (50 EA per 30 days)
<i>acyclovir oral tablet</i>	Preferred	QL (2 EA per 1 day)
<i>acyclovir suspension 200 mg/5ml oral</i>	Preferred	QL (400 ML per 30 days)
<i>valacyclovir hcl tablet 1 gm oral</i>	Preferred	QL (30 EA per 30 days)
<i>valacyclovir hcl tablet 500 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>SITAVIG</b>	Non – Preferred	
<b>VALTREX TABLET 1 GM ORAL</b>	Non – Preferred	QL (30 EA per 30 days)
<b>VALTREX TABLET 500 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>*Herpes Agents - Thymidine Analogues*** - Drugs For Viral Infections</b>		
<i>famciclovir</i>	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
<b>*Influenza Agents*** - Drugs For Viral Infections</b>		
<i>rimantadine hcl</i>	Non – Preferred	QL (14 EA Max Qty Per Fill Retail)
<b>*Misc. Antivirals*** - Drugs For Viral Infections</b>		
<b>LAGEVRIO</b>	Preferred	AL (Min 18 Years)
<b>*Neuraminidase Inhibitors*** - Drugs For Viral Infections</b>		
<i>oseltamivir phosphate capsule 30 mg oral</i>	Preferred	QL (20 EA per 30 days)
<i>oseltamivir phosphate capsule 45 mg oral</i>	Preferred	QL (10 EA per 30 days)
<i>oseltamivir phosphate capsule 75 mg oral</i>	Preferred	QL (10 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oseltamivir phosphate oral suspension reconstituted</i>	Preferred	QL (180 ML per 30 days)
<b>RELENZA DISKHALER</b>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<b>TAMIFLU CAPSULE 30 MG ORAL</b>	Non – Preferred	QL (20 EA per 30 days)
<b>TAMIFLU CAPSULE 45 MG ORAL</b>	Non – Preferred	QL (10 EA per 30 days)
<b>TAMIFLU CAPSULE 75 MG ORAL</b>	Non – Preferred	QL (10 EA per 30 days)
<b>TAMIFLU ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	QL (180 ML per 30 days)
<b><i>*Pa Endonuclease Inhibitors*** - Drugs For Viral Infections</i></b>		
<b>XOFLUZA (40 MG DOSE)</b>	Non – Preferred	
<b>XOFLUZA (80 MG DOSE)</b>	Non – Preferred	
<b><i>*Rsv Agents - Nucleoside Analogues*** - Drugs For Viral Infections</i></b>		
<i>ribavirin</i>	Preferred	
<b>VIRAZOLE</b>	Non – Preferred	
<b><i>*Beta Blockers* - Drugs For The Heart</i></b>		
<b><i>*Alpha-Beta Blockers*** - Drugs For High Blood Pressure</i></b>		
<i>carvedilol</i>	Preferred	QL (2 EA per 1 day)
<i>carvedilol phosphate er</i>	Non – Preferred	
<i>labetalol hcl</i>	Preferred	
<b>COREG</b>	Non – Preferred	QL (2 EA per 1 day)
<b>COREG CR</b>	Non – Preferred	
<b><i>*Beta Blockers Cardio-Selective*** - Drugs For High Blood Pressure</i></b>		
<i>acebutolol hcl</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>atenolol</i>	Preferred	
<i>betaxolol hcl</i>	Preferred	
<i>bisoprolol fumarate tablet 10 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>bisoprolol fumarate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>metoprolol succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	QL (1.5 EA per 1 day)
<i>metoprolol tartrate</i>	Preferred	
<i>nebivolol hcl</i>	Non – Preferred	
<b>BYSTOLIC</b>	Non – Preferred	
<b>KAPSPARGO SPRINKLE</b>	Non – Preferred	
<b>LOPRESSOR</b>	Non – Preferred	
<b>TENORMIN</b>	Non – Preferred	
<b>TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL</b>	Non – Preferred	QL (1.5 EA per 1 day)
<b>TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL</b>	Non – Preferred	QL (1.5 EA per 1 day)
<b><i>*Beta Blockers Non-Selective*** - Drugs For High Blood Pressure</i></b>		
<i>nadolol</i>	Preferred	QL (2 EA per 1 day)
<i>pindolol</i>	Preferred	
<i>propranolol hcl</i>	Preferred	

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<i>propranolol hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>sotalol hcl</i>	Preferred	
<i>sotalol hcl (af)</i>	Non – Preferred	
<i>timolol maleate</i>	Preferred	
<b>BETAPACE</b>	Non – Preferred	
<b>BETAPACE AF</b>	Non – Preferred	
<b>CORGARD</b>	Non – Preferred	QL (2 EA per 1 day)
<b>HEMANGEOL</b>	Preferred	PA
<b>INDERAL LA</b>	Non – Preferred	QL (1 EA per 1 day)
<b>INDERAL XL</b>	Non – Preferred	
<b>INNOPRAN XL</b>	Non – Preferred	
<b>SOTYLIZE</b>	Non – Preferred	
<b>*Calcium Channel Blockers* - Drugs For The Heart</b>		
<b>*Calcium Channel Blockers*** - Drugs For High Blood Pressure</b>		
<i>amlodipine besylate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>amlodipine besylate tablet 2.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>amlodipine besylate tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl</i>	Preferred	QL (4 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er beads capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>diltiazem hcl er beads capsule extended release 24 hour 420 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	
<i>diltiazem hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	
<i>diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral</i>	Preferred	
<i>diltiazem hcl er oral capsule extended release 12 hour</i>	Preferred	QL (2 EA per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour</i>	Preferred	
<i>dilt-xr capsule extended release 24 hour 120 mg oral</i>	Preferred	
<i>dilt-xr capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>dilt-xr capsule extended release 24 hour 240 mg oral</i>	Preferred	
<i>felodipine er</i>	Preferred	QL (1 EA per 1 day)
<i>isradipine</i>	Non – Preferred	
<i>levamlodipine maleate</i>	Non – Preferred	
<i>nicardipine hcl</i>	Non – Preferred	
<i>nifedipine</i>	Preferred	

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<i>nifedipine er</i>	Preferred	QL (1 EA per 1 day)
<i>nifedipine er osmotic release</i>	Preferred	QL (1 EA per 1 day)
<i>nimodipine</i>	Preferred	
<i>nisoldipine er</i>	Non – Preferred	
<i>verapamil hcl</i>	Preferred	QL (4 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 100 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 200 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 300 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er capsule extended release 24 hour 360 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>verapamil hcl er oral tablet extended release</i>	Preferred	QL (2 EA per 1 day)
<b>CARDIZEM</b>	Non – Preferred	QL (4 EA per 1 day)
<b>CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day)
<b>CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL</b>	Non – Preferred	
<b>CARDIZEM LA</b>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Preferred	QL (3 EA per 1 day)
<b>CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Preferred	QL (2 EA per 1 day)
<b>CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>KATERZIA</b>	Non – Preferred	
<b>MATZIM LA</b>	Preferred	
<b>NORLIQVA</b>	Non – Preferred	
<b>NORVASC TABLET 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>NORVASC TABLET 2.5 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>NORVASC TABLET 5 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>NYMALIZE</b>	Non – Preferred	
<b>PROCARDIA XL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>SULAR</b>	Non – Preferred	
<b>TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Preferred	QL (3 EA per 1 day)
<b>TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Preferred	QL (2 EA per 1 day)
<b>TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TAZTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Preferred	QL (3 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Preferred	QL (2 EA per 1 day)
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL</b>	Preferred	QL (1 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
<b>*Cardiotonics* - Drugs For The Heart</b>		
<b><i>*Cardiac Glycosides*** - Drugs For The Heart</i></b>		
<i>digoxin oral solution</i>	Preferred	
<i>digoxin tablet 125 mcg oral</i>	Preferred	
<i>digoxin tablet 250 mcg oral</i>	Preferred	
<i>digoxin tablet 62.5 mcg oral</i>	Non – Preferred	
<b>DIGOX</b>	Preferred	
<b>*Cardiovascular Agents - Misc.* - Drugs For The Heart</b>		
<b><i>*Calcium Channel Blocker &amp; Hmg Coa Reductase Inhibit Comb*** - Drugs For Cholesterol</i></b>		
<i>amlodipine-atorvastatin</i>	Non – Preferred	QL (1 EA per 1 day)
<b>CADUET</b>	Non – Preferred	QL (1 EA per 1 day)
<b><i>*Cardiac Myosin Inhibitors*** - Drugs For The Heart</i></b>		
<b>CAMZYOS</b>	Non – Preferred	
<b><i>*Neprilysin Inhib (Arni)-Angiotensin li Recept Antag Comb*** - Drugs For High Blood Pressure</i></b>		
<b>ENTRESTO</b>	Preferred	QL (2 EA per 1 day)
<b><i>*Nitrate &amp; Vasodilator Combinations*** - Drugs For High Blood Pressure</i></b>		
<i>isosorb dinitrate-hydralazine</i>	Preferred	
<b>BIDIL</b>	Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Prostaglandin Vasodilators*** - Drugs For High Blood Pressure</i></b>		
<i>epoprostenol sodium</i>	Preferred	PA
<i>treprostinil</i>	Non – Preferred	
<b>FLOLAN</b>	Preferred	PA
<b>ORENITRAM</b>	Non – Preferred	
<b>ORENITRAM MONTH 1</b>	Non – Preferred	
<b>ORENITRAM MONTH 2</b>	Non – Preferred	
<b>ORENITRAM MONTH 3</b>	Non – Preferred	
<b>REMODULIN</b>	Non – Preferred	
<b>TYVASO</b>	Non – Preferred	
<b>TYVASO DPI MAINTENANCE KIT</b>	Non – Preferred	
<b>TYVASO DPI TITRATION KIT</b>	Non – Preferred	
<b>TYVASO REFILL</b>	Non – Preferred	
<b>TYVASO STARTER</b>	Non – Preferred	
<b>VELETRI</b>	Non – Preferred	PA
<b>VENTAVIS</b>	Non – Preferred	
<b><i>*Pulm Hyperten-Soluble Guanylate Cyclase Stimulator (Sgc)*** - Drugs For High Blood Pressure</i></b>		
<b>ADEMPAS</b>	Non – Preferred	
<b><i>*Pulmonary Hypertension - Endothelin Receptor Antagonists*** - Drugs For High Blood Pressure</i></b>		
<i>ambrisentan</i>	Non – Preferred	PA; QL (1 EA per 1 day)
<i>bosentan</i>	Non – Preferred	PA; QL (2 EA per 1 day)
<b>LETAIRIS</b>	Preferred	PA; QL (1 EA per 1 day)
<b>OPSUMIT</b>	Non – Preferred	QL (1 EA per 1 day)
<b>TRACLEER</b>	Preferred	PA; QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Pulmonary Hypertension - Phosphodiesterase Inhibitors*** - Drugs For High Blood Pressure</i></b>		
<i>sildenafil citrate intravenous</i>	Non – Preferred	
<i>sildenafil citrate oral suspension reconstituted</i>	Non – Preferred	PA
<i>sildenafil citrate oral tablet</i>	Preferred	PA; QL (3 EA per 1 day)
<i>tadalafil (pah)</i>	Preferred	PA; QL (2 EA per 1 day)
<b>ADCIRCA</b>	Preferred	PA; QL (2 EA per 1 day)
<b>ALYQ</b>	Preferred	PA; QL (2 EA per 1 day)
<b>LIQREV</b>	Non – Preferred	
<b>REVATIO INTRAVENOUS</b>	Non – Preferred	
<b>REVATIO ORAL SUSPENSION RECONSTITUTED</b>	Preferred	PA
<b>REVATIO ORAL TABLET</b>	Non – Preferred	PA; QL (3 EA per 1 day)
<b><i>*Pulmonary Hypertension - Prostacyclin Receptor Agonist*** - Drugs For High Blood Pressure</i></b>		
<b>UPTRAVI</b>	Non – Preferred	
<b>UPTRAVI TITRATION</b>	Non – Preferred	
<b><i>*Selective Cgmp Phosphodiesterase Type 5 Inhibitors*** - Drugs For The Heart</i></b>		
<i>tadalafil</i>	Non – Preferred	
<b>CIALIS</b>	Non – Preferred	
<b><i>*Sinus Node Inhibitors** - Drugs For High Blood Pressure</i></b>		
<b>CORLANOR ORAL SOLUTION</b>	Non – Preferred	
<b>CORLANOR ORAL TABLET</b>	Non – Preferred	QL (2 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Transthyretin Stabilizers*** - Drugs For The Heart</i></b>		
VYNDAMAX	Non – Preferred	
VYNDAQEL	Non – Preferred	
<b><i>*Vasoactive Soluble Guanylate Cyclase Stimulator (Sgc)*** - Drugs For Angina</i></b>		
VERQUVO TABLET 10 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 10 MG ORAL	Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Preferred	PA
VERQUVO TABLET 5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 5 MG ORAL	Preferred	PA
<b>*Cephalosporins* - Drugs For Infections</b>		
<b><i>*Cephalosporin Combinations*** - Antibiotics</i></b>		
AVYCAZ	Preferred	
<b><i>*Cephalosporins - 1St Generation*** - Antibiotics</i></b>		
<i>cefadroxil</i>	Preferred	
<i>cefazolin sodium</i>	Preferred	
<i>cefazolin sodium-dextrose</i>	Preferred	
<i>cephalexin</i>	Preferred	
<b><i>*Cephalosporins - 2Nd Generation*** - Antibiotics</i></b>		
<i>cefaclor capsule 250 mg oral</i>	Preferred	
<i>cefaclor capsule 500 mg oral</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>cefaclor er</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefoxitin sodium</i>	Preferred	
<i>cefoxitin sodium-dextrose</i>	Preferred	
<i>cefprozil oral suspension reconstituted</i>	Preferred	
<i>cefprozil tablet 250 mg oral</i>	Non – Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>cefprozil tablet 500 mg oral</i>	Non – Preferred	
<i>cefuroxime axetil</i>	Preferred	
<b>*Cephalosporins - 3Rd Generation*** - Antibiotics</b>		
<i>cefdinir</i>	Preferred	
<i>cefixime oral capsule</i>	Preferred	QL (1 EA Max Qty Per Fill Retail)
<i>cefixime oral suspension reconstituted</i>	Non – Preferred	
<i>cefpodoxime proxetil</i>	Non – Preferred	
<i>ceftazidime</i>	Preferred	
<i>ceftriaxone sodium in dextrose</i>	Preferred	
<i>ceftriaxone sodium injection</i>	Preferred	QL (2 EA per 1 day)
<i>ceftriaxone sodium intravenous</i>	Preferred	
<i>ceftriaxone sodium-dextrose</i>	Preferred	
<b>TAZICEF</b>	Preferred	
<b>*Cephalosporins - 4Th Generation*** - Antibiotics</b>		
<i>cefepime hcl</i>	Preferred	
<i>cefepime-dextrose</i>	Preferred	
<b>*Chemicals*</b>		
<b>*Fixed Oils***</b>		
<i>castor oil</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Contraceptives* - Drugs For Women</b>		
<b>*Biphasic Contraceptives - Oral*** - Birth Control Pills</b>		
<i>desogestrel-ethinyl estradiol</i>	Preferred	
<i>viorele</i>	Preferred	
<b>AZURETTE</b>	Preferred	
<b>KARIVA</b>	Preferred	
<b>LO LOESTRIN FE</b>	Preferred	
<b>PIMTREA</b>	Preferred	
<b>SIMLIYA</b>	Preferred	
<b>VOLNEA</b>	Preferred	
<b>*Combination Contraceptives - Oral*** - Birth Control Pills</b>		
<i>alyacen 1/35</i>	Preferred	
<i>briellyn</i>	Preferred	
<i>desogestrel-ethinyl estradiol</i>	Preferred	
<i>drosipren-eth estrad-levomefol</i>	Preferred	
<i>drosiprenone-ethinyl estradiol</i>	Preferred	
<i>ethynodiol diac-eth estradiol</i>	Preferred	
<i>levonorgest-eth estradiol-iron</i>	Preferred	
<i>levonorgestrel-ethinyl estrad</i>	Preferred	
<i>marlissa</i>	Preferred	
<i>norethin ace-eth estrad-fe</i>	Preferred	
<i>norethindrone acet-ethinyl est</i>	Preferred	
<i>norethin-eth estradiol-fe</i>	Preferred	
<i>norgestimate-eth estradiol</i>	Preferred	
<b>AFIRMELLE</b>	Preferred	
<b>ALTAVERA</b>	Preferred	

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APRI	Preferred	
AUBRA EQ	Preferred	
AUROVELA 1.5/30	Preferred	
AUROVELA 1/20	Preferred	
AUROVELA 24 FE	Preferred	
AUROVELA FE 1.5/30	Preferred	
AUROVELA FE 1/20	Preferred	
AVIANE	Preferred	
AYUNA	Preferred	
BALCOLTRA	Preferred	
BALZIVA	Preferred	
BEYAZ	Preferred	
BLISOVI 24 FE	Preferred	
BLISOVI FE 1.5/30	Preferred	
BLISOVI FE 1/20	Preferred	
CHARLOTTE 24 FE	Preferred	
CHATEAL EQ	Preferred	
CRYSSELLE-28	Preferred	
CYRED EQ	Preferred	
DASETTA 1/35	Preferred	
ELINEST	Preferred	
ENSKYCE	Preferred	
ESTARYLLA	Preferred	
FALMINA	Preferred	
FINZALA	Preferred	
GEMMILY	Preferred	
HAILEY 1.5/30	Preferred	
HAILEY 24 FE	Preferred	
HAILEY FE 1.5/30	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HAILEY FE 1/20	Preferred	
ISIBLOOM	Preferred	
JASMIEL	Preferred	
JULEBER	Preferred	
JUNEL 1.5/30	Preferred	
JUNEL 1/20	Preferred	
JUNEL FE 1.5/30	Preferred	
JUNEL FE 1/20	Preferred	
JUNEL FE 24	Preferred	
KAITLIB FE	Preferred	
KALLIGA	Preferred	
KELNOR 1/35	Preferred	
KELNOR 1/50	Preferred	
KURVELO	Preferred	
LARIN 1.5/30	Preferred	
LARIN 1/20	Preferred	
LARIN 24 FE	Preferred	
LARIN FE 1.5/30	Preferred	
LARIN FE 1/20	Preferred	
LAYOLIS FE	Preferred	
LESSINA	Preferred	
LEVORA 0.15/30 (28)	Preferred	
LOESTRIN 1.5/30 (21)	Preferred	
LOESTRIN 1/20 (21)	Preferred	
LOESTRIN FE 1.5/30	Preferred	
LOESTRIN FE 1/20	Preferred	
LORYNA	Preferred	
LOW-OGESTREL	Preferred	
LO-ZUMANDIMINE	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUTERA	Preferred	
MERZEE	Preferred	
MIBELAS 24 FE	Preferred	
MICROGESTIN 1.5/30	Preferred	
MICROGESTIN 1/20	Preferred	
MICROGESTIN 24 FE	Preferred	
MICROGESTIN FE 1.5/30	Preferred	
MICROGESTIN FE 1/20	Preferred	
MILI	Preferred	
MINASTRIN 24 FE	Preferred	
MONO-LINYAH	Preferred	
NECON 0.5/35 (28)	Preferred	
NEXTSTELLIS	Preferred	
NIKKI	Preferred	
NORTREL 0.5/35 (28)	Preferred	
NORTREL 1/35 (21)	Preferred	
NORTREL 1/35 (28)	Preferred	
NYLIA 1/35	Preferred	
NYMYO	Preferred	
OCELLA	Preferred	
PHILITH	Preferred	
PORTIA-28	Preferred	
RECLIPSEN	Preferred	
SAFYRAL	Preferred	
SPRINTEC 28	Preferred	
SRONYX	Preferred	
SYEDA	Preferred	
TARINA 24 FE	Preferred	
TARINA FE 1/20 EQ	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAYSOFY	Preferred	
TAYTULLA	Preferred	
TURQOZ	Preferred	
TYBLUME	Preferred	
TYDEMY	Preferred	
VESTURA	Preferred	
VIENVA	Preferred	
VYFEMLA	Preferred	
VYLIBRA	Preferred	
WERA	Preferred	
WYMZYA FE	Preferred	
YASMIN 28	Preferred	
YAZ	Preferred	
ZOVIA 1/35 (28)	Preferred	
ZUMANDIMINE	Preferred	
<b>*Combination Contraceptives - Transdermal*** - Birth Control Pills</b>		
TWIRLA	Preferred	
XULANE	Preferred	QL (3 EA per 28 days)
ZAFEMY	Preferred	QL (3 EA per 28 days)
<b>*Combination Contraceptives - Vaginal*** - Birth Control Pills</b>		
<i>etonogestrel-ethinyl estradiol ring 0.12-0.015 mg/24hr vaginal</i>	Preferred	QL (1 EA per 28 days)
ANNOVERA	Preferred	
ELURYNG	Preferred	QL (1 EA per 28 days)
ENILLORING	Preferred	QL (1 EA per 28 days)
HALOETTE	Preferred	QL (1 EA per 28 days)
NUVARING RING 0.12-0.015 MG/24HR VAGINAL	Preferred	QL (1 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Continuous Contraceptives - Oral*** - Birth Control Pills</b>		
<i>levonorgestrel-ethinyl estrad</i>	Preferred	
<b>AMETHYST</b>	Preferred	
<b>DOLISHALE</b>	Preferred	
<b>*Emergency Contraceptives*** - Birth Control Pills</b>		
<i>levonorgestrel</i>	Preferred	OTC
<b>ECONTRA ONE-STEP</b>	Preferred	OTC
<b>ELLA</b>	Preferred	
<b>MY CHOICE</b>	Preferred	OTC
<b>MY WAY</b>	Preferred	OTC
<b>NEW DAY</b>	Preferred	OTC
<b>OPCICON ONE-STEP</b>	Preferred	OTC
<b>OPTION 2</b>	Preferred	OTC
<b>*Extended-Cycle Contraceptives - Oral*** - Birth Control Pills</b>		
<i>levonorgest-eth est &amp; eth est</i>	Preferred	
<i>levonorgest-eth estrad 91-day tablet 0.1-0.02 &amp; 0.01 mg oral</i>	Preferred	
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 &amp; 0.01 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levonorgest-eth estrad 91-day tablet 0.15-0.03 mg oral</i>	Preferred	
<b>AMETHIA</b>	Preferred	QL (1 EA per 1 day)
<b>ASHLYNA</b>	Preferred	QL (1 EA per 1 day)
<b>CAMRESE</b>	Preferred	QL (1 EA per 1 day)
<b>CAMRESE LO</b>	Preferred	
<b>DAYSEE</b>	Preferred	QL (1 EA per 1 day)
<b>ICLEVIA</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INTROVALE	Preferred	
JAIMIESS	Preferred	QL (1 EA per 1 day)
JOLESSA	Preferred	
LOJAIMIESS	Preferred	
RIVELSA	Preferred	
SETLAKIN	Preferred	AL (Min 10 Years and Max 55 Years)
SIMPESSE	Preferred	QL (1 EA per 1 day)
<b>*Four Phase Contraceptives - Oral*** - Birth Control Pills</b>		
NATAZIA	Preferred	
<b>*Progestin Contraceptives - Injectable*** - Birth Control Pills</b>		
<i>medroxyprogesterone acetate suspension 150 mg/ml intramuscular</i>	Preferred	QL (1 ML per 84 days)
<i>medroxyprogesterone acetate suspension 150 mg/ml intramuscular</i>	Preferred	QL (1 VIAL per 84 days)
<i>medroxyprogesterone acetate suspension prefilled syringe 150 mg/ml intramuscular</i>	Preferred	
<i>medroxyprogesterone acetate suspension prefilled syringe 150 mg/ml intramuscular</i>	Preferred	QL (1 ML per 84 days)
<b>DEPO-PROVERA INTRAMUSCULAR SUSPENSION</b>	Preferred	QL (1 VIAL per 84 days)
<b>DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b>	Preferred	QL (1 ML per 84 days)
<b>DEPO-SUBQ PROVERA 104</b>	Preferred	
<b>*Progestin Contraceptives - Oral*** - Birth Control Pills</b>		
<i>norethindrone</i>	Preferred	QL (1 EA per 1 day)
<b>CAMILA</b>	Preferred	QL (1 EA per 1 day)
<b>DEBLITANE</b>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERRIN	Preferred	QL (1 EA per 1 day)
HEATHER	Preferred	QL (1 EA per 1 day)
INCASSIA	Preferred	QL (1 EA per 1 day)
JENCYCLA	Preferred	QL (1 EA per 1 day)
LYLEQ	Preferred	
LYZA	Preferred	QL (1 EA per 1 day)
NORA-BE	Preferred	QL (1 EA per 1 day)
NORLYDA	Preferred	QL (1 EA per 1 day)
SHAROBEL	Preferred	QL (1 EA per 1 day)
SLYND	Preferred	
<b><i>*Triphasic Contraceptives - Oral*** - Birth Control Pills</i></b>		
<i>alyacen 7/7/7</i>	Preferred	
<i>levonorg-eth estrad triphasic</i>	Preferred	
<i>norgestim-eth estrad triphasic</i>	Preferred	
<b>ARANELLE</b>	Preferred	
<b>DASETTA 7/7/7</b>	Preferred	
<b>ENPRESSE-28</b>	Preferred	
<b>LEENA</b>	Preferred	
<b>LEVONEST</b>	Preferred	
<b>NORTREL 7/7/7</b>	Preferred	
<b>NYLIA 7/7/7</b>	Preferred	
<b>PIRMELLA 7/7/7</b>	Preferred	
<b>TILIA FE</b>	Preferred	
<b>TRI FEMYNOR</b>	Preferred	
<b>TRI-ESTARYLLA</b>	Preferred	
<b>TRI-LEGEST FE</b>	Preferred	
<b>TRI-LINYAH</b>	Preferred	
<b>TRI-LO-ESTARYLLA</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRI-LO-MARZIA	Preferred	
TRI-LO-MILI	Preferred	
TRI-LO-SPRINTEC	Preferred	
TRI-MILI	Preferred	
TRINESSA (28)	Preferred	
TRI-NYMYO	Preferred	
TRI-SPRINTEC	Preferred	
TRIVORA (28)	Preferred	
TRI-VYLIBRA	Preferred	
TRI-VYLIBRA LO	Preferred	
VELIVET	Preferred	
<b>*Corticosteroids* - Hormones</b>		
<b>*Glucocorticosteroids*** - Drugs For Inflammation</b>		
<i>budesonide</i>	Non – Preferred	
<i>budesonide er</i>	Non – Preferred	
<i>cortisone acetate</i>	Non – Preferred	
<i>dexamethasone</i>	Preferred	
<i>dexamethasone sodium phosphate</i>	Preferred	
<i>hydrocortisone</i>	Preferred	
<i>methylprednisolone oral tablet</i>	Preferred	
<i>methylprednisolone oral tablet therapy pack</i>	Preferred	QL (21 EA Max Qty Per Fill Retail)
<i>prednisolone</i>	Preferred	
<i>prednisolone sodium phosphate oral tablet dispersible</i>	Non – Preferred	
<i>prednisolone sodium phosphate solution 10 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 15 mg/5ml oral</i>	Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>prednisolone sodium phosphate solution 20 mg/5ml oral</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>prednisolone sodium phosphate solution 25 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral</i>	Preferred	
<i>prednisone oral solution</i>	Preferred	
<i>prednisone oral tablet</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 10 mg (48) oral</i>	Preferred	QL (48 EA Max Qty Per Fill Retail)
<i>prednisone tablet therapy pack 5 mg (21) oral</i>	Preferred	
<i>prednisone tablet therapy pack 5 mg (48) oral</i>	Preferred	QL (48 EA Max Qty Per Fill Retail)
<b>ALKINDI SPRINKLE</b>	Non – Preferred	
<b>CORTEF</b>	Non – Preferred	
<b>DEXAMETHASONE INTENSOL</b>	Preferred	
<b>EMFLAZA</b>	Non – Preferred	
<b>HEMADY</b>	Non – Preferred	
<b>MEDROL ORAL TABLET</b>	Non – Preferred	
<b>MEDROL ORAL TABLET THERAPY PACK</b>	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
<b>PREDNISONE INTENSOL</b>	Preferred	
<b>RAYOS</b>	Non – Preferred	
<b>SOLU-CORTEF</b>	Preferred	
<b>TAPERDEX 12-DAY</b>	Non – Preferred	
<b>TAPERDEX 6-DAY</b>	Non – Preferred	
<b>TAPERDEX 7-DAY</b>	Non – Preferred	
<b>TARPEYO</b>	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UCERIS	Non – Preferred	
<b>*Mineralocorticoids*** - Drugs For Inflammation</b>		
<i>fludrocortisone acetate</i>	Preferred	
<b>*Cough/Cold/Allergy* - Drugs For The Lungs</b>		
<b>*Antitussive - Nonnarcotic*** - Drugs For Allergies</b>		
<i>benzonatate oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day); AL (Min 10 Years)
<i>benzonatate oral capsule 200 mg</i>	Preferred	QL (3 EA per 1 day); AL (Min 10 Years)
<i>cvs tussin maximum strength</i>	Preferred	OTC
<i>dextromethorphan polistirex er</i>	Preferred	OTC
<b>*Antitussive-Antihistamine-Analgesic*** - Drugs For Cough And Cold</b>		
CORICIDIN HBP NIGHTTIME COLD	Preferred	OTC
<b>*Antitussive-Decongestant-Analgesic*** - Drugs For Cough And Cold</b>		
<i>daytime cold/flu relief</i>	Preferred	OTC
<b>*Antitussive-Expectorant*** - Drugs For Cough And Cold</b>		
<i>cvs chest congest/cough child</i>	Preferred	OTC
<i>dextromethorphan-guaifenesin</i>	Preferred	OTC
<i>guaifenesin-codeine</i>	Preferred	OTC
<b>*Decongestant &amp; Antihistamine*** - Drugs For Cough And Cold</b>		
<i>allergy relief d-24</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cetirizine-pseudoephedrine er</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>cold &amp; allergy</i>	Preferred	OTC
<i>loratadine-d 12hr</i>	Preferred	OTC; QL (2 EA per 1 day)
<i>promethazine vc</i>	Preferred	
<i>rynex pse</i>	Preferred	OTC
<b>LOHIST-D</b>	Preferred	OTC
<b>SUDOGEST SINUS/ALLERGY</b>	Preferred	OTC
<b><i>*Decongestant W/ Expectorant*** - Drugs For Cough And Cold</i></b>		
<i>ed bron gp</i>	Preferred	OTC
<b><i>*Decongestant-Analgesic*** - Drugs For Cough And Cold</i></b>		
<i>cvs cold &amp; sinus relief</i>	Preferred	OTC
<b><i>*Expectorants*** - Drugs For Cough And Cold</i></b>		
<i>guaifenesin</i>	Preferred	OTC
<i>guaifenesin er</i>	Preferred	OTC
<b><i>*Misc. Respiratory Inhalants*** - Drugs For Allergies</i></b>		
<i>sodium chloride</i>	Preferred	
<b><i>*Mucolytics*** - Drugs For The Lungs</i></b>		
<i>acetylcysteine</i>	Preferred	
<b><i>*Non-Narc Antitussive-Antihistamine*** - Drugs For Cough And Cold</i></b>		
<i>promethazine-dm</i>	Preferred	

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<b>*Non-Narc Antitussive-Decongestant*** - Drugs For Cough And Cold</b>		
SUDAFED PE COLD & COUGH CHILD	Preferred	OTC
<b>*Non-Narc Antitussive-Decongestant-Antihistamine*** - Drugs For Cough And Cold</b>		
<i>pseudoeph-bromphen-dm</i>	Preferred	
<b>*Opioid Antitussive-Antihistamine*** - Drugs For Cough And Cold</b>		
<i>promethazine-codeine</i>	Preferred	QL (180 ML per 30 days); AL (Min 18 Years)
<b>*Dermatologicals* - Drugs For The Skin</b>		
<b>*Acne Antibiotics*** - Drugs For The Skin</b>		
<i>clindamycin phosphate external foam</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin phosphate external gel</i>	Preferred	QL (2.5 GM per 1 day); AL (Min 10 Years)
<i>clindamycin phosphate external lotion</i>	Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
<i>clindamycin phosphate external solution</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
<i>clindamycin phosphate external swab</i>	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
<i>dapsone</i>	Non – Preferred	AL (Min 10 Years)
<i>ery</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
<i>erythromycin external gel</i>	Preferred	QL (1 GM per 1 day); AL (Min 10 Years)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>erythromycin external solution</i>	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
<i>sulfacetamide sodium (acne)</i>	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
<b>ACZONE</b>	Non – Preferred	AL (Min 10 Years)
<b>CLEOCIN-T</b>	Non – Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
<b>CLINDACIN</b>	Non – Preferred	AL (Min 10 Years)
<b>CLINDACIN ETZ</b>	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
<b>CLINDACIN-P</b>	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
<b>CLINDAGEL</b>	Non – Preferred	QL (2.5 ML per 1 day); AL (Min 10 Years)
<b>ERYGEL</b>	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years)
<b>KLARON</b>	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
<b>*Acne Combinations*** - Drugs For The Skin</b>		
<i>adapalene-benzoyl peroxide external gel</i>	Non – Preferred	AL (Min 10 Years)
<i>adapalene-benzoyl peroxide external pad</i>	Non – Preferred	
<i>benzoyl peroxide-erythromycin</i>	Preferred	AL (Min 10 Years)
<i>bp 10-1</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin phos-benzoyl perox</i>	Non – Preferred	AL (Min 10 Years)
<i>clindamycin-tretinoin gel 1.2-0.025 % external</i>	Non – Preferred	
<i>clindamycin-tretinoin gel 1.2-0.025 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sss 10-5</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur external cream</i>	Non – Preferred	AL (Min 10 Years)

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<i>sulfacetamide sodium-sulfur external suspension</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur liquid 10-2 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur liquid 10-5 % external</i>	Non – Preferred	
<i>sulfacetamide sodium-sulfur liquid 10-5 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur liquid 9.8-4.8 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4.5 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide sod-sulfur wash</i>	Non – Preferred	AL (Min 10 Years)
<i>sulfacetamide-sulfur in urea</i>	Non – Preferred	AL (Min 10 Years)
<b>ACANYA</b>	Non – Preferred	AL (Min 10 Years)
<b>AVAR CLEANSER</b>	Non – Preferred	
<b>BENZAMYCIN</b>	Non – Preferred	AL (Min 10 Years)
<b>CABTREO</b>	Non – Preferred	
<b>CLINDACIN ETZ</b>	Non – Preferred	AL (Min 10 Years)
<b>CLINDACIN PAC</b>	Non – Preferred	AL (Min 10 Years)
<b>NEUAC</b>	Non – Preferred	AL (Min 10 Years)
<b>ONEXTON</b>	Non – Preferred	AL (Min 10 Years)
<b>SUMADAN</b>	Non – Preferred	AL (Min 10 Years)
<b>SUMADAN WASH</b>	Non – Preferred	AL (Min 10 Years)
<b>SUMADAN XLT</b>	Non – Preferred	AL (Min 10 Years)
<b>SUMAXIN</b>	Non – Preferred	AL (Min 10 Years)
<b>SUMAXIN CP</b>	Non – Preferred	AL (Min 10 Years)
<b>ZIANA</b>	Non – Preferred	AL (Min 10 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Acne Products*** - Drugs For The Skin</b>		
<i>adapalene cream 0.1 % external</i>	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>adapalene external gel</i>	Non – Preferred	AL (Min 10 Years)
<i>adapalene external solution</i>	Non – Preferred	AL (Min 10 Years)
<i>isotretinoin capsule 10 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 20 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 25 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 30 mg oral</i>	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
<i>isotretinoin capsule 35 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>isotretinoin capsule 40 mg oral</i>	Non – Preferred	AL (Min 12 Years)
<i>tazarotene</i>	Non – Preferred	AL (Min 10 Years)
<i>tretinoin cream 0.025 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin cream 0.05 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin cream 0.1 % external</i>	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
<i>tretinoin gel 0.01 % external</i>	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
<i>tretinoin gel 0.025 % external</i>	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
<i>tretinoin gel 0.05 % external</i>	Preferred	AL (Min 10 Years)
<i>tretinoin microsphere</i>	Non – Preferred	AL (Min 10 Years)
<i>tretinoin microsphere pump</i>	Non – Preferred	AL (Min 10 Years)
<b>ABSORICA CAPSULE 10 MG ORAL</b>	Non – Preferred	AL (Min 12 Years)
<b>ABSORICA CAPSULE 20 MG ORAL</b>	Non – Preferred	AL (Min 12 Years)
<b>ABSORICA CAPSULE 25 MG ORAL</b>	Non – Preferred	AL (Min 12 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABSORICA CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
ABSORICA CAPSULE 35 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA LD	Non – Preferred	AL (Min 10 Years)
ALTRENO	Non – Preferred	AL (Min 10 Years)
AMNESTEEM	Non – Preferred	AL (Min 12 Years)
ARAZLO	Non – Preferred	AL (Min 10 Years)
ATRALIN	Non – Preferred	AL (Min 10 Years)
CLARAVIS CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
CLARAVIS CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
FABIOR	Non – Preferred	AL (Min 10 Years)
RETIN-A EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
RETIN-A EXTERNAL GEL	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
RETIN-A MICRO	Non – Preferred	AL (Min 10 Years)
RETIN-A MICRO PUMP	Non – Preferred	AL (Min 10 Years)
WINLEVI	Non – Preferred	AL (Min 10 Years)
ZENATANE CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 12 Years)
ZENATANE CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
<b><i>*Agents For External Genital And Perianal Warts*** - Drugs For The Skin</i></b>		
VEREGEN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antibiotic Mixtures Topical*** - Drugs For The Skin</b>		
<i>first aid antibiotic</i>	Preferred	OTC
<i>ra antibiotic + pain relief</i>	Preferred	OTC
<i>ra antibiotic plus</i>	Preferred	OTC
<i>sm antibiotic plus pain relief</i>	Preferred	OTC
<i>sm triple antibiotic original</i>	Preferred	OTC
<i>triple antibiotic</i>	Preferred	OTC
<i>triple antibiotic pain relief</i>	Preferred	OTC
<b>NEOSPORIN + PAIN RELIEF MAX ST</b>	Preferred	OTC
<b>NEOSPORIN PLUS PAIN RELIEF MS</b>	Preferred	OTC
<b>*Antibiotic Steroid Combinations - Topical*** - Drugs For The Skin</b>		
<b>NEO-SYNALAR</b>	Non – Preferred	
<b>*Antibiotics - Topical*** - Drugs For The Skin</b>		
<i>gentamicin sulfate</i>	Preferred	
<i>mupirocin</i>	Preferred	QL (110 GM per 30 days)
<i>mupirocin calcium</i>	Non – Preferred	
<b>XEPI</b>	Non – Preferred	
<b>*Antifungals - Topical Combinations*** - Drugs For The Skin</b>		
<i>clotrimazole-betamethasone external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	Non – Preferred	
<i>miconazole-zinc oxide-petrolat</i>	Non – Preferred	
<i>nystatin-triamcinolone</i>	Non – Preferred	
<b>VUSION</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Antifungals - Topical*** - Drugs For The Skin</b>		
<i>ciclopirox external gel</i>	Non – Preferred	
<i>ciclopirox external shampoo</i>	Non – Preferred	QL (120 ML per 30 days)
<i>ciclopirox external solution</i>	Non – Preferred	QL (6.6 ML per 30 days)
<i>ciclopirox olamine external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>ciclopirox olamine external suspension</i>	Non – Preferred	QL (30 ML per 30 days)
<i>ciclopirox treatment</i>	Non – Preferred	
<i>naftifine hcl</i>	Non – Preferred	
<i>nystatin cream 100000 unit/gm external</i>	Preferred	QL (60 GM per 30 days)
<i>nystatin external powder</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>nystatin ointment 100000 unit/gm external</i>	Preferred	QL (60 GM per 30 days)
<b>CICLODAN</b>	Non – Preferred	QL (6.6 ML per 30 days)
<b>MYCOZYL AL</b>	Non – Preferred	
<b>NAFTIN</b>	Non – Preferred	
<b>NYAMYC</b>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<b>NYSTOP</b>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<b>*Anti-Inflammatory Agents - Topical*** - Drugs For The Skin</b>		
<i>diclofenac epolamine</i>	Non – Preferred	
<i>diclofenac sodium gel 1 % external (rx)</i>	Non – Preferred	QL (200 GM per 30 days)
<i>diclofenac sodium solution 1.5 % external</i>	Non – Preferred	QL (10 ML per 1 day)
<i>diclofenac sodium solution 2 % external</i>	Non – Preferred	
<b>FLECTOR</b>	Non – Preferred	
<b>LICART</b>	Non – Preferred	
<b>PENNSAID</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Anti-Inflammatory Combinations - Topical*** - Drugs For The Skin</b>		
LEXTOL	Non – Preferred	
<b>*Antineoplastic Alkylating Agents - Topical*** - Drugs For The Skin</b>		
VALCHLOR	Non – Preferred	
<b>*Antineoplastic Antimetabolites - Topical*** - Drugs For The Skin</b>		
<i>fluorouracil</i>	Non – Preferred	
CARAC	Non – Preferred	
EFUDEX	Non – Preferred	
<b>*Antineoplastic Or Premalignant Lesions - Topical Nsaid's*** - Drugs For The Skin</b>		
<i>diclofenac sodium</i>	Non – Preferred	
<b>*Antipruritic Combinations - Topical*** - Drugs For The Skin</b>		
<i>anti-itch</i>	Preferred	OTC
<b>*Antipruritics - Topical*** - Drugs For The Skin</b>		
<i>doxepin hcl</i>	Non – Preferred	
PRUDOXIN	Non – Preferred	
ZONALON	Non – Preferred	
<b>*Antipsoriatics - Systemic*** - Drugs For The Skin</b>		
<i>acitretin</i>	Non – Preferred	
<i>methoxsalen rapid</i>	Non – Preferred	
BIMZELX	Non – Preferred	
COSENTYX	Preferred	PA

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<b>COSENTYX (300 MG DOSE)</b>	Preferred	PA
<b>COSENTYX SENSOREADY (300 MG)</b>	Preferred	PA
<b>COSENTYX SENSOREADY PEN</b>	Preferred	PA
<b>COSENTYX UNOREADY</b>	Preferred	PA
<b>ILUMYA</b>	Non – Preferred	
<b>SILIQ</b>	Non – Preferred	
<b>SKYRIZI</b>	Non – Preferred	
<b>SKYRIZI PEN</b>	Non – Preferred	
<b>STELARA</b>	Non – Preferred	
<b>TALTZ</b>	Non – Preferred	
<b>TREMFYA</b>	Non – Preferred	
<b>*Antipsoriatics*** - Drugs For The Skin</b>		
<i>calcipotriene external cream</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external ointment</i>	Preferred	QL (4 GM per 1 day)
<i>calcipotriene external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>calcitriol</i>	Non – Preferred	
<i>tazarotene external cream</i>	Non – Preferred	QL (3 GM per 1 day)
<i>tazarotene external gel</i>	Non – Preferred	
<b>SORILUX</b>	Non – Preferred	
<b>VTAMA</b>	Non – Preferred	
<b>ZORYVE</b>	Non – Preferred	
<b>*Antiseborrheic Products*** - Drugs For The Skin</b>		
<i>selenium sulfide external lotion</i>	Preferred	
<i>selenium sulfide external shampoo</i>	Non – Preferred	
<i>sodium sulfacetamide wash</i>	Non – Preferred	
<i>sulfacetamide sodium</i>	Non – Preferred	
<i>sulfacetamide sodium (cleans)</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Antiviral Topical Combinations*** - Drugs For The Skin</i></b>		
XERESE	Non – Preferred	
<b><i>*Antivirals - Topical*** - Drugs For The Skin</i></b>		
<i>acyclovir external cream</i>	Non – Preferred	
<i>acyclovir ointment 5 % external</i>	Non – Preferred	QL (15 GM per 30 days)
<i>penciclovir</i>	Non – Preferred	
DENAVIR	Non – Preferred	
ZOVIRAX EXTERNAL CREAM	Non – Preferred	
ZOVIRAX EXTERNAL OINTMENT	Non – Preferred	QL (15 GM per 30 days)
<b><i>*Astringents*** - Drugs For The Skin</i></b>		
XERAC AC	Non – Preferred	
<b><i>*Atopic Dermatitis - Janus Kinase (Jak) Inhibitors*** - Drugs For The Skin</i></b>		
CIBINQO	Non – Preferred	
OPZELURA	Non – Preferred	
<b><i>*Atopic Dermatitis - Monoclonal Antibodies*** - Drugs For The Skin</i></b>		
ADBRY	Non – Preferred	
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Preferred	PA

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<b>*Burn Products*** - Drugs For The Skin</b>		
<i>mafenide acetate</i>	Preferred	
<i>silver sulfadiazine</i>	Preferred	
<b>SILVADENE</b>	Non – Preferred	
<b>SSD</b>	Preferred	
<b>SULFAMYLON</b>	Preferred	
<b>*Cauterizing Agent Combinations*** - Drugs For The Skin</b>		
<b>ARZOL SILVER NIT APPLICATORS</b>	Non – Preferred	
<b>*Cauterizing Agents*** - Drugs For The Skin</b>		
<i>silver nitrate</i>	Non – Preferred	
<b>*Corticosteroids - Topical*** - Drugs For The Skin</b>		
<i>alclometasone dipropionate</i>	Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate aug external cream</i>	Non – Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>betamethasone dipropionate aug external gel</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	Non – Preferred	QL (60 ML per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate external cream</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone dipropionate external lotion</i>	Non – Preferred	QL (120 ML per 30 days)
<i>betamethasone dipropionate external ointment</i>	Non – Preferred	QL (60 GM per 30 days)
<i>betamethasone valerate external cream</i>	Preferred	QL (60 GM per 30 days)
<i>betamethasone valerate external foam</i>	Non – Preferred	
<i>betamethasone valerate external lotion</i>	Preferred	QL (120 ML per 30 days)

Coverage Requirements and Limits

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Drug Tier

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>betamethasone valerate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>clobetasol prop emollient base</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate e</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate emulsion</i>	Non – Preferred	
<i>clobetasol propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external foam</i>	Non – Preferred	
<i>clobetasol propionate external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external liquid</i>	Non – Preferred	
<i>clobetasol propionate external lotion</i>	Non – Preferred	
<i>clobetasol propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>clobetasol propionate external shampoo</i>	Non – Preferred	
<i>clobetasol propionate solution 0.05 % external</i>	Preferred	QL (50 ML per 30 days)
<i>clocortolone pivalate</i>	Non – Preferred	
<i>desonide external cream</i>	Preferred	
<i>desonide external lotion</i>	Non – Preferred	
<i>desonide external ointment</i>	Preferred	
<i>desoximetasone</i>	Non – Preferred	
<i>diflorasone diacetate external cream</i>	Preferred	QL (60 GM per 30 days)
<i>diflorasone diacetate ointment 0.05 % external</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinolone acetonide body</i>	Preferred	
<i>fluocinolone acetonide cream 0.01 % external</i>	Preferred	
<i>fluocinolone acetonide cream 0.025 % external</i>	Preferred	QL (60 GM per 30 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>fluocinolone acetonide external ointment</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinolone acetonide external solution</i>	Preferred	
<i>fluocinolone acetonide scalp</i>	Preferred	
<i>fluocinonide cream 0.05 % external</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide cream 0.1 % external</i>	Preferred	
<i>fluocinonide emulsified base cream 0.05 % external</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide emulsified base cream 0.05 % external</i>	Preferred	QL (60 GM per 30 days)
<i>fluocinonide external gel</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluocinonide external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>flurandrenolide</i>	Non – Preferred	
<i>fluticasone propionate external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>fluticasone propionate external lotion</i>	Non – Preferred	
<i>fluticasone propionate external ointment</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>halcinonide</i>	Non – Preferred	
<i>halobetasol propionate external cream</i>	Preferred	QL (50 GM per 30 days)
<i>halobetasol propionate external foam</i>	Non – Preferred	
<i>halobetasol propionate ointment 0.05 % external</i>	Preferred	QL (50 GM per 30 days)
<i>hydrocortisone butyr lipo base</i>	Non – Preferred	
<i>hydrocortisone butyrate</i>	Non – Preferred	
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	QL (454 GM Max Qty Per Fill Retail)
<i>hydrocortisone cream 2.5 % external</i>	Preferred	QL (90 GM per 30 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>hydrocortisone external cream 0.5 %</i>	Preferred	OTC
<i>hydrocortisone external lotion</i>	Preferred	QL (120 ML per 30 days)
<i>hydrocortisone external ointment</i>	Preferred	QL (90 GM per 30 days)
<i>hydrocortisone valerate</i>	Preferred	
<i>instacort 5</i>	Preferred	OTC
<i>mometasone furoate external cream</i>	Preferred	QL (45 GM per 30 days)
<i>mometasone furoate external ointment</i>	Preferred	QL (45 GM Max Qty Per Fill Retail)
<i>mometasone furoate external solution</i>	Preferred	QL (60 ML Max Qty Per Fill Retail)
<i>triamcinolone acetonide cream 0.025 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide cream 0.1 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide cream 0.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide external aerosol solution</i>	Non – Preferred	
<i>triamcinolone acetonide lotion 0.025 % external</i>	Preferred	QL (120 ML per 30 days)
<i>triamcinolone acetonide lotion 0.1 % external</i>	Preferred	QL (120 ML per 30 days)
<i>triamcinolone acetonide ointment 0.025 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone acetonide ointment 0.05 % external</i>	Non – Preferred	
<i>triamcinolone acetonide ointment 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.5 % external</i>	Preferred	QL (90 GM per 30 days)
<i>triamcinolone in absorbbase</i>	Non – Preferred	
<b>APEXICON E</b>	Non – Preferred	
<b>BRYHALI</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLODAN	Non – Preferred	
CLODERM	Non – Preferred	
CORDRAN	Non – Preferred	
DERMA-SMOOTH/FS BODY	Non – Preferred	
DERMA-SMOOTH/FS SCALP	Non – Preferred	
DIPROLENE OINTMENT 0.05 % EXTERNAL	Non – Preferred	QL (60 GM per 30 days)
HALOG	Non – Preferred	
KENALOG	Non – Preferred	
LEXETTE	Non – Preferred	
LOCOID	Non – Preferred	
LOCOID LIPOCREAM	Non – Preferred	
SYNALAR EXTERNAL CREAM	Non – Preferred	QL (60 GM per 30 days)
SYNALAR EXTERNAL OINTMENT	Non – Preferred	QL (60 GM per 30 days)
SYNALAR EXTERNAL SOLUTION	Non – Preferred	
TEXACORT	Non – Preferred	
TOPICORT	Non – Preferred	
TOPICORT SPRAY	Non – Preferred	
TOVET	Non – Preferred	
ULTRAVATE	Non – Preferred	
VANOS	Non – Preferred	
<b><i>*Depigmenting Agents*** - Drugs For The Skin</i></b>		
<i>hydroquinone</i>	Preferred	
BLANCHE	Preferred	
<b><i>*Emollient/Keratolytic Agents*** - Drugs For The Skin</i></b>		
<i>urea cream 39 % external</i>	Preferred	
<i>urea cream 39.5 % external</i>	Preferred	
<i>urea cream 40 % external</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>urea cream 40 % external</i>	Preferred	QL (85 GM per 30 days)
<i>urea external lotion</i>	Preferred	QL (236.3 GM per 30 days)
<b>DERMACINRX UREA</b>	Preferred	
<b>*Emollient/Keratolytic Combinations*** - Drugs For The Skin</b>		
<i>urea hydrating</i>	Non – Preferred	
<b>*Emollients*** - Drugs For The Skin</b>		
<i>ammonium lactate external cream</i>	Non – Preferred	
<i>ammonium lactate external lotion</i>	Preferred	
<b>*Imidazole-Related Antifungals - Topical*** - Drugs For The Skin</b>		
<i>clotrimazole external cream</i>	Preferred	QL (60 GM per 30 days)
<i>clotrimazole external solution</i>	Non – Preferred	QL (30 ML per 30 days)
<i>econazole nitrate</i>	Preferred	QL (30 GM per 30 days)
<i>ketoconazole external cream</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>ketoconazole external foam</i>	Non – Preferred	
<i>ketoconazole external shampoo</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
<i>luliconazole</i>	Non – Preferred	
<i>oxiconazole nitrate</i>	Non – Preferred	
<b>ERTACZO</b>	Non – Preferred	
<b>EXELDERM</b>	Non – Preferred	
<b>JUBLIA</b>	Non – Preferred	
<b>KETODAN</b>	Non – Preferred	
<b>LUZU</b>	Non – Preferred	
<b>OXISTAT</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Immunomodulators</b>		
<b>Imidazoquinolinamines - Topical*** - Drugs For The Skin</b>		
<i>imiquimod cream 3.75 % external</i>	Non – Preferred	AL (Min 10 Years)
<i>imiquimod cream 5 % external</i>	Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
<i>imiquimod pump</i>	Non – Preferred	AL (Min 10 Years)
<b>ZYCLARA</b>	Non – Preferred	AL (Min 10 Years)
<b>ZYCLARA PUMP</b>	Non – Preferred	AL (Min 10 Years)
<b>*Insect Repellents*** - Drugs For The Skin</b>		
<i>cvs insect repellent</i>	Preferred	OTC
<b>COLEMAN 100 MAX CONTINUOUS SPR</b>	Preferred	OTC
<b>OFF ACTIVE</b>	Preferred	OTC
<b>OFF DEEP WOODS</b>	Preferred	OTC
<b>REPEL SPORTSMEN MAX</b>	Preferred	OTC
<b>SAWYER INSECT REPELLENT</b>	Preferred	OTC
<b>ULTRATHON INSECT REPELLENT</b>	Preferred	OTC
<b>*Keratolytic/Antimitotic Agents*** - Drugs For The Skin</b>		
<i>bensal hp</i>	Non – Preferred	
<i>podofilox</i>	Preferred	
<i>salicylic acid external foam</i>	Non – Preferred	
<i>salicylic acid external gel</i>	Preferred	
<i>salicylic acid external ointment</i>	Preferred	
<i>salicylic acid wart remover</i>	Preferred	
<b>CONDYLOX</b>	Preferred	
<b>PODOCON-25</b>	Non – Preferred	
<b>SALICATE</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Local Anesthetics - Topical*** - Drugs For The Skin</b>		
<i>lidocaine hcl</i>	Preferred	
<i>lidocaine hcl urethral/mucosal</i>	Preferred	
<i>lidocaine ointment 5 % external</i>	Preferred	QL (50 GM per 30 days)
<i>lidocaine patch 5 % external</i>	Preferred	
<i>lidocaine patch 5 % external</i>	Preferred	QL (3 EA per 1 day)
<b>DERMACINRX LIDOGEL</b>	Non – Preferred	
<b>GLYDO</b>	Preferred	
<b>LIDODERM</b>	Non – Preferred	QL (3 EA per 1 day)
<b>LIDOREX</b>	Non – Preferred	
<b>LYDEXA</b>	Non – Preferred	
<b>QUTENZA</b>	Non – Preferred	
<b>QUTENZA (2 PATCH)</b>	Non – Preferred	
<b>QUTENZA (4 PATCH)</b>	Non – Preferred	
<b>ZTLIDO</b>	Non – Preferred	
<b>*Macrolide Immunosuppressants - Topical*** - Drugs For The Skin</b>		
<i>pimecrolimus</i>	Preferred	PA
<i>tacrolimus ointment 0.03 % external</i>	Preferred	PA
<i>tacrolimus ointment 0.03 % external</i>	Preferred	PA; ST
<i>tacrolimus ointment 0.1 % external</i>	Preferred	PA
<i>tacrolimus ointment 0.1 % external</i>	Preferred	PA; ST
<b>ELIDEL</b>	Preferred	PA
<b>*Misc. Dermatological Products*** - Drugs For The Skin</b>		
<b>ALADERM PLUS</b>	Non – Preferred	
<b>HYLATOPIC PLUS</b>	Non – Preferred	
<b>NUVAIL</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Oxaborole-Related Antifungals - Topical*** - Drugs For The Skin</b>		
<i>tavaborole</i>	Non – Preferred	
<b>KERYDIN</b>	Non – Preferred	
<b>*Phosphodiesterase 4 (Pde4) Inhibitors - Topical*** - Drugs For The Skin</b>		
<b>EUCRISA</b>	Preferred	PA
<b>*Photodynamic Therapy Agents - Topical*** - Drugs For The Skin</b>		
<b>AMELUZ</b>	Non – Preferred	
<b>LEVULAN KERASTICK</b>	Preferred	
<b>*Rosacea Agents*** - Drugs For The Skin</b>		
<i>azelaic acid</i>	Non – Preferred	
<i>doxycycline</i>	Non – Preferred	
<i>ivermectin</i>	Non – Preferred	
<i>metronidazole</i>	Preferred	
<b>FINACEA</b>	Non – Preferred	
<b>NORITATE</b>	Non – Preferred	
<b>RHOFADE</b>	Non – Preferred	
<b>*Scabicide Combinations*** - Drugs For The Skin</b>		
<i>gnp lice treatment</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>lice killing maximum strength</i>	Preferred	OTC; QL (240 ML per 30 days)
<i>sm lice killing max strength</i>	Preferred	OTC; QL (240 ML per 30 days)
<b>*Scabicides &amp; Pediculicides*** - Drugs For The Skin</b>		
<i>gnp lice treatment</i>	Preferred	OTC; QL (118 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>goodsense lice killing</i>	Preferred	OTC; QL (118 ML per 30 days)
<i>ivermectin</i>	Non – Preferred	
<i>malathion</i>	Non – Preferred	
<i>permethrin</i>	Preferred	QL (60 GM Max Qty Per Fill Retail)
<i>sm lice treatment</i>	Preferred	OTC
<i>spinosad</i>	Non – Preferred	
<b>CROTAN</b>	Non – Preferred	
<b>NATROBA</b>	Preferred	
<b>OVIDE</b>	Non – Preferred	
<b><i>*Skin Cleansers*** - Drugs For The Skin</i></b>		
<b>HYCLODEX</b>	Non – Preferred	
<b><i>*Steroid-Local Anesthetic Combinations*** - Drugs For The Skin</i></b>		
<b>EPIFOAM</b>	Non – Preferred	
<b>RADIAURA</b>	Non – Preferred	
<b><i>*Tar Products*** - Drugs For The Skin</i></b>		
<i>therapeutic</i>	Preferred	OTC
<b>THERAPEUTIC T+PLUS</b>	Preferred	OTC
<b><i>*Topical Anesthetic Combinations*** - Drugs For The Skin</i></b>		
<i>lidocaine-prilocaine</i>	Non – Preferred	
<b>LIDOTRAL-MENTHOL</b>	Non – Preferred	
<b>PLIAGLIS</b>	Non – Preferred	
<b>XYLIDERM</b>	Non – Preferred	QL (10 EA per 1 day)

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<b><i>*Topical Selective Retinoid X Receptor Agonists*** - Drugs For The Skin</i></b>		
<i>bexarotene</i>	Non – Preferred	
<b>TARGRETIN</b>	Preferred	
<b><i>*Topical Steroid Combinations*** - Drugs For The Skin</i></b>		
<i>calcipotriene-betameth diprop</i>	Non – Preferred	
<i>hydrocortisone complete kit</i>	Non – Preferred	
<b>CLODAN</b>	Non – Preferred	
<b>DUOBRII</b>	Non – Preferred	
<b>ENSTILAR</b>	Non – Preferred	
<b>SYNALAR (CREAM)</b>	Non – Preferred	
<b>SYNALAR (OINTMENT)</b>	Non – Preferred	
<b>SYNALAR TS</b>	Non – Preferred	
<b>TACLONEX</b>	Non – Preferred	
<b><i>*Wound Care Combinations*** - Drugs For The Skin</i></b>		
<i>bpcp</i>	Non – Preferred	
<b><i>*Wound Dressings*** - Drugs For The Skin</i></b>		
<b>ACTICOAT FLEX 3 4"X4"</b>	Preferred	
<b>ALLEVYN ADHESIVE</b>	Preferred	OTC
<b>COMFORT-AID 1.5"X2.5"</b>	Preferred	OTC
<b><i>*Wound Treatment - Gene Therapy*** - Drugs For The Skin</i></b>		
<b>VYJUVEK</b>	Non – Preferred	

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<b>*Diagnostic Products*</b>		
<b><i>*Diagnostic Tests***</i></b>		
<i>blood glucose test strips 333</i>	Non – Preferred	OTC; QL (5 EA per 1 day)
<i>easy talk plus ii test strips</i>	Non – Preferred	OTC
<i>gnp easy touch glucose test</i>	Non – Preferred	OTC
<i>ketone test</i>	Preferred	OTC
<b>ACCU-CHEK GUIDE</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>BLULINK GLUCOSE TEST</b>	Non – Preferred	OTC
<b>CARESENS N GLUCOSE TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>CHEMSTRIP K</b>	Preferred	OTC
<b>CONTOUR NEXT TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>CONTOUR TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO</b>	Non – Preferred	OTC
<b>EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>EASY TOUCH TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>EMBRACE BLOOD GLUCOSE TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>EMBRACE PRO GLUCOSE TEST</b>	Non – Preferred	OTC
<b>EMBRACE WAVE BLOOD GLUCOSE</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>FORA 6 CONNECT/GTEL TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>FORTISCARE G1 TEST STRIP</b>	Non – Preferred	OTC
<b>GNP TRUE METRIX GLUCOSE STRIPS</b>	Non – Preferred	OTC
<b>GNP TRUETRACK SMART SYSTEM</b>	Non – Preferred	OTC
<b>GNP TRUETRACK TEST STRIPS</b>	Non – Preferred	OTC
<b>ONETOUCH ULTRA</b>	Preferred	OTC; QL (5 EA per 1 day)
<b>ONETOUCH VERIO STRIP IN VITRO</b>	Non – Preferred	OTC
<b>ONETOUCH VERIO STRIP IN VITRO</b>	Preferred	OTC; QL (5 EA per 1 day)
<b>PIP BLOOD GLUCOSE TEST STRIP</b>	Non – Preferred	OTC; QL (5 EA per 1 day)
<b>PTS PANELS EGLU TEST</b>	Non – Preferred	OTC; QL (5 EA per 1 day)

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RELION KETONE TEST	Preferred	OTC
RIGHTEST GT333 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GT333 GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUETEST TEST	Non – Preferred	OTC
TRUETRACK TEST	Non – Preferred	OTC
VIVAGUARD INO TEST STRIPS	Non – Preferred	OTC
<b>*Digestive Aids* - Drugs For The Stomach</b>		
<b><i>*Digestive Enzymes*** - Drugs For The Stomach</i></b>		
CREON	Preferred	
PERTZYE	Non – Preferred	
VIOKACE	Non – Preferred	
ZENPEP	Preferred	
<b>*Diuretics* - Drugs For The Heart</b>		
<b><i>*Carbonic Anhydrase Inhibitors*** - Drugs For High Blood Pressure</i></b>		
<i>acetazolamide</i>	Preferred	
<i>acetazolamide er</i>	Preferred	
<i>dichlorphenamide</i>	Non – Preferred	
<i>methazolamide</i>	Preferred	
KEVEYIS	Non – Preferred	
<b><i>*Diuretic Combinations*** - Drugs For High Blood Pressure</i></b>		
<i>amiloride-hydrochlorothiazide</i>	Preferred	
<i>spironolactone-hctz</i>	Preferred	

Coverage Requirements and Limits

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Drug Tier

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>triamterene-hctz capsule 37.5-25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>triamterene-hctz capsule 37.5-25 mg oral</i>	Preferred	
<i>triamterene-hctz oral tablet</i>	Preferred	
<b>MAXZIDE</b>	Non – Preferred	
<b>MAXZIDE-25</b>	Non – Preferred	
<b>*Loop Diuretics*** - Drugs For High Blood Pressure</b>		
<i>bumetanide</i>	Preferred	
<i>ethacrynic acid</i>	Preferred	
<i>furosemide</i>	Preferred	
<i>torseamide</i>	Preferred	
<b>BUMEX</b>	Non – Preferred	
<b>EDECRIN</b>	Non – Preferred	
<b>LASIX</b>	Non – Preferred	
<b>*Potassium Sparing Diuretics*** - Drugs For High Blood Pressure</b>		
<i>amiloride hcl</i>	Preferred	
<i>spironolactone oral suspension</i>	Non – Preferred	
<i>spironolactone oral tablet</i>	Preferred	
<i>triamterene</i>	Preferred	
<b>ALDACTONE</b>	Non – Preferred	
<b>CAROSPIR</b>	Non – Preferred	
<b>*Thiazides And Thiazide-Like Diuretics*** - Drugs For High Blood Pressure</b>		
<i>chlorthalidone</i>	Preferred	
<i>hydrochlorothiazide</i>	Preferred	
<i>indapamide</i>	Preferred	
<i>metolazone</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIURIL	Preferred	
THALITONE	Non – Preferred	
<b>*Endocrine And Metabolic Agents - Misc.* - Hormones</b>		
<b>*Abortifacient - Progesterone Receptor Antagonists*** - Drugs For Women</b>		
<i>mifepristone</i>	Non – Preferred	
MIFEPREX	Non – Preferred	
<b>*Bisphosphonates*** - Drugs For Menopause And Bone Loss</b>		
<i>alendronate sodium oral solution</i>	Preferred	QL (10.8 ML per 1 day)
<i>alendronate sodium tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>alendronate sodium tablet 35 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>alendronate sodium tablet 5 mg oral</i>	Preferred	
<i>alendronate sodium tablet 70 mg oral</i>	Preferred	QL (4 EA per 28 days)
<i>ibandronate sodium tablet 150 mg oral</i>	Non – Preferred	QL (1 EA per 30 days)
<i>risedronate sodium</i>	Non – Preferred	
ACTONEL	Non – Preferred	
ATELVIA	Non – Preferred	
BINOSTO	Non – Preferred	
FOSAMAX	Non – Preferred	QL (4 EA per 28 days)
FOSAMAX PLUS D	Non – Preferred	
<b>*Calcimimetic Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>cinacalcet hcl</i>	Non – Preferred	
SENSIPAR	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Calcitonins*** - Drugs For Menopause And Bone Loss</b>		
<i>calcitonin (salmon)</i>	Preferred	QL (3.7 ML per 30 days)
<b>*Carnitine Replenisher - Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>levocarnitine</i>	Non – Preferred	
<i>levocarnitine sf</i>	Non – Preferred	
<b>CARNITOR</b>	Non – Preferred	
<b>CARNITOR SF</b>	Non – Preferred	
<b>*Cortisol Synthesis Inhibitors*** - Hormones</b>		
<b>ISTURISA</b>	Non – Preferred	
<b>RECORLEV</b>	Non – Preferred	
<b>*Dopamine Receptor Agonists*** - Drugs For Women</b>		
<i>cabergoline tablet 0.5 mg oral</i>	Preferred	QL (16 EA per 30 days)
<b>*Fabry Disease - Agents*** - Drugs For Menopause And Bone Loss</b>		
<b>GALAFOLD</b>	Non – Preferred	
<b>*Gnrh/Lhrh Antagonists*** - Drugs For Women</b>		
<b>ORILISSA</b>	Preferred	PA
<b>*Growth Hormone Releasing Hormones (Ghrh)*** - Drugs For Growth</b>		
<b>EGRIFTA SV</b>	Non – Preferred	
<b>*Growth Hormones*** - Drugs For Growth</b>		
<b>GENOTROPIN</b>	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENOTROPIN MINIQUICK	Preferred	PA
HUMATROPE	Non – Preferred	
NORDITROPIN FLEXPRO	Non – Preferred	
NUTROPIN AQ NUSPIN 10	Non – Preferred	
NUTROPIN AQ NUSPIN 20	Non – Preferred	
NUTROPIN AQ NUSPIN 5	Non – Preferred	
OMNITROPE	Non – Preferred	
SAIZEN	Non – Preferred	
SEROSTIM	Non – Preferred	
SKYTROFA	Non – Preferred	
SOGROYA	Non – Preferred	
ZOMACTON	Non – Preferred	
<b>*Hereditary Tyrosinemia Type 1 (Ht-1) Treatment - Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>nitisinone</i>	Preferred	
NITYR	Non – Preferred	
ORFADIN ORAL CAPSULE	Preferred	
ORFADIN ORAL SUSPENSION	Non – Preferred	
<b>*Homocystinuria Treatment - Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>betaine</i>	Non – Preferred	
CYSTADANE	Non – Preferred	
<b>*Hyperammonemia Treatment - Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>carglumic acid tablet soluble 200 mg oral</i>	Non – Preferred	PA
<i>carglumic acid tablet soluble 200 mg oral</i>	Preferred	PA
CARBAGLU	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Hyperparathyroid Treatment - Vitamin D Analogs*** - Drugs For Menopause And Bone Loss</b>		
<i>calcitriol</i>	Preferred	
<i>doxercalciferol</i>	Preferred	
<i>paricalcitol</i>	Non – Preferred	QL (1 EA per 1 day)
<b>RAYALDEE</b>	Non – Preferred	
<b>ROCALTROL</b>	Non – Preferred	
<b>ZEMPLAR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Insulin-Like Growth Factors (Somatomedins)*** - Hormones</b>		
<b>INCRELEX</b>	Non – Preferred	
<b>*Lhrh/Gnrh Agonist Analog Pituitary Suppressants*** - Drugs For Women</b>		
<b>SYNAREL</b>	Non – Preferred	
<b>*Non-Steroidal Mineralocorticoid Receptor Antagonists*** - Hormones</b>		
<b>KERENDIA</b>	Preferred	PA
<b>*Phenylketonuria Treatment - Agents*** - Drugs For Menopause And Bone Loss</b>		
<i>sapropterin dihydrochloride</i>	Non – Preferred	
<b>KUVAN</b>	Non – Preferred	
<b>*Selective Estrogen Receptor Modulators (Serms)*** - Drugs For Menopause And Bone Loss</b>		
<i>raloxifene hcl</i>	Non – Preferred	
<b>EVISTA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OSPHENA	Non – Preferred	
<b><i>*Selective Vasopressin V2-Receptor Antagonists*** - Hormones</i></b>		
<i>tolvaptan</i>	Non – Preferred	
JYNARQUE	Non – Preferred	
SAMSCA	Non – Preferred	
<b><i>*Somatostatic Agents*** - Drugs For Growth</i></b>		
<i>lanreotide acetate</i>	Non – Preferred	
<i>octreotide acetate</i>	Non – Preferred	
MYCAPSSA	Non – Preferred	
SANDOSTATIN	Non – Preferred	
SANDOSTATIN LAR DEPOT	Non – Preferred	
SIGNIFOR	Non – Preferred	
SIGNIFOR LAR	Non – Preferred	
SOMATULINE DEPOT	Non – Preferred	
<b><i>*Urea Cycle Disorder - Agents*** - Drugs For Menopause And Bone Loss</i></b>		
<i>sodium phenylbutyrate</i>	Non – Preferred	
BUPHENYL	Non – Preferred	
OLPRUVA (2 GM DOSE)	Non – Preferred	
OLPRUVA (3 GM DOSE)	Non – Preferred	
OLPRUVA (4 GM DOSE)	Non – Preferred	
OLPRUVA (5 GM DOSE)	Non – Preferred	
OLPRUVA (6 GM DOSE)	Non – Preferred	
OLPRUVA (6.67 GM DOSE)	Non – Preferred	
RAVICTI	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Vasopressin*** - Hormones</b>		
<i>desmopressin ace spray refrig</i>	Preferred	QL (5 ML per 30 days)
<i>desmopressin acetate</i>	Preferred	QL (3 EA per 1 day)
<i>desmopressin acetate spray solution 0.01 % nasal</i>	Preferred	QL (5 ML per 30 days)
<b>DDAVP</b>	Non – Preferred	QL (3 EA per 1 day)
<b>NOCDURNA</b>	Non – Preferred	
<b>*Estrogens* - Hormones</b>		
<b>*Estrogen &amp; Androgen*** - Drugs For Women</b>		
<i>est estrogens-methyltest ds</i>	Preferred	
<i>est estrogens-methyltest hs</i>	Preferred	
<b>*Estrogen &amp; Progestin*** - Drugs For Women</b>		
<i>estradiol-norethindrone acet</i>	Preferred	QL (1 EA per 1 day)
<i>norethindrone-eth estradiol</i>	Non – Preferred	QL (1 EA per 1 day)
<b>ACTIVELLA</b>	Non – Preferred	QL (1 EA per 1 day)
<b>AMABELZ</b>	Preferred	QL (1 EA per 1 day)
<b>ANGELIQ</b>	Non – Preferred	
<b>BIJUVA</b>	Non – Preferred	
<b>CLIMARA PRO</b>	Non – Preferred	
<b>COMBIPATCH</b>	Preferred	QL (8 PATCH per 28 days)
<b>FYAVOLV</b>	Non – Preferred	QL (1 EA per 1 day)
<b>JINTELI</b>	Non – Preferred	QL (1 EA per 1 day)
<b>MIMVEY</b>	Preferred	QL (1 EA per 1 day)
<b>PREMPHASE</b>	Preferred	QL (1 EA per 1 day)
<b>PREMPRO</b>	Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Estrogen-Progestin-Gnrh Antagonist*** - Drugs For Woman</b>		
MYFEMBREE	Preferred	PA
ORIAHNN	Preferred	PA
<b>*Estrogens*** - Drugs For Women</b>		
<i>estradiol oral</i>	Preferred	
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.025 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (8 PATCH per 28 days)
<i>estradiol patch twice weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch twice weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (8 EA per 28 days)
<i>estradiol patch weekly 0.025 mg/24hr transdermal</i>	Preferred	
<i>estradiol patch weekly 0.0375 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.05 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.06 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.075 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)
<i>estradiol patch weekly 0.1 mg/24hr transdermal</i>	Preferred	QL (4 EA per 28 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>estradiol transdermal gel</i>	Non – Preferred	
<i>estradiol valerate</i>	Non – Preferred	
<b>ALORA</b>	Non – Preferred	QL (8 EA per 28 days)
<b>CLIMARA PATCH WEEKLY 0.025 MG/24HR TRANSDERMAL</b>	Non – Preferred	
<b>CLIMARA PATCH WEEKLY 0.0375 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (4 EA per 28 days)
<b>CLIMARA PATCH WEEKLY 0.05 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (4 EA per 28 days)
<b>CLIMARA PATCH WEEKLY 0.06 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (4 EA per 28 days)
<b>CLIMARA PATCH WEEKLY 0.075 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (4 EA per 28 days)
<b>CLIMARA PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (4 EA per 28 days)
<b>DELESTROGEN</b>	Non – Preferred	
<b>DEPO-ESTRADIOL</b>	Non – Preferred	
<b>DIVIGEL</b>	Non – Preferred	
<b>DOTTI PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 PATCH per 28 days)
<b>DOTTI PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 PATCH per 28 days)
<b>DOTTI PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 EA per 28 days)
<b>DOTTI PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 EA per 28 days)
<b>DOTTI PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 EA per 28 days)
<b>ELESTRIN</b>	Non – Preferred	
<b>ESTRACE</b>	Non – Preferred	
<b>EVAMIST</b>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>LYLLANA PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL</b>	Preferred	
<b>LYLLANA PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL</b>	Preferred	
<b>LYLLANA PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL</b>	Preferred	
<b>LYLLANA PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 EA per 28 days)
<b>LYLLANA PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL</b>	Preferred	QL (8 EA per 28 days)
<b>MENEST</b>	Preferred	
<b>MENOSTAR</b>	Non – Preferred	
<b>MINIVELLE PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 PATCH per 28 days)
<b>MINIVELLE PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 PATCH per 28 days)
<b>MINIVELLE PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)
<b>MINIVELLE PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)
<b>MINIVELLE PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)
<b>PREMARIN</b>	Preferred	QL (1 EA per 1 day)
<b>VIVELLE-DOT PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 PATCH per 28 days)
<b>VIVELLE-DOT PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 PATCH per 28 days)
<b>VIVELLE-DOT PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)
<b>VIVELLE-DOT PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)
<b>VIVELLE-DOT PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL</b>	Non – Preferred	QL (8 EA per 28 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Estrogen-Selective Estrogen Receptor Modulator Comb*** - Drugs For Women</b>		
<b>DUAVEE</b>	Non – Preferred	
<b>*Fluoroquinolones* - Drugs For Infections</b>		
<b>*Fluoroquinolones*** - Antibiotics</b>		
<i>ciprofloxacin hcl tablet 100 mg oral</i>	Preferred	QL (30 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Preferred	
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Preferred	QL (28 EA per 1 day); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 500 mg oral</i>	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 750 mg oral</i>	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>ciprofloxacin hcl tablet 750 mg oral</i>	Preferred	QL (28 EA per 1 day); AL (Min 16 Years)
<i>ciprofloxacin in d5w</i>	Preferred	
<i>levofloxacin in d5w</i>	Preferred	
<i>levofloxacin intravenous</i>	Preferred	
<i>levofloxacin oral solution</i>	Preferred	QL (280 ML Max Qty Per Fill Retail); AL (Max 12 Years)
<i>levofloxacin oral tablet</i>	Preferred	QL (14 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<i>moxifloxacin hcl</i>	Preferred	AL (Min 16 Years)
<i>ofloxacin</i>	Non – Preferred	AL (Min 16 Years)
<b>BAXDELA</b>	Non – Preferred	AL (Min 16 Years)
<b>CIPRO ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	AL (Min 16 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CIPRO ORAL TABLET	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
<b>*Gastrointestinal Agents - Misc.* - Drugs For The Stomach</b>		
<b>*5-Ht4 Receptor Agonists*** - Drugs For The Stomach</b>		
MOTEGRITY	Non – Preferred	
<b>*Antiflatulents*** - Drugs For The Stomach</b>		
<i>simethicone</i>	Preferred	OTC
<b>*Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach</b>		
CHOLBAM	Non – Preferred	
<b>*Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation</b>		
TRULANCE	Non – Preferred	
<b>*Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Stomach</b>		
OCALIVA	Non – Preferred	
<b>*Gallstone Solubilizing Agents*** - Drugs For The Stomach</b>		
<i>ursodiol oral capsule</i>	Preferred	
<i>ursodiol oral tablet</i>	Non – Preferred	
CHENODAL	Non – Preferred	
RELTONE	Non – Preferred	
URSO 250	Non – Preferred	
URSO FORTE	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Gastrointestinal Antiallergy Agents*** - Drugs For The Stomach</b>		
<i>cromolyn sodium</i>	Preferred	
<b>GASTROCROM</b>	Non – Preferred	
<b>*Gastrointestinal Chloride Channel Activators*** - Drugs For Irritable Bowel Syndrome</b>		
<i>lubiprostone capsule 24 mcg oral</i>	Non – Preferred	
<i>lubiprostone capsule 24 mcg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>lubiprostone capsule 8 mcg oral</i>	Non – Preferred	
<i>lubiprostone capsule 8 mcg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<b>AMITIZA</b>	Non – Preferred	QL (2 EA per 1 day)
<b>*Gastrointestinal Stimulants*** - Drugs For The Stomach</b>		
<i>metoclopramide hcl oral solution</i>	Preferred	
<i>metoclopramide hcl oral tablet</i>	Preferred	
<i>metoclopramide hcl oral tablet dispersible</i>	Non – Preferred	
<b>GIMOTI</b>	Non – Preferred	
<b>REGLAN</b>	Non – Preferred	
<b>*Glucagon-Like Peptide-2 (Glp-2) Analogs*** - Drugs For The Stomach</b>		
<b>GATTEX</b>	Non – Preferred	
<b>*Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation</b>		
<b>LINZESS</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Ibs Agent - Mu-Opioid Receptor Agonists*** - Drugs For Irritable Bowel Syndrome</b>		
VIBERZI	Non – Preferred	
<b>*Ibs Agent - Selective 5-Ht3 Receptor Antagonists*** - Drugs For Irritable Bowel Syndrome</b>		
<i>alosetron hcl</i>	Non – Preferred	
LOTRONEX	Non – Preferred	
<b>*Ibs Agent - Sodium/Hydrogen Exchanger 3 (Nhe3) Inhibitor*** - Drugs For Irritable Bowel Syndrome</b>		
IBSRELA	Non – Preferred	
<b>*Inflammatory Bowel Agents*** - Drugs For Inflammatory Bowel Disease</b>		
<i>balsalazide disodium</i>	Preferred	
<i>mesalamine er capsule extended release 24 hour 0.375 gm oral</i>	Non – Preferred	
<i>mesalamine er capsule extended release 24 hour 0.375 gm oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>mesalamine er oral capsule extended release</i>	Preferred	
<i>mesalamine oral capsule delayed release</i>	Non – Preferred	QL (6 EA per 1 day)
<i>mesalamine rectal enema</i>	Preferred	
<i>mesalamine suppository 1000 mg rectal</i>	Preferred	QL (42 EA per 30 days)
<i>mesalamine tablet delayed release 1.2 gm oral</i>	Non – Preferred	QL (4 EA per 1 day)
<i>mesalamine tablet delayed release 800 mg oral</i>	Non – Preferred	QL (6 EA per 1 day)
<i>mesalamine-cleanser</i>	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfasalazine</i>	Preferred	
<b>APRISO</b>	Non – Preferred	QL (4 EA per 1 day)
<b>AZULFIDINE</b>	Non – Preferred	
<b>AZULFIDINE EN-TABS</b>	Non – Preferred	
<b>CANASA</b>	Non – Preferred	QL (42 EA per 30 days)
<b>COLAZAL</b>	Non – Preferred	
<b>DELZICOL</b>	Non – Preferred	QL (6 EA per 1 day)
<b>DIPENTUM</b>	Non – Preferred	
<b>LIALDA</b>	Non – Preferred	QL (4 EA per 1 day)
<b>PENTASA</b>	Preferred	
<b>ROWASA</b>	Non – Preferred	
<b>SFROWASA</b>	Preferred	
<b><i>*Integrin Receptor Antagonists*** - Drugs For Inflammatory Bowel Disease</i></b>		
<b>ENTYVIO</b>	Non – Preferred	
<b><i>*Interleukin Antagonists*** - Drugs For Inflammatory Bowel Disease</i></b>		
<b>OMVOH</b>	Non – Preferred	
<b>SKYRIZI</b>	Non – Preferred	
<b>STELARA</b>	Non – Preferred	
<b><i>*Intestinal Acidifiers*** - Drugs For The Stomach</i></b>		
<i>enulose</i>	Preferred	
<i>generlac</i>	Preferred	
<i>lactulose encephalopathy</i>	Preferred	
<b><i>*Peripheral Opioid Receptor Antagonists*** - Drugs For The Stomach</i></b>		
<i>alvimopan</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENTEREG</b>	Non – Preferred	
<b>MOVANTIK</b>	Non – Preferred	QL (1 EA per 1 day)
<b>RELISTOR</b>	Non – Preferred	
<b>SYMPROIC</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Phosphate Binder Agents*** - Drugs For The Stomach</b>		
<i>calcium acetate</i>	Preferred	
<i>calcium acetate (phos binder)</i>	Preferred	
<i>lanthanum carbonate</i>	Preferred	
<i>sevelamer carbonate oral packet</i>	Non – Preferred	
<i>sevelamer carbonate oral tablet</i>	Preferred	
<i>sevelamer hcl</i>	Preferred	
<b>AURYXIA</b>	Non – Preferred	QL (12 EA per 1 day)
<b>FOSRENOL ORAL PACKET</b>	Preferred	
<b>FOSRENOL ORAL TABLET CHEWABLE</b>	Non – Preferred	
<b>RENAGEL</b>	Non – Preferred	
<b>RENVELA</b>	Non – Preferred	
<b>VELPHORO</b>	Non – Preferred	
<b>*Tryptophan Hydroxylase Inhibitors*** - Drugs For Diarrhea</b>		
<b>XERMELO</b>	Non – Preferred	
<b>*Tumor Necrosis Factor Alpha Blockers*** - Drugs For Inflammatory Bowel Disease</b>		
<i>infliximab</i>	Non – Preferred	
<b>AVSOLA</b>	Non – Preferred	
<b>CIMZIA STARTER KIT</b>	Preferred	PA
<b>CIMZIA SUBCUTANEOUS KIT</b>	Non – Preferred	
<b>CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT</b>	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFLECTRA	Non – Preferred	
REMICADE	Non – Preferred	
RENFLEXIS	Non – Preferred	
<b>*Genitourinary Agents - Miscellaneous* - Drugs For The Urinary System</b>		
<b>*5-Alpha Reductase Inhibitors*** - Drugs For The Prostate</b>		
<i>dutasteride</i>	Non – Preferred	
<i>finasteride</i>	Preferred	QL (1 EA per 1 day)
<b>AVODART</b>	Non – Preferred	
<b>PROSCAR</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Alpha 1-Adrenoceptor Antagonists*** - Drugs For The Prostate</b>		
<i>alfuzosin hcl er</i>	Preferred	QL (1 EA per 1 day)
<i>silodosin</i>	Non – Preferred	
<i>tamsulosin hcl</i>	Preferred	QL (2 EA per 1 day)
<b>CARDURA XL</b>	Non – Preferred	
<b>FLOMAX</b>	Non – Preferred	QL (2 EA per 1 day)
<b>RAPAFLO</b>	Non – Preferred	
<b>*Citrates*** - Drugs For Infections</b>		
<i>cytra k crystals</i>	Non – Preferred	
<i>pot &amp; sod cit-cit ac</i>	Non – Preferred	
<i>potassium citrate er</i>	Non – Preferred	
<i>potassium citrate-citric acid</i>	Non – Preferred	
<i>sod citrate-citric acid solution 500-334 mg/5ml oral (rx)</i>	Preferred	QL (500 ML per 30 days)
<i>tricitrates</i>	Non – Preferred	
<b>ORACIT</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UROCIT-K 10	Non – Preferred	
UROCIT-K 15	Non – Preferred	
UROCIT-K 5	Non – Preferred	
<b>*Cystinosis Agents*** - Drugs For The Urinary System</b>		
CYSTAGON	Preferred	
PROCYSBI	Non – Preferred	
<b>*Genitourinary Irrigants*** - Drugs For The Urinary System</b>		
<i>sodium chloride</i>	Preferred	
<b>*Interstitial Cystitis Agents*** - Drugs For The Urinary System</b>		
ELMIRON	Non – Preferred	
<b>*Phosphates*** - Drugs For Infections</b>		
K-PHOS NO 2	Non – Preferred	
<b>*Prostatic Hypertrophy Agent Combinations*** - Drugs For The Prostate</b>		
<i>dutasteride-tamsulosin hcl</i>	Non – Preferred	
JALYN	Non – Preferred	
<b>*Urinary Analgesics*** - Drugs For Infections</b>		
<i>phenazopyridine hcl</i>	Preferred	
PYRIDIUM	Non – Preferred	
<b>*Urinary Stone Agents*** - Drugs For The Urinary System</b>		
<i>tiopronin</i>	Non – Preferred	
LITHOSTAT	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIOLA	Non – Preferred	
THIOLA EC	Non – Preferred	
<b>*Gout Agents* - Drugs For Pain And Fever</b>		
<b>*Gout Agent Combinations*** - Gout Drugs</b>		
<i>colchicine-probenecid</i>	Preferred	
<b>*Gout Agents*** - Gout Drugs</b>		
<i>allopurinol</i>	Preferred	
<i>colchicine capsule 0.6 mg oral</i>	Non – Preferred	QL (9 EA per 30 days)
<i>colchicine tablet 0.6 mg oral</i>	Non – Preferred	QL (9 EA per 30 days)
<i>febuxostat</i>	Non – Preferred	QL (1 EA per 1 day)
<b>COLCRYS</b>	Non – Preferred	QL (9 EA per 30 days)
<b>MITIGARE</b>	Non – Preferred	QL (9 EA per 30 days)
<b>ULORIC</b>	Non – Preferred	QL (1 EA per 1 day)
<b>*Uricosurics*** - Gout Drugs</b>		
<i>probenecid</i>	Preferred	
<b>*Hematological Agents - Misc.* - Drugs For The Blood</b>		
<b>*Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood</b>		
<b>HEMLIBRA</b>	Preferred	PA
<b>*Antihemophilic Products*** - Drugs To Prevent Bleeding</b>		
<i>adynovate</i>	Preferred	PA
<i>obizur</i>	Preferred	PA
<i>rixubis</i>	Preferred	PA
<b>ADVATE</b>	Preferred	PA

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
AFSTYLA	Preferred	PA
ALPHANATE	Preferred	PA
ALPHANINE SD	Preferred	PA
ALPROLIX	Preferred	PA
BENEFIX	Preferred	PA
COAGADEX	Preferred	PA
CORIFACT	Preferred	PA
ELOCTATE	Preferred	PA
ESPEROCT	Preferred	PA
FEIBA	Preferred	PA
HEMOFIL M	Preferred	PA
HUMATE-P	Preferred	PA
IDELVION	Preferred	PA
IXINITY	Preferred	PA
JIVI	Preferred	PA
KOATE	Preferred	PA
KOATE-DVI	Preferred	PA
KOGENATE FS	Preferred	PA
KOVALTRY	Preferred	PA
NOVOEIGHT	Preferred	PA
NOVOSEVEN RT	Preferred	PA
NUWIQ	Preferred	PA
PROFILNINE	Preferred	PA
REBINYN	Preferred	PA
RECOMBINATE	Preferred	PA
SEVENFACT	Preferred	PA
TRETTEN	Preferred	PA
VONVENDI	Preferred	PA
WILATE	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XYNTHA	Preferred	PA
XYNTHA SOLOFUSE	Preferred	PA
<b><i>*Bradykinin B2 Receptor Antagonists*** - Drugs For The Blood</i></b>		
<i>icatibant acetate</i>	Non – Preferred	
FIRAZYR	Non – Preferred	
SAJAZIR	Non – Preferred	
<b><i>*C1 Esterase Inhibitors*** - Drugs For The Blood</i></b>		
BERINERT	Preferred	PA
HAEGARDA	Non – Preferred	
<b><i>*Complement C3 Inhibitors*** - Drugs For The Blood</i></b>		
EMPAVELI	Non – Preferred	
<b><i>*Complement C5 Inhibitors*** - Drugs For The Blood</i></b>		
VEOPOZ	Non – Preferred	
<b><i>*Direct-Acting P2y12 Inhibitors*** - Drugs For The Blood</i></b>		
BRILINTA	Preferred	
<b><i>*Hematorheologic Agents*** - Drugs For The Blood</i></b>		
<i>pentoxifylline er</i>	Preferred	
<b><i>*Phosphodiesterase Iii Inhibitors*** - Drugs For The Blood</i></b>		
<i>cilostazol</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Plasma Kallikrein Inhibitors - Monoclonal Antibodies*** - Drugs For The Blood</b>		
TAKHZYRO	Non – Preferred	
<b>*Plasma Kallikrein Inhibitors*** - Drugs For The Blood</b>		
KALBITOR	Non – Preferred	
ORLADEYO	Non – Preferred	
<b>*Platelet Aggregation Inhibitor Combinations*** - Drugs For The Blood</b>		
<i>aspirin-dipyridamole er</i>	Preferred	
<b>*Platelet Aggregation Inhibitors*** - Drugs For The Blood</b>		
<i>dipyridamole</i>	Preferred	
<b>*Quinazoline Agents*** - Drugs For The Blood</b>		
<i>anagrelide hcl</i>	Preferred	
AGRYLIN	Non – Preferred	
<b>*Spleen Tyrosine Kinase (Syk) Inhibitors*** - Drugs For The Blood</b>		
TAVALISSE	Non – Preferred	
<b>*Thienopyridine Derivatives*** - Drugs For The Blood</b>		
<i>clopidogrel bisulfate tablet 300 mg oral</i>	Preferred	QL (1 EA per 30 days)
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>prasugrel hcl</i>	Non – Preferred	
EFFIENT	Non – Preferred	
PLAVIX	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Hematopoietic Agents* - Drugs For Nutrition</b>		
<b><i>*Amino Acids*** - Drugs For Nutrition</i></b>		
ENDARI	Preferred	
<b><i>*Cobalamins*** - Drugs For Nutrition</i></b>		
<i>cyanocobalamin</i>	Preferred	
<b><i>*Cytotoxic Agents*** - Drugs For Nutrition</i></b>		
DROXIA	Preferred	
SIKLOS	Non – Preferred	
<b><i>*Erythroid Maturation Agents*** - Drugs For Nutrition</i></b>		
REBLOZYL	Non – Preferred	
<b><i>*Erythropoiesis-Stimulating Agents (Esas)*** - Drugs For Nutrition</i></b>		
ARANESP (ALBUMIN FREE)	Non – Preferred	
EPOGEN	Preferred	PA
MIRCERA	Non – Preferred	
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	
<b><i>*Folic Acid/Folates*** - Drugs For Nutrition</i></b>		
<i>folic acid oral tablet 1 mg</i>	Preferred	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Granulocyte Colony-Stimulating Factors (G-Csf)*** - Drugs For Nutrition</b>		
<i>releuko solution 480 mcg/1.6ml injection</i>	Non – Preferred	
<i>releuko subcutaneous</i>	Non – Preferred	
<b>FULPHILA</b>	Non – Preferred	
<b>GRANIX</b>	Non – Preferred	
<b>NEULASTA</b>	Non – Preferred	
<b>NEULASTA ONPRO</b>	Non – Preferred	
<b>NEUPOGEN</b>	Preferred	
<b>NIVESTYM</b>	Non – Preferred	
<b>NYVEPRIA</b>	Non – Preferred	
<b>RELEUKO SOLUTION 300 MCG/ML INJECTION</b>	Non – Preferred	
<b>ROLVEDON</b>	Non – Preferred	
<b>STIMUFEND</b>	Non – Preferred	
<b>UDENYCA</b>	Non – Preferred	
<b>ZARXIO</b>	Non – Preferred	
<b>ZIEXTENZO</b>	Non – Preferred	
<b>*Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf)*** - Drugs For Nutrition</b>		
<b>LEUKINE</b>	Preferred	
<b>*Hemoglobin S (Hbs) Polymerization Inhibitors*** - Drugs For Nutrition</b>		
<b>OXBRYTA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitors*** - Drugs For Nutrition</i></b>		
JESDUVROQ	Non – Preferred	
<b><i>*Iron*** - Drugs For Nutrition</i></b>		
<i>ferretts</i>	Preferred	OTC
<i>ferric x-150</i>	Preferred	OTC
<i>ferrous fumarate</i>	Preferred	OTC
<i>ferrous sulfate</i>	Preferred	OTC
<i>iron supplement</i>	Preferred	OTC
<i>px iron</i>	Preferred	OTC
<b>FERREX 150</b>	Preferred	OTC
<b>FERROCITE</b>	Preferred	OTC
<b><i>*Selectin Blockers*** - Drugs For Nutrition</i></b>		
<b>ADAKVEO</b>	Non – Preferred	
<b><i>*Thrombopoietin (Tpo) Receptor Agonists*** - Drugs For Nutrition</i></b>		
<b>DOPTELET</b>	Non – Preferred	
<b>MULPLETA</b>	Non – Preferred	
<b>NPLATE</b>	Non – Preferred	
<b>PROMACTA ORAL PACKET</b>	Non – Preferred	
<b>PROMACTA TABLET 12.5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PROMACTA TABLET 25 MG ORAL</b>	Non – Preferred	
<b>PROMACTA TABLET 50 MG ORAL</b>	Non – Preferred	
<b>PROMACTA TABLET 75 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Hemostatics* - Drugs For The Blood</b>		
<b><i>*Hemostatics - Systemic*** - Drugs To Prevent Bleeding</i></b>		
<i>aminocaproic acid</i>	Preferred	
<i>tranexamic acid</i>	Preferred	QL (28 EA per 30 days); AL (Min 12 Years)
<b>*Hypnotics/Sedatives/Sleep Disorder Agents* - Drugs For The Nervous System</b>		
<b><i>*Antihistamine Hypnotics*** - Drugs For Insomnia</i></b>		
<i>ra nighttime sleep aid</i>	Preferred	OTC
<i>ra sleep aid</i>	Preferred	OTC
<i>sleep aid</i>	Preferred	OTC
<b><i>*Barbiturate Hypnotics*** - Drugs For Insomnia</i></b>		
<i>phenobarbital</i>	Preferred	
<b><i>*Benzodiazepine Hypnotics*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i></b>		
<i>estazolam</i>	Preferred	
<i>flurazepam hcl</i>	Non – Preferred	
<i>midazolam hcl</i>	Non – Preferred	
<i>quazepam</i>	Preferred	
<i>temazepam capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 22.5 mg oral</i>	Preferred	
<i>temazepam capsule 30 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>temazepam capsule 30 mg oral</i>	Preferred	
<i>temazepam capsule 7.5 mg oral</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>triazolam tablet 0.125 mg oral</i>	Preferred	
<i>triazolam tablet 0.125 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>triazolam tablet 0.25 mg oral</i>	Preferred	
<i>triazolam tablet 0.25 mg oral</i>	Preferred	QL (1 EA per 1 day)
<b>DORAL</b>	Non – Preferred	
<b>HALCION</b>	Non – Preferred	
<b>RESTORIL CAPSULE 15 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>RESTORIL CAPSULE 22.5 MG ORAL</b>	Non – Preferred	
<b>RESTORIL CAPSULE 30 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>RESTORIL CAPSULE 7.5 MG ORAL</b>	Non – Preferred	
<b><i>*Hypnotics - Tricyclic Agents*** - Drugs For Insomnia</i></b>		
<i>doxepin hcl</i>	Non – Preferred	
<b><i>*Non-Benzodiazepine - Gaba-Receptor Modulators*** - Drugs For Insomnia</i></b>		
<i>eszopiclone</i>	Non – Preferred	
<i>zaleplon</i>	Non – Preferred	
<i>zolpidem tartrate er</i>	Non – Preferred	
<i>zolpidem tartrate oral capsule</i>	Non – Preferred	
<i>zolpidem tartrate oral tablet</i>	Preferred	QL (1 EA per 1 day)
<i>zolpidem tartrate sublingual</i>	Non – Preferred	
<b>AMBIEN CR</b>	Non – Preferred	
<b>AMBIEN ORAL TABLET 10 MG, 5 MG</b>	Preferred	QL (1 EA per 1 day)
<b>AMBIEN TABLET 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>AMBIEN TABLET 5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>EDLUAR</b>	Non – Preferred	
<b>LUNESTA</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Orexin Receptor Antagonists*** - Drugs For Insomnia</b>		
BELSOMRA	Non – Preferred	
DAYVIGO	Non – Preferred	
QUVIVIQ	Non – Preferred	
<b>*Selective Melatonin Receptor Agonists*** - Drugs For Insomnia</b>		
<i>ramelteon tablet 8 mg oral</i>	Non – Preferred	
<i>ramelteon tablet 8 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>tasimelteon</i>	Non – Preferred	
HETLIOZ	Non – Preferred	
HETLIOZ LQ	Non – Preferred	
ROZEREM	Non – Preferred	
<b>*Laxatives* - Drugs For The Stomach</b>		
<b>*Bowel Evacuant Combinations*** - Drugs To Prevent Constipation</b>		
<i>peg 3350-kcl-na bicarb-nacl</i>	Preferred	
<i>peg-3350/electrolytes</i>	Preferred	QL (4000 ML Max Qty Per Fill Retail)
<b>*Bulk Laxatives*** - Drugs To Prevent Constipation</b>		
<i>natural fiber laxative</i>	Preferred	OTC
<i>psyllium fiber</i>	Preferred	OTC
<i>qc natural vegetable</i>	Preferred	OTC
<b>*Laxatives - Miscellaneous*** - Drugs To Prevent Constipation</b>		
<i>glycerin (adult)</i>	Preferred	OTC
<i>polyethylene glycol 3350 oral packet</i>	Preferred	QL (1 EA per 1 day)
<i>polyethylene glycol 3350 oral powder</i>	Preferred	QL (34 GM per 1 day)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Laxatives &amp; Dss*** - Drugs To Prevent Constipation</b>		
<i>senna-docusate sodium</i>	Preferred	OTC
<b>*Lubricant Laxatives*** - Drugs To Prevent Constipation</b>		
<i>cvs mineral oil enema</i>	Preferred	OTC
<i>mineral oil heavy</i>	Preferred	
<b>*Saline Laxative Mixtures*** - Drugs To Prevent Constipation</b>		
<i>enema ready-to-use</i>	Preferred	OTC
<b>*Saline Laxatives*** - Drugs To Prevent Constipation</b>		
<i>magnesium citrate</i>	Preferred	OTC
<i>milk of magnesia</i>	Preferred	OTC
<b>*Stimulant Laxatives*** - Drugs To Prevent Constipation</b>		
<i>bisacodyl</i>	Preferred	OTC
<i>castor oil</i>	Preferred	OTC
<i>sennosides</i>	Preferred	OTC
<b>*Surfactant Laxatives*** - Drugs To Prevent Constipation</b>		
<i>docusate sodium oral capsule 100 mg</i>	Preferred	OTC
<i>docusate sodium oral capsule 250 mg</i>	Preferred	
<i>docusate sodium oral syrup</i>	Preferred	OTC
<b>*Macrolides* - Drugs For Infections</b>		
<b>*Azithromycin*** - Antibiotics</b>		
<i>azithromycin oral packet</i>	Preferred	
<i>azithromycin oral suspension reconstituted</i>	Preferred	QL (30 ML Max Qty Per Fill Retail)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>azithromycin tablet 250 mg oral</i>	Preferred	QL (6 EA Max Qty Per Fill Retail)
<i>azithromycin tablet 250 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>azithromycin tablet 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>azithromycin tablet 600 mg oral</i>	Preferred	QL (8 EA per 28 days)
<b>ZITHROMAX ORAL PACKET</b>	Preferred	
<b>ZITHROMAX ORAL SUSPENSION RECONSTITUTED</b>	Non – Preferred	QL (30 ML Max Qty Per Fill Retail)
<b>ZITHROMAX TABLET 250 MG ORAL</b>	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
<b>ZITHROMAX TABLET 500 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b>ZITHROMAX TRI-PAK</b>	Non – Preferred	QL (4 EA per 1 day)
<b>ZITHROMAX Z-PAK</b>	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
<b>*Clarithromycin*** - Antibiotics</b>		
<i>clarithromycin er</i>	Preferred	QL (14 EA Max Qty Per Fill Retail)
<i>clarithromycin oral suspension reconstituted</i>	Preferred	QL (150 ML Max Qty Per Fill Retail)
<i>clarithromycin oral tablet</i>	Preferred	QL (28 EA Max Qty Per Fill Retail)
<b>*Erythromycins*** - Antibiotics</b>		
<i>erythromycin</i>	Preferred	
<i>erythromycin base</i>	Preferred	
<i>erythromycin ethylsuccinate</i>	Preferred	
<b>E.E.S. 400</b>	Preferred	
<b>E.E.S. GRANULES</b>	Preferred	
<b>ERYPED 200</b>	Preferred	
<b>ERYPED 400</b>	Preferred	
<b>ERY-TAB</b>	Preferred	
<b>ERYTHROCIN STEARATE</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Fidaxomicin*** - Antibiotics</i></b>		
DIFICID	Non – Preferred	
<b>*Medical Devices And Supplies* - Medical Supplies And Durable Medical Equipment</b>		
<b><i>*Applicators,Cotton Balls,Etc*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>alcohol prep</i>	Preferred	OTC
<i>alcohol swabs</i>	Preferred	OTC
<i>cvs alcohol prep pads</i>	Preferred	OTC
<i>easy comfort alcohol pads</i>	Preferred	OTC
<i>eql alcohol swabs</i>	Preferred	OTC
<i>hm sterile alcohol prep</i>	Preferred	OTC
<i>pure comfort alcohol prep</i>	Preferred	OTC
<i>ra alcohol swabs</i>	Preferred	OTC
<i>sb alcohol prep</i>	Preferred	OTC
<i>sm alcohol prep</i>	Preferred	OTC
<i>sure comfort alcohol prep</i>	Preferred	OTC
<b>ALCOHOL SWABSTICK</b>	Preferred	OTC
<b>CARETOUCH ALCOHOL PREP</b>	Preferred	OTC
<b>COMFORT TOUCH ALCOHOL PREP</b>	Preferred	OTC
<b>CURITY ALCOHOL PREPS</b>	Preferred	OTC
<b>EASY TOUCH ALCOHOL PREP MEDIUM</b>	Preferred	OTC
<b>RELION ALCOHOL SWABS</b>	Preferred	OTC
<b>WEBCOL ALCOHOL PREP LARGE</b>	Preferred	OTC
<b><i>*Cervical Caps*** - Medical Supplies And Durable Medical Equipment</i></b>		
<b>FEMCAP</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Condoms - Male*** - Medical Supplies And Durable Medical Equipment</b>		
<i>aimsco lubricated</i>	Preferred	OTC
<i>kimono</i>	Preferred	OTC
<i>kimono micro thin</i>	Preferred	OTC
<i>kimono micro thin plus</i>	Preferred	OTC
<i>kimono plus</i>	Preferred	OTC
<i>kimono ps</i>	Preferred	OTC
<i>kimono ps plus</i>	Preferred	OTC
<i>kimono sensation</i>	Preferred	OTC
<i>kimono sensation plus</i>	Preferred	OTC
<i>maxx</i>	Preferred	OTC
<i>maxx plus</i>	Preferred	OTC
<b>DUREX EXTRA SENSITIVE THIN</b>	Preferred	OTC
<b>FANTASY LUBRICATED</b>	Preferred	OTC
<b>FANTASY LUBRICATED/SPERMICIDE</b>	Preferred	OTC
<b>KAMELEON LUBRICATED</b>	Preferred	OTC
<b>KIMONO COLORS</b>	Preferred	OTC
<b>KIMONO SPECIAL</b>	Preferred	OTC
<b>K-Y ME &amp; YOU EXTRA LUBRICATED</b>	Preferred	OTC
<b>K-Y ME &amp; YOU INTENSE</b>	Preferred	OTC
<b>REALITY LATEX CONDOMS</b>	Preferred	OTC
<b>REALITY LATEX/ULTRA TEXTURED</b>	Preferred	OTC
<b>REALITY LATEX/ULTRA THIN</b>	Preferred	OTC
<b>TRUSTEX COLOR CONDOMS + LUBE</b>	Preferred	OTC
<b>TRUSTEX LUB/RIBBED/STUDED</b>	Preferred	OTC
<b>TRUSTEX LUB/SPERMICIDE EX ST</b>	Preferred	OTC
<b>TRUSTEX LUB/SPERMICIDE XL</b>	Preferred	OTC
<b>TRUSTEX LUBRICATED</b>	Preferred	OTC

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TRUSTEX LUBRICATED EX LARGE	Preferred	OTC
TRUSTEX LUBRICATED EXTRA ST	Preferred	OTC
TRUSTEX LUBRICATED/SPERMICIDE	Preferred	OTC
TRUSTEX NATURAL CONDOMS + LUBE	Preferred	OTC
TRUSTEX NON-LUBRICATED	Preferred	OTC
TRUSTEX RIA LUB/SPERMICIDE	Preferred	OTC
TRUSTEX RIA LUBRICATED	Preferred	OTC
TRUSTEX RIA NON-LUBRICATED	Preferred	OTC
TRUSTEX-NONNOXYNOL-9/RIB/STUD	Preferred	OTC
<b><i>*Diaphragms*** - Medical Supplies And Durable Medical Equipment</i></b>		
OMNIFLEX DIAPHRAGM	Preferred	
WIDE-SEAL DIAPHRAGM 60	Preferred	
WIDE-SEAL DIAPHRAGM 65	Preferred	
WIDE-SEAL DIAPHRAGM 70	Preferred	
WIDE-SEAL DIAPHRAGM 75	Preferred	
WIDE-SEAL DIAPHRAGM 80	Preferred	
WIDE-SEAL DIAPHRAGM 85	Preferred	
WIDE-SEAL DIAPHRAGM 90	Preferred	
WIDE-SEAL DIAPHRAGM 95	Preferred	
<b><i>*Gauze Pads &amp; Dressings*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>bandage new generation large</i>	Preferred	OTC
<i>cvs gauze</i>	Preferred	OTC
<i>cvs gauze pad sterile</i>	Preferred	OTC
<i>cvs gauze sterile</i>	Preferred	OTC
<i>eql gauze</i>	Preferred	OTC
<i>eql gauze sterile</i>	Preferred	OTC
<i>gauze pads</i>	Preferred	OTC

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<i>gauze type vii medi-pak</i>	Preferred	OTC
<i>hm sterile pads</i>	Preferred	OTC
<i>qc border island gauze</i>	Preferred	OTC
<i>qc sterile pads</i>	Preferred	OTC
<i>ra sterile</i>	Preferred	OTC
<i>sm bandage roll</i>	Preferred	OTC
<i>sm gauze</i>	Preferred	OTC
<i>sm rolled gauze 2"x4.1yd</i>	Preferred	OTC
<i>sm rolled gauze 3"x4.1yd</i>	Preferred	OTC
<i>sm sterile</i>	Preferred	OTC
<i>sterile</i>	Preferred	OTC
<i>sterile bandage roll 2.25"x3yd</i>	Preferred	OTC
<i>sterile gauze</i>	Preferred	OTC
<i>stretch gauze bandage</i>	Preferred	OTC
<i>surgical gauze sponge</i>	Preferred	OTC
<b>AMD FOAM DRESSING</b>	Preferred	
<b>AMD FOAM DRESSING TOPSHEET</b>	Preferred	
<b>BAND-AID GAUZE LARGE</b>	Preferred	OTC
<b>BAND-AID GAUZE MEDIUM</b>	Preferred	OTC
<b>BAND-AID GAUZE SMALL</b>	Preferred	OTC
<b>BAND-AID KLING ROLLED GAUZE LG</b>	Preferred	OTC
<b>BAND-AID KLING ROLLED GAUZE MD</b>	Preferred	OTC
<b>BAND-AID KLING ROLLED GAUZE SM</b>	Preferred	OTC
<b>COMPEED SKIN PROTECTOR DRESS</b>	Preferred	OTC
<b>COPA ISLAND BORDERED FOAM</b>	Preferred	OTC
<b>COPA PLUS HYDROPHILIC FOAM</b>	Preferred	OTC
<b>COVRSITE COVER DRESSING</b>	Preferred	OTC
<b>COVRSITE PLUS COMPOSITE DRESS</b>	Preferred	OTC
<b>CURITY ALL PURPOSE SPONGES</b>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CURITY AMD ANTIMICROBIAL SPNGE PAD 2"X2"	Preferred	OTC
CURITY AMD ANTIMICROBIAL SPNGE PAD 4"X4"	Preferred	
CURITY COVER SPONGE	Preferred	OTC
CURITY GAUZE	Preferred	OTC
CURITY GAUZE SPONGE	Preferred	OTC
CURITY NON-ADHERENT STRIPS	Preferred	OTC
CURITY SPONGES	Preferred	OTC
DERMACEA GAUZE SPONGE	Preferred	OTC
DERMACEA IV DRAIN SPONGES	Preferred	OTC
DERMACEA IV SPONGES	Preferred	OTC
DERMACEA NON-WOVEN SPONGES	Preferred	OTC
DERMACEA TYPE VII GAUZE	Preferred	OTC
EXCILON IV SPONGES	Preferred	OTC
J & J GAUZE	Preferred	OTC
KENDALL HYDROPHILIC FOAM DRESS	Preferred	OTC
KENDALL HYDROPHILIC FOAM PLUS	Preferred	OTC
MIRASORB SPONGES	Preferred	OTC
RESTORE CONTACT LAYER	Preferred	OTC
SOF-WIK	Preferred	OTC
TEGADERM FILM 1-3/4"X1-3/4"	Preferred	OTC
TEGADERM FOAM	Preferred	OTC
TEGADERM FOAM ROLL 4"X24"	Preferred	OTC
THERAGAUZE	Preferred	OTC
<b>*Glucose Monitoring Test Supplies*** - Medical Supplies And Durable Medical Equipment</b>		
<i>blood glucose monitor system</i>	Non – Preferred	OTC
<i>blood glucose monitoring 333</i>	Non – Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>blood glucose system pak</i>	Non – Preferred	OTC
<i>careone advanced lancing dev</i>	Preferred	OTC
<i>careone lancet thin 23g</i>	Preferred	OTC
<i>comfort assured lancets 28g</i>	Preferred	OTC
<i>comfort assured lancets 33g</i>	Preferred	OTC
<i>control</i>	Preferred	OTC
<i>cvs lancets 21g</i>	Preferred	OTC
<i>cvs lancets micro thin 33g</i>	Preferred	OTC
<i>cvs lancets original</i>	Preferred	OTC
<i>cvs lancets thin 26g</i>	Preferred	OTC
<i>diatrue plus blood glucose</i>	Non – Preferred	OTC
<i>easy mini eject lancing device</i>	Preferred	OTC
<i>easy mini lancing device</i>	Preferred	OTC
<i>easy plus ii control</i>	Preferred	OTC
<i>easy plus ii glucose system</i>	Non – Preferred	OTC
<i>easy talk blood glucose system</i>	Non – Preferred	OTC
<i>easy talk control</i>	Preferred	OTC
<i>easy trak blood glucose system</i>	Non – Preferred	OTC
<i>easy trak ii blood glucose sys</i>	Non – Preferred	OTC
<i>element compact control 2</i>	Preferred	OTC
<i>element compact control 3</i>	Preferred	OTC
<i>element compact glucose system</i>	Non – Preferred	OTC
<i>element compact v glucose sys</i>	Non – Preferred	OTC
<i>embrace lancing device/ejector</i>	Preferred	OTC
<i>eql color lancets 21g</i>	Preferred	OTC
<i>eql color lancets micro 33g</i>	Preferred	OTC
<i>eql super thin lancets 30g</i>	Preferred	OTC
<i>eql thin lancets 26g</i>	Preferred	OTC
<i>ge100 blood glucose system</i>	Non – Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>ght blood glucose monitor</i>	Non – Preferred	OTC
<i>glucose control</i>	Preferred	OTC
<i>goodsense blood glucose</i>	Non – Preferred	OTC
<i>guardian sensor 3</i>	Non – Preferred	PA
<i>kroger blood glucose</i>	Non – Preferred	OTC
<i>kroger premium blood glucose</i>	Non – Preferred	OTC
<i>lancet transporter case</i>	Preferred	OTC
<i>liberty blood glucose meter</i>	Non – Preferred	OTC
<i>meijer blood glucose</i>	Non – Preferred	OTC
<i>meijer essential blood glucose</i>	Non – Preferred	OTC
<i>meijer premium blood glucose</i>	Non – Preferred	OTC
<i>one drop blood glucose monitor</i>	Non – Preferred	OTC
<i>oval tape</i>	Non – Preferred	OTC
<i>pro voice v8 glucose system</i>	Non – Preferred	OTC
<i>pro voice v9 glucose system</i>	Non – Preferred	OTC
<i>safety lancet 30gl/pressure act</i>	Preferred	OTC
<i>safety lancets 28g</i>	Preferred	OTC
<i>select-lite devicellancets</i>	Preferred	OTC
<i>tgt blood glucose monitoring</i>	Non – Preferred	OTC
<i>verasens blood glucose meter</i>	Non – Preferred	OTC
<i>verasens blood glucose system</i>	Non – Preferred	OTC
<b>ACCU-CHEK AVIVA</b>	Preferred	OTC
<b>ACCU-CHEK AVIVA PLUS</b>	Non – Preferred	OTC
<b>ACCU-CHEK FASTCLIX LANCET</b>	Preferred	OTC
<b>ACCU-CHEK FASTCLIX LANCETS</b>	Preferred	OTC
<b>ACCU-CHEK GUIDE</b>	Non – Preferred	OTC
<b>ACCU-CHEK GUIDE CONTROL</b>	Preferred	OTC
<b>ACCU-CHEK GUIDE ME</b>	Non – Preferred	OTC
<b>ACCU-CHEK SAFE-T PRO LANCETS</b>	Preferred	OTC

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<b>ACCU-CHEK SMARTVIEW CONTROL</b>	Preferred	OTC
<b>ACCU-CHEK SOFTCLIX LANCET DEV</b>	Preferred	OTC
<b>ACCU-CHEK SOFTCLIX LANCETS</b>	Preferred	OTC
<b>ACCUTREND GLUCOSE CONTROL</b>	Preferred	OTC
<b>ADVANCE INTUITION METER</b>	Non – Preferred	OTC
<b>ADVANCE INTUITION MONITOR</b>	Non – Preferred	OTC
<b>ADVANCE MICRO-DRAW CONTROL</b>	Preferred	OTC
<b>ADVANCE MICRO-DRAW METER</b>	Non – Preferred	OTC
<b>ADVANCE MICRO-DRAW NORMAL</b>	Preferred	OTC
<b>ADVOCATE BLOOD GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>ADVOCATE BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>ADVOCATE CONTROL SOLUTION</b>	Preferred	OTC
<b>ADVOCATE LANCETS</b>	Preferred	OTC
<b>ADVOCATE LANCETS 30G</b>	Preferred	OTC
<b>ADVOCATE LANCING DEVICE</b>	Preferred	OTC
<b>ADVOCATE RAPID-SAFE LANCING</b>	Preferred	OTC
<b>ADVOCATE REDI-CODE</b>	Non – Preferred	OTC
<b>ADVOCATE REDI-CODE+</b>	Non – Preferred	OTC
<b>ADVOCATE REDI-CODE+ CONTROL</b>	Preferred	OTC
<b>ADVOCATE SAFETY LANCETS</b>	Preferred	OTC
<b>ADVOCATE SAFETY LANCETS 26G</b>	Preferred	OTC
<b>AGAMATRIX AMP</b>	Non – Preferred	OTC
<b>AGAMATRIX CONTROL</b>	Preferred	OTC
<b>AGAMATRIX CONTROL LEVEL 2</b>	Preferred	OTC
<b>AGAMATRIX CONTROL LEVEL 4</b>	Preferred	OTC
<b>AGAMATRIX JAZZ WIRELESS 2</b>	Non – Preferred	OTC
<b>AGAMATRIX PRESTO</b>	Non – Preferred	OTC
<b>AGAMATRIX PRESTO PRO METER</b>	Non – Preferred	OTC
<b>ASSURE 3 CONTROL</b>	Preferred	OTC

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<b>ASSURE 3 METER</b>	Non – Preferred	OTC
<b>ASSURE 4 CONTROL LEVEL 1 &amp; 2</b>	Preferred	OTC
<b>ASSURE 4 METER</b>	Non – Preferred	OTC
<b>ASSURE PLATINUM METER</b>	Non – Preferred	OTC
<b>ASSURE PRISM MULTI METER</b>	Non – Preferred	OTC
<b>ASSURE PRO BLOOD GLUCOSE METER</b>	Non – Preferred	OTC
<b>AUTO-LANCET</b>	Preferred	OTC
<b>AUTO-LANCET MINI</b>	Preferred	OTC
<b>AUTOLET II CLINISAFE</b>	Preferred	OTC
<b>AUTOLET LANCING DEVICE</b>	Preferred	OTC
<b>AUTOLET LITE CLINISAFE</b>	Preferred	OTC
<b>AUTOLET LITE STARTER PACK</b>	Preferred	OTC
<b>AUTOLET MINI</b>	Preferred	OTC
<b>AUTOLET PLATFORMS</b>	Preferred	OTC
<b>AUTOLET PLUS</b>	Preferred	OTC
<b>BD LATITUDE DIABETES</b>	Non – Preferred	OTC
<b>BD LOGIC BLOOD GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>BD MICROTAINER LANCETS</b>	Preferred	
<b>BIGFOOT UNITY PROGRAM</b>	Non – Preferred	
<b>BIOTEL CARE BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>BIOTEL CARE BLOOD GLUCOSE SYST</b>	Non – Preferred	OTC
<b>BLULINK GLUCOSE MONITORING SYS</b>	Non – Preferred	OTC
<b>CAREONE BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>CAREONE LANCET SUPER THIN 30G</b>	Preferred	OTC
<b>CARESENS LANCETS</b>	Preferred	OTC
<b>CARESENS N FELIZ</b>	Non – Preferred	OTC
<b>CARESENS N FELIZ BT</b>	Non – Preferred	OTC
<b>CARESENS N GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>CARESENS N VOICE SYSTEM</b>	Non – Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
CARETOUCH MONITOR SYSTEM	Non – Preferred	OTC
CARETOUCH SAFETY LANCETS	Preferred	OTC
CARETOUCH SAFETY LANCETS 26G	Preferred	OTC
CARETOUCH TWIST LANCETS 28G	Preferred	OTC
CARETOUCH TWIST LANCETS 30G	Preferred	OTC
CARETOUCH TWIST LANCETS 33G	Preferred	OTC
CLEANLET LANCETS 28G	Preferred	OTC
CLEVER CHEK AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK LANCETS	Preferred	OTC
CLEVER CHEK SYSTEM	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHOICE LANCETS 21G	Preferred	OTC
CLEVER CHOICE LANCETS 23G	Preferred	OTC
CLEVER CHOICE LANCETS 28G	Preferred	OTC
CLEVER CHOICE MICRO SYSTEM	Non – Preferred	OTC
CLEVER CHOICE MINI SYSTEM	Non – Preferred	OTC
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
COAGUCHEK LANCETS	Preferred	OTC
CONTOUR BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CONTOUR CONTROL	Preferred	OTC
CONTOUR MONITOR	Non – Preferred	OTC
CONTOUR NEXT CONTROL	Preferred	OTC
CONTOUR NEXT EZ	Non – Preferred	OTC
CONTOUR NEXT GEN MONITOR	Non – Preferred	OTC
CONTOUR NEXT LINK	Non – Preferred	OTC
CONTOUR NEXT MONITOR	Non – Preferred	OTC
CONTOUR NEXT ONE	Non – Preferred	OTC
COOL MONITOR	Non – Preferred	OTC

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<b>COOL MONITOR KIT</b>	Non – Preferred	OTC
<b>CVS BLOOD GLUCOSE METER</b>	Non – Preferred	OTC
<b>D-CARE GLUCOMETER</b>	Non – Preferred	
<b>DEXCOM G6 RECEIVER</b>	Preferred	PA; QL (1 EA per 365 days)
<b>DEXCOM G6 SENSOR</b>	Preferred	PA; QL (3 EA per 30 days)
<b>DEXCOM G6 TRANSMITTER</b>	Preferred	PA; QL (1 EA per 90 days)
<b>DEXCOM G7 RECEIVER</b>	Preferred	PA; QL (1 EA per 365 days)
<b>DEXCOM G7 SENSOR</b>	Preferred	PA; QL (3 EA per 30 days)
<b>DIATHRIVE BLOOD GLUCOSE METER</b>	Non – Preferred	OTC
<b>DIATHRIVE+ GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>EASY STEP CONTROL</b>	Preferred	OTC
<b>EASY STEP GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>EASY TOUCH GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>EASY TOUCH HEALTHPRO GLUCOSE</b>	Non – Preferred	OTC
<b>EASY TOUCH LANCETS 21G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 23G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 26G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 28G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 28G/TWIST</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 30G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 30G/TWIST</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 32G</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 32G/TWIST</b>	Preferred	OTC
<b>EASY TOUCH LANCETS 33G/TWIST</b>	Preferred	OTC
<b>EASY TOUCH LANCING DEVICE</b>	Preferred	OTC
<b>EASY TOUCH SAFETY LANCETS 21G</b>	Preferred	OTC
<b>EASY TOUCH SAFETY LANCETS 23G</b>	Preferred	OTC
<b>EASY TOUCH SAFETY LANCETS 26G</b>	Preferred	OTC
<b>EASY TOUCH SAFETY LANCETS 28G</b>	Preferred	OTC

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<b>EASYGLUCO</b>	Non – Preferred	OTC
<b>EASYMAX NG BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>EASYMAX V BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>EASYPRO BLOOD GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>EASYPRO PLUS</b>	Non – Preferred	OTC
<b>ELEMENT AUTOCODE SYSTEM</b>	Non – Preferred	OTC
<b>ELEMENT CONTROL</b>	Preferred	OTC
<b>ELEMENT PLUS</b>	Non – Preferred	OTC
<b>EMBRACE BLOOD GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>EMBRACE CONTROL</b>	Preferred	OTC
<b>EMBRACE EVO GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>EMBRACE EVO GLUCOSE MONITORING</b>	Non – Preferred	OTC
<b>EMBRACE PRO GLUCOSE METER</b>	Non – Preferred	OTC
<b>EMBRACE TALK BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>EMBRACE TALK MONITORING SYSTEM</b>	Non – Preferred	OTC
<b>EMBRACE WAVE BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>EMBRACE WAVE GLUCOSE METER</b>	Non – Preferred	OTC
<b>ENLITE GLUCOSE SENSOR</b>	Non – Preferred	PA
<b>EVERSENSE E3 SENSOR/HOLDER</b>	Non – Preferred	PA
<b>EVERSENSE E3 SMART TRANSMITTER</b>	Non – Preferred	PA
<b>EVERSENSE SENSOR/HOLDER</b>	Non – Preferred	PA
<b>EVERSENSE SMART TRANSMITTER</b>	Non – Preferred	PA
<b>EVOLUTION AUTOCODE</b>	Non – Preferred	OTC
<b>E-Z JECT LANCET MICRO-THIN 33G</b>	Preferred	OTC
<b>E-Z JECT LANCET SUPER THIN 30G</b>	Preferred	OTC
<b>E-Z JECT LANCETS</b>	Preferred	OTC
<b>E-Z JECT LANCETS 21G</b>	Preferred	OTC
<b>E-Z JECT LANCETS THIN 26G</b>	Preferred	OTC
<b>EZ-LETS LANCETS 21G</b>	Preferred	OTC

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<b>EZ-LETS LANCETS 26G</b>	Preferred	OTC
<b>FIFTY50 GLUCOSE METER 2.0</b>	Non – Preferred	OTC
<b>FORA G20 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA G30A BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA GD20 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA GD50 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA GTEL BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA PREMIUM V10 BLE SYSTEM</b>	Non – Preferred	OTC
<b>FORA TEST N' GO MONITOR</b>	Non – Preferred	OTC
<b>FORA TN'G VOICE</b>	Non – Preferred	OTC
<b>FORA V10 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA V10/V12/D10/D20 TEST</b>	Non – Preferred	OTC
<b>FORA V12 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA V20 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORA V30A BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FORACARE GD40 MONITOR</b>	Non – Preferred	OTC
<b>FORACARE PREMIUM V10</b>	Non – Preferred	OTC
<b>FORACARE TEST N GO MONITOR</b>	Non – Preferred	OTC
<b>FORTISCARE T1 GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>FREESTYLE CONTROL SOLUTION</b>	Preferred	OTC
<b>FREESTYLE FREEDOM LITE</b>	Non – Preferred	OTC
<b>FREESTYLE LIBRE 14 DAY READER</b>	Preferred	PA; QL (1 EA per 365 days)
<b>FREESTYLE LIBRE 14 DAY SENSOR</b>	Preferred	PA; QL (2 EA per 28 days)
<b>FREESTYLE LIBRE 2 READER</b>	Preferred	PA; QL (1 EA per 365 days)
<b>FREESTYLE LIBRE 2 SENSOR</b>	Preferred	PA
<b>FREESTYLE LIBRE 3 READER</b>	Preferred	PA
<b>FREESTYLE LIBRE 3 SENSOR</b>	Preferred	PA; QL (2 EA per 28 days)
<b>FREESTYLE LIBRE READER</b>	Non – Preferred	PA; QL (1 EA per 365 days)
<b>FREESTYLE LITE</b>	Non – Preferred	OTC

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<b>FREESTYLE PRECISION NEO SYSTEM</b>	Non – Preferred	OTC
<b>GENTEEL CONTACT TIPS (BLUE)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (CLEAR)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (GREEN)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (ORANGE)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (RAINBOW)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (VIOLET)</b>	Preferred	OTC
<b>GENTEEL CONTACT TIPS (YELLOW)</b>	Preferred	OTC
<b>GENTEEL LANCING KIT (BLUE)</b>	Preferred	OTC
<b>GENTEEL NOZZLES</b>	Preferred	OTC
<b>GENTLE-LET PLATFORMS</b>	Preferred	OTC
<b>GLUCO PERFECT 3 METER</b>	Non – Preferred	OTC
<b>GLUCOCARD 01 BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>GLUCOCARD 01-MINI GLUCOSE</b>	Non – Preferred	OTC
<b>GLUCOCARD EXPRESSION MONITOR</b>	Non – Preferred	OTC
<b>GLUCOCARD SHINE</b>	Non – Preferred	OTC
<b>GLUCOCARD SHINE CONNEX</b>	Non – Preferred	OTC
<b>GLUCOCARD SHINE EXPRESS</b>	Non – Preferred	OTC
<b>GLUCOCARD SHINE XL</b>	Non – Preferred	OTC
<b>GLUCOCARD VITAL MONITOR</b>	Non – Preferred	OTC
<b>GLUCOCARD X-METER</b>	Non – Preferred	OTC
<b>GLUCOCOM BLOOD GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>GLUCOCOM MONITOR</b>	Non – Preferred	OTC
<b>GLUCONAVII BLOOD GLUCOSE SYS</b>	Non – Preferred	OTC
<b>GNP EASY TOUCH CONT HIGH/LOW</b>	Preferred	OTC
<b>GNP EASY TOUCH GLUCOSE METER</b>	Non – Preferred	OTC
<b>GNP TRUE METRIX AIR METER</b>	Non – Preferred	OTC
<b>GNP TRUE METRIX GLUCOSE METER</b>	Non – Preferred	OTC
<b>GUARDIAN 4 GLUCOSE SENSOR</b>	Non – Preferred	PA

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>GUARDIAN 4 TRANSMITTER</b>	Non – Preferred	PA
<b>GUARDIAN CONNECT TRANSMITTER</b>	Non – Preferred	PA
<b>GUARDIAN LINK 3 TRANSMITTER</b>	Non – Preferred	PA
<b>GUARDIAN REAL-TIME CHARGER</b>	Non – Preferred	
<b>GUARDIAN REAL-TIME REPLACE PED</b>	Non – Preferred	PA
<b>GUARDIAN REAL-TIME TEST PLUG</b>	Non – Preferred	
<b>GUARDIAN SENSOR (3)</b>	Non – Preferred	PA
<b>HEALTHPRO BLOOD GLUCOSE MONITO</b>	Non – Preferred	OTC
<b>HM EMBRACE TALK SYSTEM</b>	Non – Preferred	OTC
<b>HW EMBRACE PRO GLUCOSE METER</b>	Non – Preferred	OTC
<b>HW EMBRACE TALK BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>HYPOLANCE AST LANCING</b>	Preferred	OTC
<b>IGLUCOSE MONITORING SYSTEM</b>	Non – Preferred	OTC
<b>IN TOUCH</b>	Non – Preferred	OTC
<b>IN TOUCH GLUCOSE CONTROL</b>	Preferred	OTC
<b>INFINITY BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>INFINITY CONTROL</b>	Preferred	OTC
<b>INFINITY VOICE</b>	Non – Preferred	OTC
<b>KROGER HEALTHPRO CONTROL HI/LO</b>	Preferred	OTC
<b>LIBERTY NXT GENERATION MONITOR</b>	Non – Preferred	OTC
<b>MEIJER TRUE2GO BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>MEIJER TRUERESULT GLUCOSE SYS</b>	Non – Preferred	OTC
<b>MEIJER TRUETRACK GLUCOSE SYS</b>	Non – Preferred	OTC
<b>MICRODOT BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>MINILINK REAL-TIME TRANSMITTER</b>	Non – Preferred	PA
<b>MINIMED 630G GUARDIAN PRESS</b>	Non – Preferred	PA
<b>MM EASY TOUCH GLUCOSE METER</b>	Non – Preferred	OTC
<b>MULTI-LANCET DEVICE 2</b>	Preferred	OTC
<b>MYGLUCOHEALTH BLOOD GLUCOSE</b>	Non – Preferred	OTC

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<b>NOVA MAX BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>ON CALL EXPRESS MONITORING SYS</b>	Non – Preferred	OTC
<b>ONETOUCH DELICA PLUS LANCET30G</b>	Preferred	OTC
<b>ONETOUCH DELICA PLUS LANCET33G</b>	Preferred	OTC
<b>ONETOUCH DELICA PLUS LANCING</b>	Preferred	OTC
<b>ONETOUCH ULTRA</b>	Preferred	OTC
<b>ONETOUCH ULTRA 2 KIT W/DEVICE</b>	Preferred	OTC; QL (5 EA per 1 day)
<b>ONETOUCH ULTRA 2 KIT W/DEVICE</b>	Non – Preferred	OTC
<b>ONETOUCH VERIO</b>	Preferred	OTC
<b>ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE</b>	Preferred	OTC; QL (5 EA per 1 day)
<b>ONETOUCH VERIO FLEX SYSTEM KIT W/DEVICE</b>	Non – Preferred	OTC
<b>ONETOUCH VERIO REFLECT</b>	Non – Preferred	OTC
<b>PARADIGM REAL-TIME TRANSMITTER</b>	Non – Preferred	PA
<b>PERFECT LANCETS 28G</b>	Preferred	OTC
<b>PHARMACIST CHOICE AUTOCODE SYS</b>	Non – Preferred	OTC
<b>PHARMACIST CHOICE MINI SYSTEM</b>	Non – Preferred	OTC
<b>PIP BLOOD GLUCOSE MONITORING</b>	Non – Preferred	OTC
<b>POCKETCHEM EZ CONTROL</b>	Preferred	OTC
<b>POCKETCHEM EZ SYSTEM</b>	Non – Preferred	OTC
<b>PRECISION XTRA</b>	Non – Preferred	OTC
<b>PRODIGY AUTOCODE BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>PRODIGY CONTROL SOLUTION</b>	Preferred	OTC
<b>PRODIGY LANCING DEVICE</b>	Preferred	OTC
<b>PRODIGY NO CODING BLOOD GLUC</b>	Non – Preferred	OTC
<b>PRODIGY POCKET BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>PRODIGY VOICE BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>PSS SELECT PLATFORMS</b>	Preferred	OTC
<b>QUICKTEK</b>	Non – Preferred	OTC

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<b>QUICKTEK/METER</b>	Non – Preferred	OTC
<b>QUINTET AC BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>QUINTET BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>REFUAH PLUS MONITORING SYSTEM</b>	Non – Preferred	OTC
<b>RELION ALL-IN-ONE</b>	Non – Preferred	OTC
<b>RELION CONFIRM GLUCOSE MONITOR</b>	Non – Preferred	OTC
<b>RELION LANCETS MICRO-THIN 33G</b>	Preferred	OTC
<b>RELION LANCETS THIN 26G</b>	Preferred	OTC
<b>RELION LANCETS ULTRA-THIN 30G</b>	Preferred	OTC
<b>RELION LANCING DEVICE</b>	Preferred	OTC
<b>RELION MICRO</b>	Non – Preferred	OTC
<b>RELION PREMIER BLU MONITOR</b>	Non – Preferred	OTC
<b>RELION PREMIER CLASSIC</b>	Non – Preferred	OTC
<b>RELION PREMIER COMPACT SYSTEM</b>	Non – Preferred	OTC
<b>RELION PREMIER VOICE MONITOR</b>	Non – Preferred	OTC
<b>RELION PRIME MONITOR</b>	Non – Preferred	OTC
<b>RELION TRUE MET AIR GLUC METER</b>	Non – Preferred	OTC
<b>RELION ULTIMA GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>RELION ULTRA THIN LANCETS 30G</b>	Preferred	OTC
<b>RELION ULTRA THIN PLUS LANCETS</b>	Preferred	OTC
<b>REXALL BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>RIGHTEST ALTERNATE SITE ADAPT</b>	Preferred	OTC
<b>RIGHTEST GM100 BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>RIGHTEST GM300 BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>RIGHTEST GM550 BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>RIGHTEST GT333 BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>SAFETY LANCETS</b>	Preferred	OTC
<b>SAFETY LANCETS 21G</b>	Preferred	OTC
<b>SMART SENSE PREMIUM SYSTEM</b>	Non – Preferred	OTC

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<b>SMART SENSE VALUE GLUCOSE SYS</b>	Non – Preferred	OTC
<b>SMARTEST EJECT</b>	Non – Preferred	OTC
<b>SMARTEST EJECT STARTER</b>	Non – Preferred	OTC
<b>SMARTEST PERSONA STARTER</b>	Non – Preferred	OTC
<b>SMARTEST PRONTO STARTER</b>	Non – Preferred	OTC
<b>SMARTEST PROTEGE</b>	Non – Preferred	OTC
<b>SMARTEST PROTEGE STARTER</b>	Non – Preferred	OTC
<b>SOLUS V2 BLOOD GLUCOSE SYSTEM</b>	Non – Preferred	OTC
<b>STERILANCE PA</b>	Preferred	OTC
<b>TEMPO REFILL</b>	Non – Preferred	OTC
<b>TEMPO WELCOME</b>	Non – Preferred	
<b>TRUE FOCUS BLOOD GLUCOSE METER</b>	Non – Preferred	OTC
<b>TRUE METRIX AIR GLUCOSE METER</b>	Non – Preferred	OTC
<b>TRUE METRIX GO GLUCOSE METER</b>	Non – Preferred	OTC
<b>TRUE METRIX METER</b>	Non – Preferred	OTC
<b>TRUERESULT BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>TRUETRACK BLOOD GLUCOSE</b>	Non – Preferred	OTC
<b>TRUETRACK SMART SYSTEM</b>	Non – Preferred	OTC
<b>UNISTIK 1</b>	Preferred	OTC
<b>UNISTIK 2</b>	Preferred	OTC
<b>UNISTIK 2 COMFORT</b>	Preferred	OTC
<b>UNISTIK 2 EXTRA</b>	Preferred	OTC
<b>UNISTIK 2 NEONATAL</b>	Preferred	OTC
<b>UNISTIK 2 NORMAL</b>	Preferred	OTC
<b>UNISTIK 2 SUPER</b>	Preferred	OTC
<b>UNISTIK 3</b>	Preferred	OTC
<b>UNISTIK 3 COMFORT</b>	Preferred	OTC
<b>UNISTIK 3 EXTRA</b>	Preferred	OTC
<b>UNISTIK 3 NEONATAL</b>	Preferred	OTC

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UNISTIK 3 NORMAL	Preferred	OTC
UNISTIK CZT COMFORT	Preferred	OTC
UNISTIK CZT NORMAL	Preferred	OTC
VIVAGUARD INO GLUCOSE METER	Non – Preferred	OTC
VIVAGUARD INO SMART GLUC METER	Non – Preferred	OTC
WAVESENSE AMP	Non – Preferred	OTC
<b><i>*Insulin Administration Supplies*** - Medical Supplies And Durable Medical Equipment</i></b>		
OMNIPOD 5 G6 INTRO (GEN 5)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD 5 G6 POD (GEN 5)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD CLASSIC PODS (GEN 3)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD DASH INTRO (GEN 4)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD DASH PDM (GEN 4)	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD GO	Preferred	PA; QL (15 EA per 30 days)
V-GO 20	Non – Preferred	PA
V-GO 30	Non – Preferred	PA
V-GO 40	Non – Preferred	PA
<b><i>*Misc. Devices*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>14-count warmer</i>	Preferred	OTC
<i>2-way foley stabilization dev</i>	Preferred	
<i>3-in-1 bedside toilet</i>	Preferred	OTC
<i>adapter cap</i>	Preferred	
<i>adjust bath/shower seat</i>	Preferred	OTC
<i>adjust bath/shower seat/back</i>	Preferred	OTC
<i>adjust fold canelyork handle</i>	Preferred	OTC
<i>adjustable aluminum cane</i>	Preferred	OTC
<i>adjustable aluminum cane 3/4"</i>	Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>adjustable aluminum cane 5/8"</i>	Preferred	OTC
<i>adjustable aluminum cane 7/8"</i>	Preferred	OTC
<i>adjustable folding cane</i>	Preferred	OTC
<i>adult push button alum crutch</i>	Preferred	OTC
<i>aluminum blanket support</i>	Preferred	OTC
<i>aluminum flip off seals 13mm</i>	Preferred	
<i>aluminum flip off seals 20mm</i>	Preferred	
<i>amber glass bottle</i>	Preferred	
<i>amber glass vials 2ml</i>	Preferred	
<i>amber glass vials 2ml/13mm</i>	Preferred	
<i>autoclave air filter</i>	Preferred	
<i>autoclave paper 36" x 36"</i>	Preferred	
<i>autoclave printer paper</i>	Preferred	
<i>baby fridge</i>	Preferred	OTC
<i>bamboo cane</i>	Preferred	OTC
<i>bandage scissors</i>	Preferred	OTC
<i>bath/shower seat</i>	Preferred	OTC
<i>bathtub safety rail</i>	Preferred	OTC
<i>bed wedge</i>	Preferred	OTC
<i>beutlich ph test roll</i>	Preferred	OTC
<i>bi-focal magnifier</i>	Preferred	OTC
<i>blood collection tube holder</i>	Preferred	OTC
<i>blood pressure smart card</i>	Preferred	OTC
<i>bmi digital smart scale</i>	Preferred	OTC
<i>bottle 120ml/spray/clr plastic</i>	Preferred	
<i>bottle 2oz/blue glass/dropper</i>	Preferred	
<i>bottle 500ml/boston round/cap</i>	Preferred	
<i>bottle 8oz/boston round/cap</i>	Preferred	
<i>breast pump</i>	Preferred	OTC

Coverage Requirements and Limits

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>breathe comfort nasal irrigat</i>	Preferred	OTC
<i>breathe ease pulse oximeter</i>	Preferred	OTC
<i>cane holder</i>	Preferred	OTC
<i>cane tips</i>	Preferred	OTC
<i>cane tips 3/4"</i>	Preferred	OTC
<i>cane tips 7/8"</i>	Preferred	OTC
<i>cane tips for alum 3/4"</i>	Preferred	OTC
<i>cane tips for wood 3/4"</i>	Preferred	OTC
<i>cane tips for wood 5/8"</i>	Preferred	OTC
<i>cane tips for wood 7/8"</i>	Preferred	OTC
<i>cane wrist strap</i>	Preferred	OTC
<i>cervical pillow</i>	Preferred	OTC
<i>cervical pillow/cover</i>	Preferred	OTC
<i>chemo transfer pin</i>	Preferred	OTC
<i>classics rolling walker</i>	Preferred	OTC
<i>cleanroom tacky mat 18"x36"</i>	Preferred	
<i>clear glass vial 10ml</i>	Preferred	
<i>clear glass vials 2ml</i>	Preferred	
<i>comfort curve massage cushion</i>	Preferred	OTC
<i>commode bedside</i>	Preferred	OTC
<i>commode bedside/back</i>	Preferred	OTC
<i>commode pail</i>	Preferred	OTC
<i>commode splash guard</i>	Preferred	OTC
<i>contour fitted sheets</i>	Preferred	OTC
<i>contour mattress cover</i>	Preferred	OTC
<i>coverall boots/disposable/univ</i>	Preferred	
<i>coverall w/hood/3xl</i>	Preferred	
<i>coverall w/hood/small</i>	Preferred	
<i>coverall w/hood/xl</i>	Preferred	

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<i>coverall w/hood/xxl</i>	Preferred	
<i>cvs alkaline batteries size aa</i>	Preferred	OTC
<i>cvs diabetic organizer</i>	Preferred	OTC
<i>cvs ear plugs</i>	Preferred	OTC
<i>dental guard</i>	Preferred	OTC
<i>deodorant tubes 2.65oz-caps</i>	Preferred	
<i>dial-a-dose syringe 15ml</i>	Preferred	
<i>dial-a-dose syringe 30ml</i>	Preferred	
<i>dial-a-dose syringe 60ml</i>	Preferred	
<i>dispenser 50ml/foamer pump</i>	Preferred	
<i>dispenser md jar 50ml</i>	Preferred	
<i>dispenser md pen 6.5ml</i>	Preferred	
<i>dispenser md pump 0.5ml</i>	Preferred	
<i>dropping bottle 30ml</i>	Preferred	
<i>droptainer tip caps</i>	Preferred	OTC
<i>droptainers ophthalmic 3ml</i>	Preferred	
<i>droptainers ophthalmic 7ml</i>	Preferred	
<i>earpopper middle ear inflation</i>	Preferred	
<i>easy feed electric breast pump</i>	Preferred	OTC
<i>egg crate bed pad</i>	Preferred	OTC
<i>extendable bedside rail</i>	Preferred	OTC
<i>eye/ear dropper</i>	Preferred	OTC
<i>face shield full length</i>	Preferred	
<i>face shield full length/clear</i>	Preferred	
<i>filter 0.22 micron/73mm/1000ml</i>	Preferred	
<i>filter attachment</i>	Preferred	
<i>foil wrapper 3" x 3"</i>	Preferred	
<i>folding reacher</i>	Preferred	OTC
<i>foot massager</i>	Preferred	OTC

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<i>head lice comb</i>	Preferred	OTC
<i>heelboot laundry bag</i>	Preferred	OTC
<i>heelboot liner large</i>	Preferred	OTC
<i>heelboot liner regular</i>	Preferred	OTC
<i>illusions aa breast prosthesis</i>	Preferred	
<i>illusions c breast prosthesis</i>	Preferred	
<i>indicator/biological test</i>	Preferred	
<i>lumbar cushion</i>	Preferred	OTC
<i>magnifier hands-free</i>	Preferred	OTC
<b>ACU-LIFE CRUSHER/CONTAINER</b>	Preferred	OTC
<b>ADD-VANTAGE ADDAPTOR CONNECTOR</b>	Preferred	
<b>ALEVE TENS REFILL PADS</b>	Preferred	OTC
<b>ALL-BODY MASSAGE</b>	Preferred	OTC
<b>ALPHAMOP FOAM REPLACEMENT PADS</b>	Preferred	
<b>AMEDA ADAPTER CAP</b>	Preferred	OTC
<b>AMEDA BREAST FLANGE INSERT</b>	Preferred	OTC
<b>AMEDA ONE-HAND BREAST PUMP</b>	Preferred	OTC
<b>AMEDA PLATINUM BREAST PUMP</b>	Preferred	OTC
<b>AMEDA SILICONE TUBING</b>	Preferred	OTC
<b>AMEDA TUBING ADAPTER</b>	Preferred	OTC
<b>AMIELLE VAGINAL TRAINER</b>	Preferred	
<b>ANGEL WING BLOOD COLLECT SET</b>	Preferred	
<b>ANGEL WING LUER ADAPTER/HOLDER</b>	Preferred	
<b>ANGEL WING TRANSFER DEVICE</b>	Preferred	
<b>ANGEL WING TUBE HOLDER</b>	Preferred	
<b>APNEASTRIP</b>	Preferred	
<b>ARGYLE SARATOGA SUMP DRAIN</b>	Preferred	
<b>ARGYLE TRACH TUBE HOLDER</b>	Preferred	OTC
<b>AVOSTARTGRIP</b>	Preferred	

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CAREX WHEELCHAIR	Preferred	OTC
CINIS PREEMIE HALO LARGE	Preferred	OTC
CINIS PREEMIE HALO MEDIUM	Preferred	OTC
CINIS PREEMIE HALO SMALL	Preferred	OTC
CLEVER CHOICE HYDROTHERAPY SYS	Preferred	OTC
CLEVER CHOICE PULSE OXIMETER	Preferred	
CLINERE EARWAX CLEANERS	Preferred	OTC
COMAR PRESS-IN BOTTLE ADAPTERS	Preferred	
COMFORT FIT FLANGES LARGE	Preferred	OTC
COMFORT PERSONAL CLEANS CART	Preferred	OTC
COMFORT PERSONAL SHAMPOO CAP	Preferred	OTC
COMFORT PERSONAL WARMER 14-CT	Preferred	OTC
COMFORT PERSONAL WARMER 28-CT	Preferred	OTC
ECO-SMARTFUNNEL 186ML	Preferred	
E-Z LOCK RAISED TOILET SEAT	Preferred	OTC
EZY DOSE ADULT-LOCK PILL CUT	Preferred	OTC
HEAT THERAPY	Preferred	OTC
HURRIPAK PERIO IRRIGATION TIPS	Preferred	OTC
HURRIPAK PERIODONTAL ANESTHETI	Preferred	OTC
ICY DIAMOND TOTE CANVAS	Preferred	OTC
ICY DIAMOND TOTE NON LEATHER	Preferred	OTC
ICY HOT TENS THERAPY REFILL	Preferred	OTC
MAD NASAL	Preferred	
MAD NASAL ATOMIZATION DEVICE	Preferred	
<b><i>*Needles &amp; Syringes*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>1st tier unifine pentips</i>	Non – Preferred	OTC
<i>1st tier unifine pentips plus</i>	Non – Preferred	OTC
<i>aq insulin syringe</i>	Non – Preferred	

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<i>aqinject pen needle</i>	Non – Preferred	
<i>aum insulin safety pen needle</i>	Non – Preferred	OTC
<i>aum mini insulin pen needle</i>	Non – Preferred	OTC
<i>aum pen needle</i>	Non – Preferred	OTC
<i>aurora pen needles</i>	Non – Preferred	OTC
<i>careone insulin syringe</i>	Non – Preferred	OTC
<i>careone unifine pentips plus</i>	Non – Preferred	OTC
<i>clickfine pen needles 31g x 8 mm</i>	Non – Preferred	OTC
<i>crono syringe</i>	Preferred	OTC
<i>dropsafe safety pen needles</i>	Non – Preferred	OTC
<i>drug mart unifine pentips</i>	Non – Preferred	OTC
<i>drug mart unifine pentips plus</i>	Non – Preferred	OTC
<i>easy comfort insulin syringe</i>	Non – Preferred	OTC
<i>easy comfort pen needles</i>	Non – Preferred	OTC
<i>easy glide pen needles</i>	Non – Preferred	OTC
<i>eql insulin syringe</i>	Non – Preferred	OTC
<i>global ease inject pen needles</i>	Non – Preferred	OTC
<i>global easy glide insulin syr</i>	Non – Preferred	OTC
<i>global easy glide pen needles</i>	Non – Preferred	OTC
<i>global inject ease insulin syr</i>	Non – Preferred	OTC
<i>global insulin syringes</i>	Non – Preferred	OTC
<i>gnp clickfine pen needles</i>	Non – Preferred	OTC
<i>gnp insulin syringe</i>	Non – Preferred	OTC
<i>gnp insulin syringes</i>	Non – Preferred	OTC
<i>gnp insulin syringes 28gx1/2"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 29gx1/2"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 30gx5/16"</i>	Non – Preferred	OTC
<i>gnp insulin syringes 31gx5/16"</i>	Non – Preferred	OTC
<i>gnp ulticare pen needles</i>	Non – Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>gnp ultra com insulin syringe</i>	Non – Preferred	OTC
<i>goodsense clickfine pen needle</i>	Non – Preferred	OTC
<i>healthwise insulin syrlneedle</i>	Non – Preferred	OTC
<i>healthwise micron pen needles</i>	Non – Preferred	OTC
<i>healthwise short pen needles</i>	Non – Preferred	OTC
<i>h-e-b incontrol pen needles</i>	Non – Preferred	OTC
<i>insulin syringe</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 27g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 28g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 29g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (otc)</i>	Non – Preferred	

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<i>insulin syringe-needle u-100 30g x 1/2" 1 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 5/16" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 30g x 5/16" 1 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 0.5 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 1/4" 1 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 5/16" 0.3 ml</i>	Non – Preferred	OTC
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (otc)</i>	Non – Preferred	
<i>insulin syringe-needle u-100 31g x 5/16" 1 ml (rx)</i>	Non – Preferred	
<i>insupen pen needles</i>	Non – Preferred	OTC
<i>kinray insulin syringe</i>	Non – Preferred	OTC
<i>kmart valu insulin syringe 29g</i>	Non – Preferred	OTC
<i>kmart valu insulin syringe 30g</i>	Non – Preferred	OTC
<i>kroger insulin syringe</i>	Non – Preferred	OTC
<i>kroger pen needles</i>	Non – Preferred	OTC
<i>leader insulin syringe</i>	Non – Preferred	OTC
<i>longs insulin syringe</i>	Non – Preferred	OTC

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<i>medic insulin syringe</i>	Non – Preferred	OTC
<i>medicine shoppe pen needles</i>	Non – Preferred	OTC
<i>meijer pen needles</i>	Non – Preferred	OTC
<i>mm insulin syringe/needle</i>	Non – Preferred	OTC
<i>ms insulin syringe</i>	Non – Preferred	OTC
<i>pc unifine pentips</i>	Non – Preferred	OTC
<i>pen needles 29g x 12mm</i>	Non – Preferred	OTC
<i>pen needles 30g x 5 mm (otc)</i>	Non – Preferred	
<i>pen needles 30g x 5 mm (rx)</i>	Non – Preferred	
<i>pen needles 30g x 8 mm</i>	Non – Preferred	OTC
<i>pen needles 31g x 5 mm (otc)</i>	Non – Preferred	
<i>pen needles 31g x 5 mm (rx)</i>	Non – Preferred	
<i>pen needles 31g x 6 mm</i>	Non – Preferred	OTC
<i>pen needles 31g x 8 mm (otc)</i>	Non – Preferred	
<i>pen needles 31g x 8 mm (rx)</i>	Non – Preferred	
<i>pen needles 32g x 4 mm (otc)</i>	Non – Preferred	
<i>pen needles 32g x 4 mm (rx)</i>	Non – Preferred	
<i>pen needles 32g x 5 mm</i>	Non – Preferred	OTC
<i>pen needles 32g x 6 mm</i>	Non – Preferred	OTC
<i>pen needles 33g x 4 mm</i>	Non – Preferred	OTC
<i>pen needles 5/16"</i>	Non – Preferred	OTC
<i>pip pen needles 31g x 5mm</i>	Non – Preferred	OTC
<i>pip pen needles 32g x 4mm</i>	Non – Preferred	OTC
<i>preferred plus insulin syringe</i>	Non – Preferred	OTC
<i>preferred plus unifine pentips</i>	Non – Preferred	OTC
<i>pro comfort pen needles 31g x 8 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 4 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 5 mm</i>	Non – Preferred	
<i>pro comfort pen needles 32g x 6 mm</i>	Non – Preferred	OTC

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<i>pure comfort pen needle</i>	Non – Preferred	OTC
<i>pure comfort safety pen needle</i>	Non – Preferred	OTC
<i>px extra short pen needles</i>	Non – Preferred	OTC
<i>px insulin syringe</i>	Non – Preferred	OTC
<i>px mini pen needles</i>	Non – Preferred	OTC
<i>px pen needle</i>	Non – Preferred	OTC
<i>px shortlength pen needles</i>	Non – Preferred	OTC
<i>qc pen needles</i>	Non – Preferred	OTC
<i>qc unifine pentips</i>	Non – Preferred	OTC
<i>ra insulin syringe</i>	Non – Preferred	OTC
<i>ra pen needles</i>	Non – Preferred	OTC
<i>reality insulin syringe</i>	Non – Preferred	OTC
<i>safety pen needles</i>	Non – Preferred	OTC
<i>sb insulin syringe</i>	Non – Preferred	OTC
<i>sure comfort insulin syringe 28g x 1/2" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 28g x 1/2" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 29g x 1/2" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 0.5 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 1/2" 1 ml</i>	Non – Preferred	OTC

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<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 1 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 30g x 5/16" 1 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 0.3 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 0.5 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 1/4" 1 ml</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.3 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.5 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 0.5 ml (rx)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 1 ml (otc)</i>	Non – Preferred	
<i>sure comfort insulin syringe 31g x 5/16" 1 ml (rx)</i>	Non – Preferred	
<i>sure comfort pen needles 29g x 12.7mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 30g x 8 mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 31g x 5 mm</i>	Non – Preferred	OTC
<i>sure comfort pen needles 31g x 6 mm</i>	Non – Preferred	
<i>sure comfort pen needles 31g x 8 mm</i>	Non – Preferred	OTC

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<i>sure comfort pen needles 32g x 4 mm (otc)</i>	Non – Preferred	
<i>sure comfort pen needles 32g x 4 mm (rx)</i>	Non – Preferred	
<i>sure comfort pen needles 32g x 6 mm</i>	Non – Preferred	OTC
<i>syringe luer lock</i>	Preferred	OTC
<i>syringe luer slip</i>	Preferred	OTC
<i>syringe/hypodermic safety</i>	Preferred	OTC
<i>techlite insulin syringe</i>	Non – Preferred	OTC
<i>todays health pen needles</i>	Non – Preferred	OTC
<i>todays health short pen needle</i>	Non – Preferred	OTC
<i>topcare clickfine pen needles</i>	Non – Preferred	OTC
<i>topcare ultra comfort ins syr</i>	Non – Preferred	OTC
<i>true comfort insulin syringe</i>	Non – Preferred	OTC
<i>true comfort pen needles</i>	Non – Preferred	OTC
<i>true comfort pro insulin syr</i>	Non – Preferred	OTC
<i>true comfort pro pen needles</i>	Non – Preferred	OTC
<i>ultra comfort insulin syringe</i>	Non – Preferred	OTC
<i>ultracare insulin syringe</i>	Non – Preferred	OTC
<i>ultracare pen needles</i>	Non – Preferred	OTC
<i>value health insulin syringe</i>	Non – Preferred	OTC
<i>vp insulin syringe</i>	Non – Preferred	OTC
<i>wegmans unifine pentips plus</i>	Non – Preferred	OTC
<i>zevrx insulin syringe</i>	Non – Preferred	OTC
<i>zevrx pen needles</i>	Non – Preferred	OTC
<b>ABOUTTIME PEN NEEDLE</b>	Non – Preferred	OTC
<b>ADVOCATE INSULIN PEN NEEDLES</b>	Non – Preferred	OTC
<b>ADVOCATE INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>ASSURE ID INSULIN SAFETY SYR</b>	Non – Preferred	OTC
<b>ASSURE ID SAFETY PEN NEEDLES</b>	Non – Preferred	OTC
<b>AUM READYGARD DUO PEN NEEDLE</b>	Non – Preferred	OTC

Coverage Requirements and Limits

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>AUM SAFETY PEN NEEDLE</b>	Non – Preferred	OTC
<b>BD AUTOSHIELD DUO</b>	Non – Preferred	OTC
<b>BD ECLIPSE SYRINGE</b>	Preferred	OTC
<b>BD ECLIPSE SYRINGE/NEEDLE</b>	Preferred	OTC
<b>BD INSULIN SYR ULTRAFINE II</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE HALF-UNIT</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE MICROFINE</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE U/F</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE U/F 1/2UNIT</b>	Non – Preferred	OTC
<b>BD INSULIN SYRINGE ULTRAFINE</b>	Non – Preferred	OTC
<b>BD INTEGRA SYRINGE</b>	Preferred	OTC
<b>BD LUER-LOCK SYRINGE</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1" 1 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1" 10 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1-1/2" 10 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 20G X 1-1/2" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 21G X 1" 10 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 21G X 1" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 21G X 1" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 21G X 1-1/2" 10 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 21G X 1-1/2" 3 ML</b>	Preferred	OTC

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<b>BD LUER-LOK SYRINGE 21G X 1-1/2" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 22G X 1" 10 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 22G X 1" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 22G X 1" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 22G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 22G X 1-1/2" 5 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 23G X 1" 3 ML (OTC)</b>	Preferred	
<b>BD LUER-LOK SYRINGE 23G X 1" 3 ML (RX)</b>	Preferred	
<b>BD LUER-LOK SYRINGE 23G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 25G X 1" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 25G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 25G X 5/8" 1 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 25G X 5/8" 3 ML</b>	Preferred	OTC
<b>BD LUER-LOK SYRINGE 26G X 5/8" 3 ML</b>	Preferred	OTC
<b>BD PEN NEEDLE MICRO U/F</b>	Non – Preferred	OTC
<b>BD PEN NEEDLE MINI U/F</b>	Non – Preferred	OTC
<b>BD PEN NEEDLE NANO 2ND GEN</b>	Non – Preferred	OTC
<b>BD PEN NEEDLE NANO U/F</b>	Non – Preferred	
<b>BD PEN NEEDLE ORIGINAL U/F</b>	Non – Preferred	OTC
<b>BD PEN NEEDLE SHORT U/F</b>	Non – Preferred	OTC
<b>BD PLASTIPAK SYRINGE</b>	Preferred	OTC
<b>BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML</b>	Non – Preferred	OTC
<b>BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML</b>	Non – Preferred	OTC

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<b>BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML</b>	Non – Preferred	OTC
<b>BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML</b>	Non – Preferred	
<b>BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML</b>	Non – Preferred	OTC
<b>BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML</b>	Non – Preferred	OTC
<b>BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML</b>	Non – Preferred	OTC
<b>BD SAFETYGLIDE SHIELDED NEEDLE</b>	Preferred	OTC
<b>BD SAFETYGLIDE SYRINGE/NEEDLE</b>	Preferred	OTC
<b>BD SYRINGE SLIP TIP</b>	Preferred	OTC
<b>BD SYRINGE/NEEDLE</b>	Preferred	OTC
<b>BD VEO INSULIN SYR U/F 1/2UNIT</b>	Non – Preferred	OTC
<b>BD VEO INSULIN SYRINGE U/F</b>	Non – Preferred	OTC
<b>CAREFINE PEN NEEDLES</b>	Non – Preferred	OTC
<b>CARETOUCH INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>CARETOUCH PEN NEEDLES</b>	Non – Preferred	OTC
<b>CLEVER CHOICE COMFORT EZ</b>	Non – Preferred	OTC
<b>CLICKFINE PEN NEEDLES 31G X 5 MM</b>	Non – Preferred	OTC
<b>CLICKFINE PEN NEEDLES 31G X 6 MM</b>	Non – Preferred	OTC
<b>CLICKFINE PEN NEEDLES 32G X 4 MM</b>	Non – Preferred	OTC
<b>COMFORT ASSIST INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>COMFORT EZ INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>COMFORT EZ MICRO PEN NEEDLES</b>	Non – Preferred	OTC
<b>COMFORT EZ PEN NEEDLES</b>	Non – Preferred	OTC
<b>COMFORT EZ PRO PEN NEEDLES</b>	Non – Preferred	OTC
<b>COMFORT EZ SHORT PEN NEEDLES</b>	Non – Preferred	OTC
<b>COMFORT TOUCH INSULIN PEN NEED</b>	Non – Preferred	OTC
<b>DIATHRIVE PEN NEEDLE</b>	Non – Preferred	OTC

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<b>DROPLET INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>DROPLET MICRON</b>	Non – Preferred	OTC
<b>DROPLET PEN NEEDLES</b>	Non – Preferred	OTC
<b>EASY TOUCH FLIPLOCK INSULIN SY</b>	Non – Preferred	OTC
<b>EASY TOUCH FLIPLOCK SAFETY SYR</b>	Preferred	OTC
<b>EASY TOUCH FLURINGE</b>	Preferred	OTC
<b>EASY TOUCH FLURINGE FLIPLOCK</b>	Preferred	OTC
<b>EASY TOUCH FLURINGE SHEATHLOCK</b>	Preferred	OTC
<b>EASY TOUCH INSULIN SAFETY SYR</b>	Non – Preferred	OTC
<b>EASY TOUCH INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>EASY TOUCH PEN NEEDLES</b>	Non – Preferred	OTC
<b>EASY TOUCH SAFETY PEN NEEDLES</b>	Non – Preferred	OTC
<b>EASY TOUCH SAFETY SYRINGE</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 10 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 5 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 22G X 1" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 10 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 5 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 23G X 1" 3 ML</b>	Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>EASY TOUCH SHEATHLOCK SYRINGE 25G X 1" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 25G X 5/8" 3 ML</b>	Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML</b>	Non – Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML</b>	Non – Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML</b>	Non – Preferred	OTC
<b>EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML</b>	Non – Preferred	OTC
<b>EASY TOUCH TB SHEATHLOCK SYR</b>	Preferred	OTC
<b>EMBRACE PEN NEEDLES</b>	Non – Preferred	OTC
<b>FIFTY50 PEN NEEDLES</b>	Non – Preferred	OTC
<b>FIFTY50 SUPERIOR COMFORT SYR</b>	Non – Preferred	OTC
<b>GLUCOPRO INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>GNP ULTIGUARD SAFEPACK NEEDLE</b>	Non – Preferred	OTC
<b>GOODSENSE PEN NEEDLE PENFINE</b>	Non – Preferred	OTC
<b>H-E-B INCONTROL UNIFINE PENTIP</b>	Non – Preferred	OTC
<b>HM ULTICARE INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>HM ULTICARE MINI PEN NEEDLES</b>	Non – Preferred	OTC
<b>HM ULTICARE SHORT PEN NEEDLES</b>	Non – Preferred	OTC
<b>INCONTROL ULTICARE PEN NEEDLES</b>	Non – Preferred	OTC
<b>INSUPEN SENSITIVE</b>	Non – Preferred	OTC
<b>INSUPEN ULTRAFIN</b>	Non – Preferred	OTC
<b>LEADER UNIFINE PENTIPS</b>	Non – Preferred	OTC
<b>LEADER UNIFINE PENTIPS PLUS</b>	Non – Preferred	OTC
<b>LITETOUCH INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>LITETOUCH PEN NEEDLES</b>	Non – Preferred	OTC
<b>LUER LOCK SAFETY SYRINGES</b>	Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>MAGELLAN INSULIN SAFETY SYR</b>	Non – Preferred	
<b>MAGELLAN SYRINGE-SAFETY NEEDLE</b>	Preferred	
<b>MARATHON MEDICAL PENTIPS</b>	Non – Preferred	
<b>MAXICOMFORT II PEN NEEDLE</b>	Non – Preferred	OTC
<b>MAXI-COMFORT INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>MAXI-COMFORT SAFETY PEN NEEDLE</b>	Non – Preferred	OTC
<b>MAXICOMFORT SYR 27G X 1/2"</b>	Non – Preferred	OTC
<b>MICRODOT PEN NEEDLE</b>	Non – Preferred	OTC
<b>MM PEN NEEDLES</b>	Non – Preferred	OTC
<b>MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML</b>	Non – Preferred	OTC
<b>MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (RX)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (OTC)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)</b>	Non – Preferred	
<b>MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML</b>	Non – Preferred	OTC
<b>MONOJECT INSULIN SYRINGE U-100 1 ML</b>	Non – Preferred	
<b>MONOJECT LIFESHIELD SYRINGE</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 18G X 1" 12 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 18G X 1" 6 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML</b>	Preferred	OTC
<b>MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 12 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 6 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1" 12 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1" 6 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 12 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 6 ML</b>	Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>MONOJECT MAGELLAN SYRINGE 22G X 1" 3 ML</b>	Preferred	OTC
<b>MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 12 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 6 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 23G X 1" 1 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 23G X 1" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 25G X 1" 1 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 25G X 1" 3 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 25G X 5/8" 1 ML</b>	Preferred	
<b>MONOJECT MAGELLAN SYRINGE 25G X 5/8" 3 ML</b>	Preferred	
<b>MONOJECT SYRINGE 18G X 1" 12 ML (OTC)</b>	Preferred	
<b>MONOJECT SYRINGE 18G X 1" 12 ML (RX)</b>	Preferred	
<b>MONOJECT SYRINGE 20G X 1" 3 ML</b>	Preferred	
<b>MONOJECT SYRINGE 20G X 1-1/2" 12 ML (OTC)</b>	Preferred	OTC
<b>MONOJECT SYRINGE 20G X 1-1/2" 3 ML</b>	Preferred	
<b>MONOJECT SYRINGE 20G X 1-1/2" 6 ML</b>	Preferred	
<b>MONOJECT SYRINGE 20G X 3/4" 3 ML (RX)</b>	Preferred	
<b>MONOJECT SYRINGE 21G X 1" 3 ML</b>	Preferred	
<b>MONOJECT SYRINGE 21G X 1" 6 ML</b>	Preferred	

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MONOJECT SYRINGE 21G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 21G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 22G X 1" 3 ML	Preferred	OTC
MONOJECT SYRINGE 22G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 22G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 23G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1-1/4" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 5/8" 3 ML	Preferred	
MONOJECT SYRINGE 27G X 1-1/4" 3 ML	Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	

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<b>MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.3 ML</b>	Non – Preferred	OTC
<b>MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.5 ML</b>	Non – Preferred	OTC
<b>NOVOFINE AUTOCOVER PEN NEEDLE</b>	Non – Preferred	OTC
<b>NOVOFINE PEN NEEDLE</b>	Non – Preferred	OTC
<b>NOVOFINE PLUS PEN NEEDLE</b>	Non – Preferred	OTC
<b>PENTIPS 29G X 12MM (OTC)</b>	Non – Preferred	
<b>PENTIPS 29G X 12MM (RX)</b>	Non – Preferred	
<b>PENTIPS 31G X 5 MM (OTC)</b>	Non – Preferred	
<b>PENTIPS 31G X 5 MM (RX)</b>	Non – Preferred	
<b>PENTIPS 31G X 6 MM</b>	Non – Preferred	OTC
<b>PENTIPS 31G X 8 MM (OTC)</b>	Non – Preferred	
<b>PENTIPS 31G X 8 MM (RX)</b>	Non – Preferred	
<b>PENTIPS 32G X 4 MM (OTC)</b>	Non – Preferred	
<b>PENTIPS 32G X 4 MM (RX)</b>	Non – Preferred	
<b>PENTIPS 32G X 6 MM</b>	Non – Preferred	OTC
<b>PRECISION SURE-DOSE SYRINGE</b>	Non – Preferred	OTC
<b>PREVENT DROPSAFE PEN NEEDLES</b>	Non – Preferred	OTC
<b>PREVENT SAFETY PEN NEEDLES</b>	Non – Preferred	OTC
<b>PRO COMFORT INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>PRODIGY INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>RELION INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>RELION MINI PEN NEEDLES</b>	Non – Preferred	OTC
<b>RELION PEN NEEDLES</b>	Non – Preferred	OTC
<b>RELION SHORT PEN NEEDLES</b>	Non – Preferred	OTC
<b>SECURESAFE INSULIN SYRINGE</b>	Non – Preferred	OTC
<b>SECURESAFE SAFETY PEN NEEDLES</b>	Non – Preferred	OTC
<b>SECURESAFE SYRINGE/NEEDLE</b>	Preferred	OTC
<b>TECHLITE PEN NEEDLES</b>	Non – Preferred	OTC

Coverage Requirements and Limits

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Drug Tier

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
TRUEPLUS 5-BEVEL PEN NEEDLES	Preferred	OTC
TRUEPLUS INSULIN SYRINGE	Preferred	OTC
TRUEPLUS PEN NEEDLES	Preferred	OTC
ULTICARE INSULIN SAFETY SYR	Non – Preferred	
ULTICARE INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE	Non – Preferred	OTC
ULTICARE MICRO PEN NEEDLES	Non – Preferred	OTC
ULTICARE MINI PEN NEEDLES	Non – Preferred	OTC
ULTICARE PEN NEEDLES	Non – Preferred	OTC
ULTICARE SHORT PEN NEEDLES	Non – Preferred	OTC
ULTICARE SYRINGE	Preferred	OTC
ULTICARE TUBERCULIN SAFETY SYR	Preferred	OTC
ULTIGUARD SAFEPACK PEN NEEDLE	Non – Preferred	OTC
ULTIGUARD SAFEPACK SYR/NEEDLE	Non – Preferred	OTC
ULTILET PEN NEEDLE	Non – Preferred	OTC
ULTRA FLO INSULIN PEN NEEDLES	Non – Preferred	OTC
ULTRA FLO INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTRA FLO INSULIN SYRINGE	Non – Preferred	OTC
ULTRA THIN PEN NEEDLES	Non – Preferred	OTC
ULTRA-THIN II INS SYR SHORT	Non – Preferred	OTC
ULTRA-THIN II INSULIN SYRINGE	Non – Preferred	OTC
ULTRA-THIN II MINI PEN NEEDLE	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLE SHORT	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLES	Non – Preferred	OTC
UNIFINE PENTIPS	Non – Preferred	OTC
UNIFINE PENTIPS PLUS	Non – Preferred	OTC
UNIFINE SAFECONTROL PEN NEEDLE	Non – Preferred	OTC
UNIFINE ULTRA PEN NEEDLE	Non – Preferred	OTC
VANISHPOINT INSULIN SYRINGE	Non – Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANISHPOINT SAFETY SYRINGE	Preferred	OTC
VANISHPOINT SYRINGE	Preferred	OTC
VERIFINE INSULIN PEN NEEDLE	Non – Preferred	OTC
VERIFINE INSULIN SYRINGE	Non – Preferred	OTC
VERIFINE PLUS PEN NEEDLE	Non – Preferred	OTC
<b><i>*Peak Flow Meters*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>breathe ease peak flow meter</i>	Preferred	OTC
<i>lung perform peak flow meter</i>	Preferred	OTC
<i>peak a-i-r flow meter</i>	Preferred	OTC
<i>peak flow meter universal rang</i>	Preferred	OTC
<i>pure comfort flow meter adult</i>	Preferred	OTC
<i>pure comfort flow meter child</i>	Preferred	OTC
<b>AIRZONE PEAK FLOW METER</b>	Preferred	OTC
<b>ASSESS PEAK FLOW METER</b>	Preferred	OTC
<b>CLEVER CHOICE PEAK FLOW METER</b>	Preferred	OTC
<b>MICROLIFE DIGITAL PEAK FLOW</b>	Preferred	OTC
<b>MINI WRIGHT PEAK FLOW METER</b>	Preferred	OTC
<b>PEAK AIR PEAK FLOW METER</b>	Preferred	OTC
<b>PERSONAL BEST FULL RANGE</b>	Preferred	OTC
<b>PIKO 1</b>	Preferred	OTC
<b>POCKET PEAK FLOW METER</b>	Preferred	OTC
<b>POCKETPEAK PEAK FLOW METER</b>	Preferred	OTC
<b>TRUZONE PEAK FLOW METER</b>	Preferred	
<b><i>*Respiratory Therapy Supplies*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>adult aerosol mask</i>	Preferred	OTC
<i>adult disposable</i>	Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>breathe ease neb mask/child</i>	Preferred	
<i>breathe ease neb mask/infant</i>	Preferred	
<i>co monitor replacement pieces</i>	Preferred	
<i>disposable full range</i>	Preferred	
<i>disposable low range</i>	Preferred	
<i>disposable low range/pediatric</i>	Preferred	
<i>disposable paper</i>	Preferred	OTC
<i>disposable universal range</i>	Preferred	
<i>expiratory mouthpiece</i>	Preferred	OTC
<i>filter air pp</i>	Preferred	
<i>full kit nebulizer set</i>	Preferred	
<i>nebulizer air tube/plugs</i>	Preferred	
<i>nose clip</i>	Preferred	OTC
<i>one-way valved expiratory</i>	Preferred	OTC
<i>one-way valved inspiratory</i>	Preferred	OTC
<i>ped disposable</i>	Preferred	OTC
<i>pediatric mouthpiece</i>	Preferred	OTC
<i>pharmacist choice mask wipes</i>	Preferred	OTC
<i>pillow mask/adult</i>	Preferred	
<i>pillow mask/child</i>	Preferred	
<i>pillow mask/pediatric</i>	Preferred	
<i>replacement air filter</i>	Preferred	
<i>replacement filters</i>	Preferred	OTC
<i>silicone mask/adult</i>	Preferred	
<i>silicone mask/infant</i>	Preferred	
<i>silicone mask/pediatric</i>	Preferred	
<i>sootheneb nbl 100 adult mask</i>	Preferred	OTC
<i>sootheneb nbl 100 child mask</i>	Preferred	OTC
<i>sootheneb nbl 100 med cup</i>	Preferred	OTC

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>sootheneb nbl 100 mesh cap</i>	Preferred	OTC
<i>tubing/wing tip</i>	Preferred	OTC
<b>ACE AEROSOL CLOUD ENHANCER</b>	Preferred	
<b>ACTIVITY POUCH</b>	Preferred	
<b>ADAPTER PED DISPOSABLE</b>	Preferred	OTC
<b>AEROBIKA</b>	Preferred	
<b>AEROTRACH PLUS</b>	Preferred	
<b>AIRS PEDIATRIC AEROSOL MASK</b>	Preferred	
<b>ALL FLOW 1000 PFT FILTER</b>	Preferred	
<b>BUBBLES THE FISH II PEDI MASK</b>	Preferred	OTC
<b>CARETOUCH 2 CPAP HOSE HANGER</b>	Preferred	
<b>CARETOUCH CPAP &amp; BIPAP HOSE</b>	Preferred	
<b>CARETOUCH CPAP MASK WIPES</b>	Preferred	
<b>CARETOUCH CPAP PRE-WASH SOLN</b>	Preferred	
<b>CARETOUCH CPAP TUBE BRUSH</b>	Preferred	
<b>CARETOUCH UNIVERSL CPAP FILTER</b>	Preferred	
<b>EBASE CONTROLLER KIT</b>	Preferred	
<b>FLYP HYPERSONIQ CARTRIDGE</b>	Preferred	OTC
<b>IN-CHECK INSPIRATORY FLOW MTR</b>	Preferred	
<b>KOKO PEAK PRO MOUTHPIECE</b>	Preferred	OTC
<b>LITETOUCH MASK LARGE</b>	Preferred	
<b>ONE FLOW TESTER</b>	Preferred	OTC
<b>PARI ALTERA NEBULIZER HANDSET</b>	Preferred	
<b>PARI BABY CONVERSION KIT</b>	Preferred	
<b>PARI ERAPID NEBULIZER HANDSET</b>	Preferred	
<b>PARI EXPIRATORY FILTER SET</b>	Preferred	
<b>PARI MASK SET</b>	Preferred	
<b>PARI SOFT PLASTIC ADULT MASK</b>	Preferred	
<b>PARI SOFT PLASTIC PED MASK</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRONEB ULTRA FILTER SET	Preferred	OTC
SIDESTREAM ADULT FACE MASK	Preferred	
SIDESTREAM PEDIATRIC FACE MASK	Preferred	
WINDMILL TRAINER	Preferred	
<b><i>*Sanitary Napkins &amp; Tampons*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>cvs maxi overnight</i>	Preferred	OTC
<i>eq maxi long super</i>	Preferred	OTC
<b>ALWAYS MAXI MAXIMUM PROTECTION</b>	Preferred	OTC
<b>ALWAYS PANTILINERS/THONG</b>	Preferred	OTC
<b>ALWAYS ULTRA OVERNIGHT/WINGS</b>	Preferred	OTC
<b>ALWAYS ULTRA THIN</b>	Preferred	OTC
<b>KOTEX CURVED MAXI</b>	Preferred	OTC
<b>KOTEX LIGHTDAYS PANTILINERS</b>	Preferred	OTC
<b>KOTEX MAXI</b>	Preferred	OTC
<b>KOTEX MAXI OVERNITE</b>	Preferred	OTC
<b>KOTEX MAXI WITH WINGS</b>	Preferred	OTC
<b>KOTEX OVERNITE</b>	Preferred	OTC
<b>KOTEX SUPER MAXI</b>	Preferred	OTC
<b>KOTEX THIN MAXI</b>	Preferred	OTC
<b>KOTEX ULTRA COMPACT MAXI</b>	Preferred	OTC
<b>KOTEX ULTRA MAXI OVERNIGHT</b>	Preferred	OTC
<b>KOTEX ULTRA THIN MAXI</b>	Preferred	OTC
<b>KOTEX ULTRA THIN MAXI LONG</b>	Preferred	OTC
<b><i>*Spacer/Aerosol-Holding Chambers &amp; Supplies*** - Medical Supplies And Durable Medical Equipment</i></b>		
<i>breathe ease large</i>	Preferred	
<i>breathe ease medium</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>breathe ease small</i>	Preferred	
<i>eq space chamber anti-static</i>	Preferred	
<i>eq space chamber anti-static l</i>	Preferred	
<i>eq space chamber anti-static m</i>	Preferred	
<i>eq space chamber anti-static s</i>	Preferred	
<b>AEROCHAMBER MINI CHAMBER</b>	Preferred	
<b>AEROCHAMBER MV</b>	Preferred	
<b>AEROCHAMBER PLUS FLO-VU</b>	Preferred	
<b>AEROCHAMBER PLUS FLO-VU LARGE</b>	Preferred	
<b>AEROCHAMBER PLUS FLO-VU MEDIUM</b>	Preferred	
<b>AEROCHAMBER PLUS FLO-VU SMALL</b>	Preferred	
<b>AEROCHAMBER PLUS FLO-VU W/MASK</b>	Preferred	
<b>AEROCHAMBER PLUS FLOW VU</b>	Preferred	
<b>AEROCHAMBER W/FLOWSIGNAL</b>	Preferred	
<b>AEROCHAMBER Z-STAT PLUS</b>	Preferred	
<b>AEROCHAMBER Z-STAT PLUS CHAMBR</b>	Preferred	
<b>AEROCHAMBER Z-STAT PLUS/LARGE</b>	Preferred	
<b>AEROCHAMBER Z-STAT PLUS/MEDIUM</b>	Preferred	
<b>CLEVER CHOICE HOLDING CHAMBER</b>	Preferred	
<b>COMPACT SPACE CHAMBER</b>	Preferred	
<b>COMPACT SPACE CHAMBER/LG MASK</b>	Preferred	
<b>COMPACT SPACE CHAMBER/MED MASK</b>	Preferred	
<b>EASIVENT</b>	Preferred	
<b>EASIVENT MASK LARGE</b>	Preferred	
<b>EASIVENT MASK MEDIUM</b>	Preferred	
<b>EASIVENT MASK SMALL</b>	Preferred	
<b>FLEXICHAMBER</b>	Preferred	
<b>FLEXICHAMBER ADULT MASK/SMALL</b>	Preferred	
<b>FLEXICHAMBER CHILD MASK/LARGE</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLEXICHAMBER CHILD MASK/SMALL	Preferred	
INSPIREASE	Preferred	
MASK VORTEX/CHILD/FROG	Preferred	OTC
MASK VORTEX/TODDLER/LADYBUG	Preferred	OTC
PANDA MASK LARGE	Preferred	OTC
PANDA MASK MEDIUM	Preferred	OTC
PANDA MASK SMALL	Preferred	OTC
PARI VORTEX ADULT MASK	Preferred	OTC
PEDIATRIC PANDA MASK	Preferred	OTC
VORTEX HOLD CHMBR/MASK/CHILD	Preferred	
<b>*Migraine Products* - Drugs For The Nervous System</b>		
<b><i>*Calcitonin Gene-Related Peptide Receptor Antag (Cgrp)*** - Drugs For Migraine Headaches</i></b>		
NURTEC	Preferred	PA
QULIPTA	Preferred	PA
UBRELVY	Preferred	PA; QL (50 EA per 365 days)
ZAVZPRET	Non – Preferred	
<b><i>*Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For Migraine Headaches</i></b>		
AIMOVIG	Preferred	PA
AJOVY	Preferred	PA
EMGALITY	Preferred	PA
EMGALITY (300 MG DOSE)	Preferred	PA
VYEPTI	Non – Preferred	
<b><i>*Ergot Combinations*** - Drugs For Migraine Headaches</i></b>		
MIGERGOT	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Migraine Products - Cyclooxygenase 2 (Cox-2) Inhibitors*** - Drugs For Migraine Headaches</b>		
ELYXYB	Non – Preferred	
<b>*Migraine Products - Nsaids*** - Drugs For Migraine Headaches</b>		
<i>diclofenac potassium(migraine)</i>	Non – Preferred	
<b>*Migraine Products*** - Drugs For Migraine Headaches</b>		
<i>dihydroergotamine mesylate</i>	Non – Preferred	
MIGRANAL	Non – Preferred	
TRUDHESA	Non – Preferred	
<b>*Selective Serotonin Agonist-Nsaid Combinations*** - Drugs For Migraine Headaches</b>		
<i>sumatriptan-naproxen sodium</i>	Non – Preferred	
<b>*Selective Serotonin Agonists 5-Ht(1)*** - Drugs For Migraine Headaches</b>		
<i>almotriptan malate</i>	Non – Preferred	
<i>eletriptan hydrobromide</i>	Non – Preferred	
<i>frovatriptan succinate</i>	Non – Preferred	
<i>naratriptan hcl</i>	Non – Preferred	
<i>rizatriptan benzoate oral tablet</i>	Preferred	QL (9 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 10 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>rizatriptan benzoate tablet dispersible 5 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan solution 20 mg/lact nasal</i>	Preferred	QL (6 EA per 30 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>sumatriptan solution 5 mg/act nasal</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan succinate refill solution cartridge 4 mg/0.5ml subcutaneous</i>	Preferred	QL (4 ML per 28 days)
<i>sumatriptan succinate refill solution cartridge 6 mg/0.5ml subcutaneous</i>	Preferred	QL (4 VIAL per 30 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml subcutaneous</i>	Preferred	QL (4 EA per 28 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous</i>	Preferred	QL (4 VIAL per 30 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution</i>	Preferred	QL (4 VIAL per 28 days)
<i>sumatriptan succinate tablet 100 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 25 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>sumatriptan succinate tablet 50 mg oral</i>	Preferred	QL (9 EA per 30 days)
<i>zolmitriptan</i>	Non – Preferred	
<b>FROVA</b>	Non – Preferred	
<b>IMITREX NASAL</b>	Non – Preferred	QL (6 EA per 30 days)
<b>IMITREX ORAL</b>	Non – Preferred	QL (9 EA per 30 days)
<b>IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (4 ML per 28 days)
<b>IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (4 VIAL per 30 days)
<b>IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (4 EA per 28 days)
<b>IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS</b>	Non – Preferred	QL (4 VIAL per 30 days)
<b>MAXALT</b>	Non – Preferred	QL (9 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAXALT-MLT TABLET DISPERSIBLE 10 MG ORAL	Non – Preferred	QL (9 EA per 30 days)
RELPAK	Non – Preferred	
TOSYMRA	Non – Preferred	
ZEMBRACE SYMTOUCH	Non – Preferred	
ZOMIG	Non – Preferred	
<b>*Selective Serotonin Agonists 5-Ht(1F)*** - Drugs For Migraine Headaches</b>		
REYVOW	Non – Preferred	
<b>*Minerals &amp; Electrolytes* - Drugs For Nutrition</b>		
<b>*Calcium*** - Drugs For Nutrition</b>		
<i>calcium carbonate oral tablet</i>	Preferred	OTC
<i>calcium carbonate oral tablet chewable</i>	Preferred	OTC
<b>*Electrolytes Oral*** - Drugs For Nutrition</b>		
ORALYTE	Preferred	OTC
REHYDRALYTE	Preferred	OTC
<b>*Fluoride*** - Drugs For Nutrition</b>		
<i>sodium fluoride</i>	Preferred	
<b>*Magnesium*** - Drugs For Nutrition</b>		
<i>magnesium oxide -mg supplement</i>	Preferred	OTC
<b>*Phosphate*** - Drugs For Nutrition</b>		
PHOSPHA 250 NEUTRAL	Preferred	
PHOSPHO-TRIN 250 NEUTRAL	Preferred	
<b>*Potassium*** - Drugs For Nutrition</b>		
<i>potassium chloride</i>	Preferred	
<i>potassium chloride crys er</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>potassium chloride er</i>	Preferred	
<b>EFFER-K</b>	Preferred	
<b>KLOR-CON</b>	Preferred	
<b>KLOR-CON 10</b>	Preferred	
<b>KLOR-CON M10</b>	Preferred	
<b>KLOR-CON M15</b>	Preferred	
<b>KLOR-CON M20</b>	Preferred	
<b>KLOR-CON/EF</b>	Preferred	
<b>K-PRIME</b>	Preferred	
<b>*Sodium*** - Drugs For Nutrition</b>		
<i>sodium chloride</i>	Preferred	
<i>sodium chloride (pf)</i>	Preferred	
<b>*Miscellaneous Therapeutic Classes* - Vitamins And Minerals</b>		
<b>*Antileptotics*** - Vitamins And Minerals</b>		
<b>THALOMID</b>	Non – Preferred	
<b>*B-Lymphocyte Stimulator (Blys)- Specific Inhibitors*** - Vitamins And Minerals</b>		
<b>BENLYSTA</b>	Non – Preferred	
<b>*Chelating Agents*** - Vitamins And Minerals</b>		
<i>penicillamine</i>	Preferred	
<i>trientine hcl</i>	Preferred	
<b>CUPRIMINE</b>	Non – Preferred	
<b>CUVRIOR</b>	Non – Preferred	
<b>DEPEN TITRATABS</b>	Preferred	
<b>SYPRINE</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Cyclosporine Analogs*** - Vitamins And Minerals</b>		
<i>cyclosporine</i>	Preferred	
<i>cyclosporine modified</i>	Preferred	
<b>GENGRAF</b>	Preferred	
<b>LUPKYNIS</b>	Non – Preferred	
<b>NEORAL</b>	Non – Preferred	
<b>SANDIMMUNE ORAL CAPSULE</b>	Non – Preferred	
<b>SANDIMMUNE ORAL SOLUTION</b>	Preferred	
<b>*Immunomodulators - Combinations*** - Vitamins And Minerals</b>		
<b>VYVGART HYTRULO</b>	Non – Preferred	
<b>*Immunomodulators For Myelodysplastic Syndromes*** - Vitamins And Minerals</b>		
<i>lenalidomide capsule 10 mg oral</i>	Non – Preferred	
<i>lenalidomide capsule 10 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lenalidomide capsule 15 mg oral</i>	Non – Preferred	
<i>lenalidomide capsule 15 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lenalidomide capsule 2.5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lenalidomide capsule 20 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lenalidomide capsule 25 mg oral</i>	Non – Preferred	
<i>lenalidomide capsule 25 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>lenalidomide capsule 5 mg oral</i>	Non – Preferred	
<i>lenalidomide capsule 5 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<b>REVLIMID</b>	Non – Preferred	

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>*Inosine Monophosphate Dehydrogenase Inhibitors*** - Vitamins And Minerals</i></b>		
<i>mycophenolate mofetil</i>	Preferred	
<i>mycophenolate sodium</i>	Preferred	
<b>CELLCEPT</b>	Non – Preferred	
<b>MYFORTIC TABLET DELAYED RELEASE 180 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>MYFORTIC TABLET DELAYED RELEASE 360 MG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)
<b><i>*Macrolide Immunosuppressants*** - Vitamins And Minerals</i></b>		
<i>everolimus</i>	Non – Preferred	
<i>sirolimus</i>	Preferred	
<i>tacrolimus</i>	Preferred	
<b>ASTAGRAF XL</b>	Non – Preferred	
<b>ENVARBUS XR</b>	Non – Preferred	
<b>PROGRAF</b>	Non – Preferred	
<b>RAPAMUNE</b>	Non – Preferred	
<b>ZORTRESS</b>	Non – Preferred	
<b><i>*Neonatal Fc Receptor (Fc<math>\gamma</math>n) Antagonists*** - Vitamins And Minerals</i></b>		
<b>RYSTIGGO</b>	Non – Preferred	
<b>VYVGART</b>	Non – Preferred	
<b><i>*Potassium Removing Agents*** - Vitamins And Minerals</i></b>		
<i>sodium polystyrene sulfonate</i>	Preferred	
<b>LOKELMA</b>	Non – Preferred	
<b>SPS</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VELTASSA	Non – Preferred	
<b><i>*Purine Analogs*** - Vitamins And Minerals</i></b>		
<i>azathioprine tablet 100 mg oral</i>	Non – Preferred	
<i>azathioprine tablet 50 mg oral</i>	Preferred	
<i>azathioprine tablet 75 mg oral</i>	Non – Preferred	
AZASAN	Non – Preferred	
IMURAN	Non – Preferred	
<b><i>*Rock Inhibitors*** - Vitamins And Minerals</i></b>		
REZUROCK	Non – Preferred	
<b>*Mouth/Throat/Dental Agents* - Drugs For The Mouth And Throat</b>		
<b><i>*Anesthetics Topical Oral*** - Drugs For The Mouth And Throat</i></b>		
<i>lidocaine hcl</i>	Preferred	
<i>lidocaine viscous hcl</i>	Preferred	
<b><i>*Anti-Infectives - Throat*** - Drugs For The Mouth And Throat</i></b>		
<i>clotrimazole</i>	Preferred	
<i>nystatin</i>	Preferred	QL (120 ML Max Qty Per Fill Retail)
ORAVIG	Non – Preferred	
<b><i>*Antiseptics - Mouth/Throat*** - Drugs For The Mouth And Throat</i></b>		
<i>chlorhexidine gluconate</i>	Preferred	
<b><i>*Dry Mouth Agents And Artificial Saliva*** - Drugs For The Mouth And Throat</i></b>		
AQUORAL	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Fluoride Dental Products*** - Drugs For The Mouth And Throat</b>		
<i>sodium fluoride</i>	Non – Preferred	
<i>sodium fluoride 5000 plus</i>	Non – Preferred	
<i>sodium fluoride 5000 ppm</i>	Non – Preferred	
<b>DENTA 5000 PLUS</b>	Non – Preferred	
<b>DENTAGEL</b>	Non – Preferred	
<b>*Protectants - Mouth/Throat*** - Drugs For The Mouth And Throat</b>		
<b>GELX</b>	Non – Preferred	
<b>*Saliva Stimulants*** - Drugs For The Mouth And Throat</b>		
<i>cevimeline hcl</i>	Non – Preferred	
<i>pilocarpine hcl</i>	Preferred	
<b>EVOXAC</b>	Non – Preferred	
<b>*Steroids - Mouth/Throat/Dental*** - Drugs For The Mouth And Throat</b>		
<i>triamcinolone acetonide</i>	Preferred	
<b>ORALONE</b>	Preferred	
<b>*Multivitamins* - Drugs For Nutrition</b>		
<b>*B-Complex W/ C &amp; Folic Acid*** - Drugs For Nutrition</b>		
<b>DIALYVITE</b>	Preferred	
<b>GENICIN VITA-S</b>	Preferred	
<b>RENAL</b>	Preferred	
<b>*Multiple Vitamins W/ Calcium*** - Drugs For Nutrition</b>		
<i>essential one daily multivit</i>	Preferred	OTC
<i>sm one daily essential</i>	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE-A-DAY WOMENS FORMULA	Preferred	OTC
<b>*Multiple Vitamins W/ Iron*** - Drugs For Nutrition</b>		
<i>multi-vitamin/iron</i>	Preferred	OTC
<b>*Multiple Vitamins W/ Minerals*** - Drugs For Nutrition</b>		
<i>i-vite</i>	Preferred	OTC
<i>multipro</i>	Preferred	
KP VISION FORMULA	Preferred	OTC
MULTI COMPLETE	Preferred	OTC
<b>*Multivitamins*** - Drugs For Nutrition</b>		
ONE DAILY ESSENTIAL	Preferred	OTC
ONE-A-DAY ADULT VITACRAVES+DHA	Preferred	OTC
<b>*Ped Multi Vitamins W/Fl &amp; Fe*** - Drugs For Nutrition</b>		
<i>multi-vit/iron/fluoride</i>	Preferred	OTC; AL (Max 13 Years)
<i>multi-vitamin/fluoride/iron</i>	Preferred	AL (Max 13 Years)
<b>*Ped Mv W/ Fluoride*** - Drugs For Nutrition</b>		
<i>multivitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	OTC; AL (Min 13 Years)
<i>multivitamin/fluoride oral solution 0.5 mg/ml</i>	Preferred	OTC; AL (Max 13 Years)
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 0.25 mg oral (rx)</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 0.5 mg oral (rx)</i>	Preferred	AL (Max 13 Years)
<i>multivitamin/fluoride tablet chewable 1 mg oral (rx)</i>	Preferred	AL (Max 13 Years)

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<i>poly-vitamin/fluoride</i>	Preferred	AL (Max 13 Years)
<b>QUFLORA PEDIATRIC</b>	Preferred	AL (Max 13 Years)
<b>*Ped Mv W/ Iron*** - Drugs For Nutrition</b>		
<b>FLINTSTONES W/IRON</b>	Preferred	OTC; AL (Max 13 Years)
<b>*Ped Vitamins Acd W/ Fluoride*** - Drugs For Nutrition</b>		
<i>adclf (0.5mg/ml)</i>	Preferred	AL (Max 13 Years)
<i>tri-vitamin/fluoride</i>	Preferred	AL (Max 13 Years)
<i>tri-vite/fluoride</i>	Preferred	AL (Max 13 Years)
<i>vitamins acd-fluoride</i>	Preferred	AL (Max 13 Years)
<b>*Pediatric Multiple Vitamins*** - Drugs For Nutrition</b>		
<i>childrens chewable vitamins</i>	Preferred	OTC; AL (Max 13 Years)
<b>FLINTSTONES PLUS CALCIUM</b>	Preferred	OTC; AL (Max 13 Years)
<b>*Prenatal Mv &amp; Min W/Fe-Fa*** - Drugs For Nutrition</b>		
<i>c-nate dha</i>	Non – Preferred	
<i>completenate</i>	Preferred	QL (100 EA per 90 days)
<i>m-natal plus</i>	Preferred	QL (100 EA per 90 days)
<i>natal pnv</i>	Non – Preferred	
<i>pnv-omega</i>	Non – Preferred	
<i>pnv-select</i>	Non – Preferred	
<i>prenatal</i>	Preferred	QL (100 EA per 90 days)
<i>prenatal plus vitamin/mineral</i>	Preferred	QL (100 EA per 90 days)
<i>relnate dha</i>	Non – Preferred	
<i>se-natal 19</i>	Preferred	QL (100 EA per 90 days)
<i>thrivite rx</i>	Preferred	
<i>trinatal rx 1</i>	Preferred	QL (100 EA per 90 days)

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<i>wescap-c dha</i>	Non – Preferred	QL (100 EA per 90 days)
<i>wesnate dha</i>	Non – Preferred	
<i>westab plus</i>	Preferred	QL (100 EA per 90 days)
<b>CITRANATAL B-CALM</b>	Non – Preferred	
<b>DERMACINRX PRETRATE</b>	Non – Preferred	
<b>ELITE-OB</b>	Preferred	
<b>ENBRACE HR</b>	Non – Preferred	
<b>FOLIVANE-OB</b>	Non – Preferred	QL (90 EA per 100 days)
<b>NESTABS</b>	Non – Preferred	
<b>NESTABS DHA</b>	Non – Preferred	
<b>NIVA-PLUS</b>	Preferred	QL (100 EA per 90 days)
<b>OB COMPLETE</b>	Preferred	
<b>OB COMPLETE ONE</b>	Non – Preferred	
<b>OB COMPLETE PETITE</b>	Non – Preferred	
<b>OB COMPLETE PREMIER</b>	Non – Preferred	
<b>OB COMPLETE/DHA</b>	Non – Preferred	
<b>PRENATE ELITE</b>	Non – Preferred	
<b>PRENATRIX</b>	Non – Preferred	QL (100 EA per 90 days)
<b>PRENATRYL</b>	Non – Preferred	QL (100 EA per 90 days)
<b>PRIMACARE</b>	Non – Preferred	
<b>SELECT-OB</b>	Non – Preferred	
<b>TARON-C DHA</b>	Non – Preferred	QL (100 EA per 90 days)
<b>VINATE DHA RF</b>	Non – Preferred	
<b>VITAFOL GUMMIES</b>	Non – Preferred	
<b>VITAFOL-NANO</b>	Non – Preferred	
<b>VITAFOL-OB</b>	Preferred	QL (1 EA per 1 day)
<b>VITAPEARL</b>	Non – Preferred	

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<b>*Prenatal Mv &amp; Min WIFe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition</b>		
<i>complete natal dha</i>	Non – Preferred	QL (100 EA per 90 days)
<i>wesnatal dha complete</i>	Non – Preferred	QL (100 EA per 90 days)
<b>*Prenatal Mv &amp; Min WIFe-Fa-Dha*** - Drugs For Nutrition</b>		
<i>pnv-dha</i>	Non – Preferred	
<i>pnv-dha+docusate</i>	Non – Preferred	
<i>prenaissance</i>	Non – Preferred	
<i>prenaissance plus</i>	Non – Preferred	
<i>tristart dha</i>	Non – Preferred	
<i>wescap-pn dha</i>	Non – Preferred	
<i>westgel dha</i>	Non – Preferred	
<b>CITRANATAL 90 DHA</b>	Non – Preferred	
<b>CITRANATAL ASSURE</b>	Non – Preferred	
<b>CITRANATAL HARMONY</b>	Non – Preferred	
<b>CITRANATAL MEDLEY</b>	Non – Preferred	
<b>NESTABS ONE</b>	Non – Preferred	
<b>PRENATE DHA</b>	Non – Preferred	
<b>PRENATE ENHANCE</b>	Non – Preferred	
<b>PRENATE ESSENTIAL</b>	Non – Preferred	
<b>PRENATE MINI</b>	Non – Preferred	
<b>PRENATE PIXIE</b>	Non – Preferred	
<b>PRENATE RESTORE</b>	Non – Preferred	
<b>SELECT-OB+DHA</b>	Non – Preferred	
<b>VITAFOL FE+</b>	Non – Preferred	
<b>VITAFOL ULTRA</b>	Non – Preferred	
<b>VITAFOL-OB+DHA</b>	Non – Preferred	
<b>VITAFOL-ONE</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMEDMD ONE RX/QUATREFOLIC	Non – Preferred	
<b>*Prenatal Mv &amp; Minerals WIFa Without Iron*** - Drugs For Nutrition</b>		
PRENATE	Non – Preferred	
<b>*Prenatal Vitamins*** - Drugs For Nutrition</b>		
PREMESISRX	Non – Preferred	
PRENATE AM	Non – Preferred	
VITAFOL STRIPS	Non – Preferred	
<b>*Specialty Vitamins Products*** - Drugs For Nutrition</b>		
<i>biotin plus keratin</i>	Preferred	OTC
<i>healthy heart complex</i>	Preferred	OTC
CENTRUM SPECIALIST ENERGY	Preferred	OTC
<b>*Musculoskeletal Therapy Agents* - Drugs For Muscles, Ligaments, Tendons, And Bones</b>		
<b>*Central Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones</b>		
<i>baclofen oral solution</i>	Non – Preferred	
<i>baclofen oral suspension</i>	Preferred	
<i>baclofen oral tablet</i>	Preferred	QL (4 EA per 1 day)
<i>carisoprodol tablet 250 mg oral</i>	Non – Preferred	
<i>carisoprodol tablet 350 mg oral</i>	Non – Preferred	
<i>carisoprodol tablet 350 mg oral</i>	Non – Preferred	QL (3 EA per 1 day)
<i>chlorzoxazone</i>	Preferred	
<i>cyclobenzaprine hcl er</i>	Non – Preferred	
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	QL (3 EA per 1 day)

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<i>cyclobenzaprine hcl tablet 7.5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>metaxalone</i>	Non – Preferred	
<i>methocarbamol</i>	Preferred	QL (4 EA per 1 day)
<i>orphenadrine citrate er</i>	Preferred	QL (2 EA per 1 day)
<i>tizanidine hcl oral capsule</i>	Non – Preferred	
<i>tizanidine hcl tablet 2 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>tizanidine hcl tablet 4 mg oral</i>	Preferred	QL (6 EA per 1 day)
<b>AMRIX</b>	Non – Preferred	
<b>FEXMID</b>	Preferred	QL (4 EA per 1 day)
<b>FLEQSUVY</b>	Non – Preferred	
<b>LORZONE</b>	Preferred	
<b>LYVISPAH</b>	Non – Preferred	
<b>SOMA TABLET 250 MG ORAL</b>	Non – Preferred	
<b>SOMA TABLET 350 MG ORAL</b>	Non – Preferred	QL (3 EA per 1 day)
<b>ZANAFLEX ORAL CAPSULE</b>	Non – Preferred	
<b>ZANAFLEX ORAL TABLET</b>	Non – Preferred	QL (6 EA per 1 day)
<b><i>*Direct Muscle Relaxants*** - Drugs For Muscles, Ligaments, Tendons, And Bones</i></b>		
<i>dantrolene sodium</i>	Preferred	QL (4 EA per 1 day)
<b>DANTRIUM</b>	Non – Preferred	QL (4 EA per 1 day)
<b><i>*Muscle Relaxant Combinations*** - Drugs For Muscles, Ligaments, Tendons, And Bones</i></b>		
<i>norgesic forte</i>	Non – Preferred	
<i>orphenadrine-aspirin-caffeine</i>	Preferred	
<b>NORGESIC</b>	Preferred	
<b>ORPHENGESIC FORTE</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Retinoic Acid Receptor Gamma Selective Agonists*** - Drugs For Muscles, Ligaments, Tendons, And Bones</b>		
SOHONOS	Non – Preferred	
<b>*Nasal Agents - Systemic And Topical* - Drugs For The Nose</b>		
<b>*Antihistamine-Steroid*** - Allergy</b>		
<i>azelastine-fluticasone</i>	Non – Preferred	
DYMISTA	Non – Preferred	
<b>*Nasal Agents - Misc.*** - Allergy</b>		
<i>saline nasal spray</i>	Preferred	OTC
<b>*Nasal Anticholinergics*** - Allergy</b>		
<i>ipratropium bromide solution 0.03 % nasal</i>	Non – Preferred	
<i>ipratropium bromide solution 0.06 % nasal</i>	Non – Preferred	QL (15 ML per 30 days)
<b>*Nasal Antihistamines*** - Allergy</b>		
<i>azelastine hcl solution 0.1 % nasal</i>	Preferred	QL (30 ML per 30 days)
<i>azelastine hcl solution 0.15 % nasal</i>	Preferred	
<i>azelastine hcl solution 137 mcg/spray nasal</i>	Preferred	QL (30 ML per 30 days)
<i>olopatadine hcl</i>	Preferred	
<b>*Nasal Mast Cell Stabilizers*** - Allergy</b>		
<i>cromolyn sodium</i>	Preferred	OTC
<b>*Nasal Steroids*** - Allergy</b>		
<i>flunisolide</i>	Preferred	QL (1.6667 ML per 1 day)
<i>fluticasone propionate</i>	Preferred	QL (16 GM Max Qty Per Fill Retail)
<i>mometasone furoate</i>	Non – Preferred	QL (1.1333 GM per 1 day)
OMNARIS	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROPEL MINI SDS	Non – Preferred	
QNASL	Non – Preferred	
QNASL CHILDRENS	Non – Preferred	
SINUVA	Non – Preferred	
XHANCE	Non – Preferred	
ZETONNA	Non – Preferred	
<b>*Systemic Decongestants*** - Allergy</b>		
<i>phenylephrine hcl</i>	Preferred	OTC
<i>pseudoephedrine hcl er</i>	Preferred	OTC
<i>pseudoephedrine hcl oral tablet 30 mg</i>	Preferred	OTC
<i>pseudoephedrine hcl oral tablet 60 mg</i>	Preferred	
SUDOGEST	Preferred	
<b>*Neuromuscular Agents* - Drugs For Nerves And Muscles</b>		
<b>*Als Agent Combinations*** - Drugs For Nerves And Muscles</b>		
RELYVRIO	Non – Preferred	
<b>*Als Agents - Miscellaneous*** - Drugs For Nerves And Muscles</b>		
RADICAVA ORS	Non – Preferred	
RADICAVA ORS STARTER KIT	Non – Preferred	
<b>*Benzothiazoles*** - Drugs For Nerves And Muscles</b>		
<i>riluzole</i>	Preferred	
EXSERVAN	Non – Preferred	
RILUTEK	Non – Preferred	
TIGLUTIK	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Rett Syndrome Agents - Glycine-Proline-Glutamate Analogs*** - Drugs For Nerves And Muscles</b>		
DAYBUE	Non – Preferred	
<b>*Nutrients* - Drugs For Nutrition</b>		
<b>*Carbohydrates*** - Drugs For Nutrition</b>		
<i>dextrose</i>	Preferred	
<b>*Ophthalmic Agents* - Drugs For The Eye</b>		
<b>*Alpha Adrenergic Agonist &amp; Carbonic Anhydrase Inhib Comb*** - Drugs For Glaucoma</b>		
SIMBRINZA	Non – Preferred	
<b>*Artificial Tear And Lubricant Combinations*** - Drugs For The Eye</b>		
<i>eye lubricant</i>	Preferred	OTC
EQ RESTORE PM	Preferred	OTC
GENTEAL TEARS NIGHT-TIME	Preferred	OTC
<b>*Artificial Tear Inserts*** - Drugs For The Eye</b>		
LACRISERT	Preferred	
<b>*Artificial Tear Solutions*** - Drugs For The Eye</b>		
<i>just tears eye drops</i>	Preferred	OTC
<i>sm artificial tears</i>	Preferred	OTC
GENTEAL TEARS	Preferred	OTC

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Artificial Tears And Lubricants*** - Drugs For The Eye</b>		
<i>polyvinyl alcohol</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
<b>*Beta-Blockers - Ophthalmic Combinations*** - Drugs For Glaucoma</b>		
<i>brimonidine tartrate-timolol solution 0.2-0.5 % ophthalmic</i>	Non – Preferred	QL (10 ML per 30 days)
<i>brimonidine tartrate-timolol solution 0.2-0.5 % ophthalmic</i>	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>dorzolamide hcl-timolol mal</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>dorzolamide hcl-timolol mal pf</i>	Non – Preferred	
<b>COMBIGAN</b>	Non – Preferred	QL (10 ML per 30 days)
<b>COSOPT</b>	Non – Preferred	QL (10 ML per 150 days)
<b>COSOPT PF</b>	Non – Preferred	
<b>*Beta-Blockers - Ophthalmic*** - Drugs For Glaucoma</b>		
<i>betaxolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>carteolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>levobunolol hcl</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate (once-daily)</i>	Preferred	
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	QL (5 ML per 1 day)
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>timolol maleate ophthalmic solution</i>	Preferred	QL (10 ML per 30 days)
<i>timolol maleate pf</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETIMOL	Non – Preferred	
BETOPTIC-S	Non – Preferred	
ISTALOL	Non – Preferred	
TIMOLOL MALEATE OCUDOSE	Non – Preferred	
TIMOPTIC OCUDOSE	Non – Preferred	
<b>*Cycloplegic Mydriatic Combinations*** - Drugs For The Eye</b>		
CYCLOMYDRIL	Preferred	
<b>*Cycloplegic Mydriatics*** - Drugs For The Eye</b>		
<i>atropine sulfate ointment 1 % ophthalmic</i>	Preferred	QL (3.5 GM per 30 days)
<i>atropine sulfate ophthalmic solution</i>	Preferred	QL (5 ML per 30 days)
<i>cyclopentolate hcl</i>	Preferred	QL (6 ML per 30 days)
<i>phenylephrine hcl ophthalmic solution 2.5 %</i>	Non – Preferred	QL (2 EA per 30 days)
<i>phenylephrine hcl solution 10 % ophthalmic</i>	Non – Preferred	
<i>phenylephrine hcl solution 2.5 % ophthalmic</i>	Non – Preferred	QL (2 EA per 30 days)
<i>tropicamide</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)
<b>CYCLOGYL SOLUTION 0.5 % OPTHALMIC</b>	Non – Preferred	
<b>CYCLOGYL SOLUTION 1 % OPTHALMIC</b>	Non – Preferred	QL (6 ML per 30 days)
<b>CYCLOGYL SOLUTION 2 % OPTHALMIC</b>	Non – Preferred	QL (5 ML per 30 days)
<b>MYDRIACYL</b>	Non – Preferred	QL (15 ML Max Qty Per Fill Retail)
<b>*Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag*** - Anti-Infective/Anti-Inflammatories</b>		
XIIDRA	Non – Preferred	

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<b>*Miotics - Cholinesterase Inhibitors*** - Drugs For Glaucoma</b>		
PHOSPHOLINE IODIDE	Non – Preferred	
<b>*Miotics - Direct Acting*** - Drugs For Glaucoma</b>		
<i>pilocarpine hcl solution 1 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>pilocarpine hcl solution 2 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
<i>pilocarpine hcl solution 4 % ophthalmic</i>	Preferred	QL (15 ML per 30 days)
VUITY	Non – Preferred	
<b>*Ophthalmic Antiallergic*** - Drugs For Itchy Eye</b>		
<i>azelastine hcl</i>	Preferred	QL (6 ML Max Qty Per Fill Retail)
<i>bepotastine besilate</i>	Non – Preferred	
<i>cromolyn sodium</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>epinastine hcl</i>	Non – Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Non – Preferred	QL (5 ML per 30 days)
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Non – Preferred	
<b>ALOCRI</b>	Non – Preferred	
<b>ALOMIDE</b>	Non – Preferred	
<b>BEPREVE</b>	Non – Preferred	
<b>ZERVIATE</b>	Non – Preferred	
<b>*Ophthalmic Antibiotics*** - Anti-Infective/Anti-Inflammatories</b>		
<i>bacitracin</i>	Preferred	
<i>ciprofloxacin hcl</i>	Preferred	QL (5 ML per 30 days)
<i>erythromycin</i>	Preferred	

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<i>gatifloxacin</i>	Non – Preferred	
<i>gentamicin sulfate</i>	Preferred	QL (5 ML per 30 days)
<i>moxifloxacin hcl</i>	Non – Preferred	
<i>moxifloxacin hcl (2x day)</i>	Non – Preferred	
<i>ofloxacin solution 0.3 % ophthalmic</i>	Preferred	QL (5 ML per 30 days)
<i>tobramycin</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<b>AZASITE</b>	Non – Preferred	
<b>BESIVANCE</b>	Non – Preferred	
<b>CILOXAN</b>	Preferred	QL (3.5 GM per 30 days)
<b>OCUFLOX</b>	Non – Preferred	QL (5 ML per 30 days)
<b>VIGAMOX</b>	Non – Preferred	
<b>ZYMAXID</b>	Non – Preferred	
<b>*Ophthalmic Antifungal*** - Drugs For The Eye</b>		
<b>NATACYN</b>	Non – Preferred	
<b>*Ophthalmic Anti-Infective Combinations*** - Anti-Infective/Anti-Inflammatories</b>		
<i>bacitracin-polymyxin b</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx ointment 3.5-400-10000 ophthalmic</i>	Preferred	
<i>neomycin-bacitracin zn-polymyx ointment 5-400-10000 ophthalmic</i>	Preferred	QL (7 GM per 30 days)
<i>neomycin-polymyxin-gramicidin</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<i>polymyxin b-trimethoprim</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<b>NEO-POLYCIN</b>	Preferred	QL (7 GM per 30 days)
<b>POLYCIN</b>	Preferred	

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<b>*Ophthalmic Antiseptics*** - Anti-Infective/Anti-Inflammatories</b>		
BETADINE OPHTHALMIC PREP	Non – Preferred	
<b>*Ophthalmic Antivirals*** - Anti-Infective/Anti-Inflammatories</b>		
<i>trifluridine</i>	Preferred	QL (7.5 ML Max Qty Per Fill Retail)
ZIRGAN	Preferred	
<b>*Ophthalmic Carbonic Anhydrase Inhibitors*** - Drugs For Glaucoma</b>		
<i>brinzolamide</i>	Non – Preferred	QL (10 ML per 30 days)
<i>dorzolamide hcl</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
AZOPT	Non – Preferred	QL (10 ML per 30 days)
<b>*Ophthalmic Decongestants*** - Drugs For Itchy Eye</b>		
<i>redness reliever eye drops</i>	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
<i>sm eye drops</i>	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
<b>*Ophthalmic Diagnostic Products*** - Drugs For The Eye</b>		
<i>fluorescein sodium/benoxinate</i>	Non – Preferred	
GLOSTRIPS	Non – Preferred	
<b>*Ophthalmic Immunomodulators*** - Anti-Infective/Anti-Inflammatories</b>		
<i>cyclosporine</i>	Non – Preferred	
CEQUA	Non – Preferred	
RESTASIS	Non – Preferred	
RESTASIS MULTIDOSE	Non – Preferred	

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<b>*Ophthalmic Kinase Inhibitors - Combinations*** - Drugs For Glaucoma</b>		
<b>ROCKLATAN</b>	Non – Preferred	
<b>*Ophthalmic Local Anesthetics*** - Drugs For The Eye</b>		
<i>proparacaine hcl</i>	Non – Preferred	
<i>tetracaine hcl</i>	Non – Preferred	
<b>AKTEN</b>	Non – Preferred	
<b>ALCAINE</b>	Non – Preferred	
<b>*Ophthalmic Nerve Growth Factors*** - Drugs For The Eye</b>		
<b>OXERVATE</b>	Non – Preferred	
<b>*Ophthalmic Nonsteroidal Anti-Inflammatory Agents*** - Anti-Infective/Anti-Inflammatories</b>		
<i>bromfenac sodium (once-daily)</i>	Non – Preferred	
<i>diclofenac sodium</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>flurbiprofen sodium</i>	Preferred	QL (5 ML per 25 days)
<i>ketorolac tromethamine solution 0.4 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<i>ketorolac tromethamine solution 0.5 % ophthalmic</i>	Preferred	QL (10 ML Max Qty Per Fill Retail)
<b>ACULAR</b>	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
<b>ACULAR LS</b>	Non – Preferred	QL (10 ML per 30 days)
<b>ACUVAIL</b>	Non – Preferred	
<b>BROMSITE</b>	Non – Preferred	
<b>ILEVRO</b>	Non – Preferred	
<b>PROLENSA</b>	Non – Preferred	

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<b>*Ophthalmic Rho Kinase Inhibitors*** - Drugs For Glaucoma</b>		
<b>RHOPRESSA</b>	Non – Preferred	
<b>*Ophthalmic Selective Alpha Adrenergic Agonists*** - Drugs For Glaucoma</b>		
<i>apraclonidine hcl</i>	Non – Preferred	
<i>brimonidine tartrate solution 0.1 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.15 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.2 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<b>ALPHAGAN P</b>	Preferred	
<b>IOPIDINE</b>	Non – Preferred	
<b>*Ophthalmic Steroid Combinations*** - Anti-Infective/Anti-Inflammatories</b>		
<i>bacitra-neomycin-polymyxin-hc</i>	Preferred	
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	Preferred	QL (3.5 GM per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic suspension</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>neomycin-polymyxin-hc</i>	Preferred	QL (7.5 ML per 30 days)
<i>sulfacetamide-prednisolone</i>	Non – Preferred	QL (5 ML per 30 days)
<i>tobramycin-dexamethasone suspension 0.3-0.1 % ophthalmic</i>	Preferred	QL (10 ML per 30 days)
<b>MAXITROL OPHTHALMIC OINTMENT</b>	Preferred	QL (3.5 GM per 30 days)
<b>MAXITROL OPHTHALMIC SUSPENSION</b>	Non – Preferred	QL (5 ML Max Qty Per Fill Retail)
<b>NEO-POLYCIN HC</b>	Preferred	

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<b>TOBRADEX</b>	Non – Preferred	
<b>TOBRADEX ST</b>	Non – Preferred	
<b>ZYLET</b>	Non – Preferred	
<b>*Ophthalmic Steroids*** - Anti-Infective/Anti-Inflammatories</b>		
<i>dexamethasone sodium phosphate</i>	Preferred	QL (5 ML Max Qty Per Fill Retail)
<i>difluprednate</i>	Non – Preferred	
<i>fluorometholone</i>	Preferred	QL (10 ML per 30 days)
<i>loteprednol etabonate ophthalmic gel</i>	Non – Preferred	
<i>loteprednol etabonate ophthalmic suspension</i>	Preferred	
<i>prednisolone acetate</i>	Preferred	QL (10 ML per 30 days)
<i>prednisolone sodium phosphate</i>	Preferred	QL (10 ML per 30 days)
<b>ALREX</b>	Preferred	
<b>DEXTENZA</b>	Non – Preferred	
<b>DUREZOL</b>	Non – Preferred	
<b>EYSUVIS</b>	Non – Preferred	
<b>FLAREX</b>	Preferred	
<b>FML FORTE</b>	Preferred	
<b>FML LIQUIFILM</b>	Non – Preferred	QL (10 ML per 30 days)
<b>INVELTYS</b>	Non – Preferred	
<b>LOTEMAX</b>	Non – Preferred	
<b>LOTEMAX SM</b>	Non – Preferred	
<b>PRED FORTE</b>	Non – Preferred	QL (10 ML per 30 days)
<b>PRED MILD</b>	Preferred	QL (10 ML per 30 days)
<b>*Ophthalmic Sulfonamides*** - Anti-Infective/Anti-Inflammatories</b>		
<i>sulfacetamide sodium ophthalmic ointment</i>	Preferred	
<i>sulfacetamide sodium ophthalmic solution</i>	Preferred	QL (15 ML Max Qty Per Fill Retail)

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<b>*Ophthalmics - Cystinosis Agents** - Drugs For The Eye</b>		
CYSTADROPS	Non – Preferred	
CYSTARAN	Non – Preferred	
<b>*Prostaglandins - Ophthalmic*** - Drugs For Glaucoma</b>		
<i>bimatoprost</i>	Non – Preferred	
<i>latanoprost solution 0.005 % ophthalmic</i>	Preferred	QL (2.5 ML per 25 days)
<i>tafluprost (pf)</i>	Non – Preferred	
<i>travoprost (bak free)</i>	Non – Preferred	
IYUZEH	Non – Preferred	
LUMIGAN	Non – Preferred	
TRAVATAN Z	Non – Preferred	
VYZULTA	Non – Preferred	
XALATAN	Non – Preferred	QL (2.5 ML per 25 days)
XELPROS	Non – Preferred	
ZIOPTAN	Non – Preferred	
<b>*Otic Agents* - Drugs For The Ear</b>		
<b>*Otic Agents - Miscellaneous*** - Wax Removal</b>		
<i>acetic acid</i>	Preferred	
<b>*Otic Anti-Infectives*** - Antibiotics</b>		
<i>ciprofloxacin hcl</i>	Non – Preferred	QL (28 EA per 30 days)
<i>ofloxacin</i>	Preferred	QL (15 ML per 30 days)
<b>*Otic Steroid-Anti-Infective Combinations*** - Anti- Infective/Anti-Inflammatories</b>		
<i>ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic</i>	Preferred	QL (7.5 ML per 30 days)

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<i>ciprofloxacin-fluocinolone pf</i>	Non – Preferred	
<i>neomycin-polymyxin-hc</i>	Preferred	QL (10 ML per 30 days)
<b>CORTISPORIN-TC</b>	Non – Preferred	
<b>*Otic Steroids*** - Anti-Infective/Anti-Inflammatories</b>		
<i>fluocinolone acetonide</i>	Non – Preferred	
<i>hydrocortisone-acetic acid</i>	Non – Preferred	
<b>DERMOTIC</b>	Non – Preferred	
<b>FLAC</b>	Non – Preferred	
<b>*Oxytocics* - Hormones</b>		
<b>*Oxytocics*** - Drugs For Women</b>		
<i>methylergonovine maleate</i>	Preferred	
<b>METHERGINE</b>	Preferred	
<b>*Passive Immunizing And Treatment Agents* - Biological Agents</b>		
<b>*Antiviral Monoclonal Antibodies*** - Biological Agents</b>		
<b>SYNAGIS</b>	Preferred	PA; QL (1 VIAL per 26 days)
<b>*Immune Serums*** - Biological Agents</b>		
<b>GAMMAGARD</b>	Preferred	PA
<b>GAMUNEX-C</b>	Preferred	PA
<b>HIZENTRA</b>	Preferred	PA
<b>HYPERRHO S/D</b>	Preferred	
<b>MICRHOGAM ULTRA-FILTERED PLUS</b>	Preferred	
<b>PRIVIGEN</b>	Preferred	PA
<b>RHOGAM ULTRA-FILTERED PLUS</b>	Preferred	

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<b>*Penicillins* - Drugs For Infections</b>		
<b>*Aminopenicillins*** - Antibiotics</b>		
<i>amoxicillin</i>	Preferred	
<i>ampicillin capsule 500 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>ampicillin capsule 500 mg oral</i>	Preferred	
<i>ampicillin sodium</i>	Preferred	
<b>*Natural Penicillins*** - Antibiotics</b>		
<i>penicillin g pot in dextrose</i>	Preferred	
<i>penicillin g potassium</i>	Preferred	
<i>penicillin g sodium</i>	Preferred	
<i>penicillin v potassium</i>	Preferred	
<b>BICILLIN L-A</b>	Preferred	
<b>PFIZERPEN</b>	Preferred	
<b>*Penicillin Combinations*** - Antibiotics</b>		
<i>amoxicillin-pot clavulanate er</i>	Non – Preferred	QL (28 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 250-125 mg oral</i>	Preferred	QL (30 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 500-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>amoxicillin-pot clavulanate tablet 875-125 mg oral</i>	Preferred	QL (28 EA per 30 days)
<i>amoxicillin-pot clavulanate tablet 875-125 mg oral</i>	Preferred	QL (20 EA Max Qty Per Fill Retail)
<i>ampicillin-sulbactam sodium</i>	Preferred	
<i>piperacillin sod-tazobactam so</i>	Preferred	

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<b>AUGMENTIN</b>	Preferred	
<b>AUGMENTIN ES-600</b>	Non – Preferred	
<b>BICILLIN C-R</b>	Preferred	
<b>BICILLIN C-R 900/300</b>	Preferred	
<b>ZOSYN</b>	Preferred	
<b>*Penicillinase-Resistant Penicillins*** - Antibiotics</b>		
<i>dicloxacillin sodium</i>	Preferred	
<b>*Pharmaceutical Adjuvants*</b>		
<b>*Parenteral Vehicles***</b>		
<i>saline bacteriostatic</i>	Preferred	
<b>*Semi Solid Vehicles***</b>		
<i>polyethylene glycol 3350</i>	Preferred	
<b>*Progestins* - Hormones</b>		
<b>*Progestins*** - Drugs For Women</b>		
<i>medroxyprogesterone acetate</i>	Preferred	
<i>megestrol acetate</i>	Non – Preferred	
<i>norethindrone acetate</i>	Non – Preferred	
<i>progesterone intramuscular</i>	Preferred	
<i>progesterone oral</i>	Preferred	QL (2 EA per 1 day)
<b>PROMETRIUM</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PROVERA</b>	Non – Preferred	
<b>*Psychotherapeutic And Neurological Agents - Misc.* - Drugs For The Nervous System</b>		
<b>*Agents For Opioid Withdrawal*** - Drugs For The Nervous System</b>		
<b>LUCEMYRA</b>	Preferred	

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<b>*Alcohol Deterrents*** - Drugs For The Nervous System</b>		
<i>acamprosate calcium</i>	Preferred	
<i>disulfiram</i>	Preferred	
<b>*Alzheimer's Treatment - Anti-Amyloid Antibodies*** - Drugs For Alzheimer's Disease</b>		
ADUHELM	Non – Preferred	
LEQEMBI	Non – Preferred	
<b>*Anti-Cataplectic Agents*** - Drugs For Sleep Disorder</b>		
<i>sodium oxybate</i>	Non – Preferred	
XYREM	Non – Preferred	
<b>*Anti-Cataplectic Combinations*** - Drugs For Sleep Disorder</b>		
XYWAV	Non – Preferred	
<b>*Antidementia Agent Combinations*** - Drugs For Alzheimer's Disease</b>		
NAMZARIC	Non – Preferred	
<b>*Antisense Oligonucleotide (Aso) Inhibitor Agents*** - Drugs For The Nervous System</b>		
TEGSEDI	Non – Preferred	
<b>*Benzodiazepines &amp; Tricyclic Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<i>chlordiazepoxide-amitriptyline</i>	Preferred	

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<b>*Cholinomimetics - Ache Inhibitors*** - Drugs For Alzheimer's Disease</b>		
<i>donepezil hcl oral tablet dispersible</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>donepezil hcl tablet 23 mg oral</i>	Preferred	
<i>donepezil hcl tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>galantamine hydrobromide er</i>	Non – Preferred	
<i>galantamine hydrobromide oral solution</i>	Non – Preferred	QL (2 ML per 1 day)
<i>galantamine hydrobromide oral tablet</i>	Non – Preferred	
<i>rivastigmine</i>	Non – Preferred	
<i>rivastigmine tartrate</i>	Non – Preferred	
<b>ADLARITY</b>	Non – Preferred	
<b>ARICEPT TABLET 10 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>ARICEPT TABLET 23 MG ORAL</b>	Non – Preferred	
<b>ARICEPT TABLET 5 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>EXELON</b>	Non – Preferred	
<b>*Fibromyalgia Agent - Snris*** - Drugs For Seizures /Personality Disorder/Nerve Pain</b>		
<b>SAVELLA</b>	Non – Preferred	
<b>SAVELLA TITRATION PACK</b>	Non – Preferred	QL (55 EA per 90 days)
<b>*Movement Disorder Drug Therapy*** - Drugs For The Nervous System</b>		
<i>tetrabenazine</i>	Non – Preferred	
<b>AUSTEDO</b>	Preferred	PA; QL (4 EA per 1 day)
<b>AUSTEDO XR</b>	Non – Preferred	
<b>AUSTEDO XR PATIENT TITRATION</b>	Non – Preferred	
<b>INGREZZA</b>	Preferred	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XENAZINE	Non – Preferred	
<b><i>*Ms Agents - Pyrimidine Synthesis Inhibitors*** - Drugs For Multiple Sclerosis</i></b>		
<i>teriflunomide tablet 14 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>teriflunomide tablet 7 mg oral</i>	Non – Preferred	QL (1 EA per 1 day)
<i>teriflunomide tablet 7 mg oral</i>	Preferred	QL (1 EA per 1 day)
AUBAGIO	Non – Preferred	QL (1 EA per 1 day)
<b><i>*Multiple Sclerosis Agents - Antimetabolites*** - Drugs For Multiple Sclerosis</i></b>		
MAVENCLAD (10 TABS)	Non – Preferred	
MAVENCLAD (4 TABS)	Non – Preferred	
MAVENCLAD (5 TABS)	Non – Preferred	
MAVENCLAD (6 TABS)	Non – Preferred	
MAVENCLAD (7 TABS)	Non – Preferred	
MAVENCLAD (8 TABS)	Non – Preferred	
MAVENCLAD (9 TABS)	Non – Preferred	
<b><i>*Multiple Sclerosis Agents - Interferons*** - Drugs For Multiple Sclerosis</i></b>		
AVONEX PEN	Non – Preferred	QL (1 KIT per 28 days)
AVONEX PREFILLED	Non – Preferred	QL (1 SYRINGE per 28 days)
BETASERON	Preferred	QL (15 VIAL per 30 days)
EXTAVIA	Non – Preferred	QL (15 VIAL per 30 days)
PLEGRIDY	Non – Preferred	
PLEGRIDY STARTER PACK	Non – Preferred	
REBIF	Preferred	QL (12 ML per 30 days)

Coverage Requirements and Limits

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
REBIF TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
<b>*Multiple Sclerosis Agents - Monoclonal Antibodies*** - Drugs For Multiple Sclerosis</b>		
KESIMPTA	Non – Preferred	
LEMTRADA	Non – Preferred	
OCREVUS	Non – Preferred	
TYSABRI	Non – Preferred	
<b>*Multiple Sclerosis Agents - Nrf2 Pathway Activators*** - Drugs For Multiple Sclerosis</b>		
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Non – Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Preferred	PA; QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 240 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>dimethyl fumarate capsule delayed release 240 mg oral</i>	Preferred	PA; QL (2 EA per 1 day)
<i>dimethyl fumarate starter pack capsule delayed release therapy pack 120 &amp; 240 mg oral</i>	Preferred	QL (60 EA per 90 days)
BAFIERTAM	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TECFIDERA ORAL CAPSULE DELAYED RELEASE	Preferred	QL (2 EA per 1 day)
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK	Preferred	QL (60 EA per 90 days)
VUMERITY	Non – Preferred	
<b>*Multiple Sclerosis Agents - Potassium Channel Blockers*** - Drugs For Multiple Sclerosis</b>		
<i>dalfampridine er</i>	Non – Preferred	
AMPYRA	Non – Preferred	
<b>*Multiple Sclerosis Agents*** - Drugs For Multiple Sclerosis</b>		
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	Non – Preferred	QL (1 ML per 1 day)
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	Non – Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Preferred	QL (1 ML per 1 day)
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Preferred	
GLATOPA SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Non – Preferred	QL (1 ML per 1 day)
GLATOPA SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Non – Preferred	
<b>*N-Methyl-D-Aspartate (Nmda) Receptor Antagonists*** - Drugs For Alzheimer's Disease</b>		
<i>memantine hcl er</i>	Non – Preferred	
<i>memantine hcl oral solution</i>	Non – Preferred	
<i>memantine hcl tablet 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>memantine hcl tablet 28 x 5 mg &amp; 21 x 10 mg oral</i>	Non – Preferred	

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>memantine hcl tablet 5 mg oral</i>	Preferred	QL (2 EA per 1 day)
<b>NAMENDA</b>	Non – Preferred	QL (2 EA per 1 day)
<b>NAMENDA TITRATION PAK</b>	Non – Preferred	
<b>NAMENDA XR</b>	Non – Preferred	
<b><i>*Phenothiazines &amp; Tricyclic Agents*** - Drugs For Depression</i></b>		
<i>perphenazine-amitriptyline</i>	Preferred	
<b><i>*Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents*** - Drugs For Seizures /Personality Disorder/Nerve Pain</i></b>		
<i>pregabalin er</i>	Non – Preferred	
<b>GRALISE</b>	Non – Preferred	
<b>LYRICA CR</b>	Non – Preferred	
<b><i>*Premenstrual Dysphoric Disorder (Pmdd) Agents - SsrIs*** - Drugs For Depression</i></b>		
<i>fluoxetine hcl (pmdd)</i>	Non – Preferred	
<b><i>*Pseudobulbar Affect Agent Combinations*** - Drugs For Severe Mental Disorders</i></b>		
<b>NUDEXTA</b>	Non – Preferred	
<b><i>*Psychotherapeutic And Neurological Agents - Misc.*** - Drugs For Severe Mental Disorders</i></b>		
<i>ergoloid mesylates</i>	Preferred	
<i>pimozide</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Restless Leg Syndrome (RLs) Agents*** - Drugs For The Nervous System</b>		
HORIZANT	Non – Preferred	
<b>*Small Interfering Ribonucleic Acid (Sirna) Agents*** - Drugs For The Nervous System</b>		
AMVUTTRA	Non – Preferred	
<b>*Smoking Deterrents*** - Drugs For Depression</b>		
<i>bupropion hcl er (smoking det)</i>	Preferred	
<i>gnp nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>gnp nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>gnp nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat lozenge</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>goodsense nicotine mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>hm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>hm nicotine polacrilex mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine patch 24 hour 14 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 21 mg/24hr transdermal (otc)</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine patch 24 hour 7 mg/24hr transdermal (otc)</i>	Preferred	OTC
<i>nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine polacrilex mini</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>nicotine step 1</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 2</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>nicotine step 3</i>	Preferred	OTC
<i>nicotine transdermal kit</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	OTC; QL (1 EA per 1 day)
<i>sm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	OTC
<i>sm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	OTC; QL (200 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat gum</i>	Preferred	OTC; QL (200 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>varenicline tartrate</i>	Preferred	
<i>varenicline tartrate (starter)</i>	Preferred	
<i>varenicline tartrate(continue)</i>	Preferred	
<b>NICOTROL</b>	Preferred	QL (3 INHALER per 30 days)
<b>NICOTROL NS</b>	Preferred	QL (120 ML per 30 days)
<b>*<i>Spingosine 1-Phosphate (S1p) Receptor Modulators*** - Drugs For Multiple Sclerosis</i></b>		
<i> fingolimod hcl capsule 0.5 mg oral</i>	Non – Preferred	PA
<i> fingolimod hcl capsule 0.5 mg oral</i>	Non – Preferred	PA; QL (1 EA per 1 day)
<b>GILENYA CAPSULE 0.25 MG ORAL</b>	Non – Preferred	
<b>GILENYA CAPSULE 0.5 MG ORAL</b>	Preferred	PA
<b>MAYZENT</b>	Non – Preferred	
<b>MAYZENT STARTER PACK</b>	Non – Preferred	
<b>PONVORY</b>	Non – Preferred	
<b>PONVORY STARTER PACK</b>	Non – Preferred	
<b>TASCENSO ODT</b>	Non – Preferred	
<b>ZEPOSIA</b>	Non – Preferred	
<b>ZEPOSIA 7-DAY STARTER PACK</b>	Non – Preferred	
<b>*<i>Thienbenzodiazepines &amp; Opioid Antagonists*** - Drugs For Severe Mental Disorders</i></b>		
<b>LYBALVI</b>	Non – Preferred	
<b>*<i>Thienbenzodiazepines &amp; Ssrís*** - Drugs For Severe Mental Disorders</i></b>		
<i>olanzapine-fluoxetine hcl</i>	Non – Preferred	QL (1 EA per 1 day)
<b>SYMBYAX</b>	Non – Preferred	QL (1 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Vasomotor Symptom Agents - SsrIs*** - Drugs For The Nervous System</b>		
<i>paroxetine mesylate</i>	Non – Preferred	
<b>*Respiratory Agents - Misc.* - Drugs For The Lungs</b>		
<b>*Cftr Potentiators*** - Drugs For Cystic Fibrosis</b>		
KALYDECO	Non – Preferred	
<b>*Cystic Fibrosis Agent - Combinations*** - Drugs For Cystic Fibrosis</b>		
ORKAMBI	Non – Preferred	
SYMDEKO	Non – Preferred	
TRIKAFTA	Non – Preferred	
<b>*Cystic Fibrosis Agents - Miscellaneous*** - Drugs For Cystic Fibrosis</b>		
BRONCHITOL	Non – Preferred	
BRONCHITOL TOLERANCE TEST	Non – Preferred	
<b>*Hydrolytic Enzymes*** - Drugs For The Lungs</b>		
PULMOZYME	Preferred	QL (5 ML per 1 day)
<b>*Pulmonary Fibrosis Agents - Kinase Inhibitors*** - Drugs For The Lungs</b>		
OFEV	Non – Preferred	
<b>*Pulmonary Fibrosis Agents*** - Drugs For The Lungs</b>		
<i>pirfenidone</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ESBRIET	Non – Preferred	
<b>*Sulfonamides* - Drugs For Infections</b>		
<b>*Sulfonamides*** - Antibiotics</b>		
<i>sulfadiazine</i>	Preferred	
<b>*Tetracyclines* - Drugs For Infections</b>		
<b>*Aminomethylcyclines*** - Antibiotics</b>		
NUZYRA	Non – Preferred	
<b>*Tetracyclines*** - Antibiotics</b>		
<i>demeclocycline hcl</i>	Preferred	
<i>doxycycline hyclate intravenous</i>	Preferred	
<i>doxycycline hyclate oral capsule</i>	Preferred	
<i>doxycycline hyclate oral tablet</i>	Preferred	
<i>doxycycline hyclate oral tablet delayed release</i>	Non – Preferred	
<i>doxycycline monohydrate</i>	Preferred	
<i>minocycline hcl</i>	Preferred	
<i>minocycline hcl er</i>	Non – Preferred	
<i>tetracycline hcl</i>	Preferred	
DORYX	Non – Preferred	
DORYX MPC	Non – Preferred	
DOXY 100	Preferred	
MINOLIRA	Non – Preferred	
SOLODYN	Non – Preferred	
VIBRAMYCIN	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Thyroid Agents* - Hormones</b>		
<b>*Antithyroid Agents*** - Drugs For Thyroid</b>		
<i>methimazole</i>	Preferred	
<i>propylthiouracil</i>	Preferred	
<b>*Thyroid Hormones*** - Drugs For Thyroid</b>		
<i>levothyroxine sodium oral capsule</i>	Non – Preferred	
<i>levothyroxine sodium tablet 100 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 112 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 125 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 137 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 150 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 175 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 200 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 25 mcg oral</i>	Preferred	
<i>levothyroxine sodium tablet 25 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 300 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 50 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 75 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>levothyroxine sodium tablet 88 mcg oral</i>	Preferred	QL (1 EA per 1 day)
<i>liothyronine sodium tablet 25 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>liothyronine sodium tablet 5 mcg oral</i>	Preferred	QL (4 EA per 1 day)
<i>liothyronine sodium tablet 50 mcg oral</i>	Preferred	QL (2 EA per 1 day)
<i>thyroid</i>	Preferred	QL (1 EA per 1 day)
<b>ADTHYZA</b>	Preferred	
<b>ARMOUR THYROID</b>	Preferred	QL (1 EA per 1 day)
<b>CYTOMEL TABLET 25 MCG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b>CYTOMEL TABLET 5 MCG ORAL</b>	Non – Preferred	QL (4 EA per 1 day)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYTOMEL TABLET 50 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
ERMEZA	Non – Preferred	
EUTHYROX	Preferred	QL (1 EA per 1 day)
LEVO-T	Preferred	QL (1 EA per 1 day)
LEVOXYL	Preferred	QL (1 EA per 1 day)
NP THYROID	Preferred	QL (1 EA per 1 day)
SYNTHROID	Non – Preferred	QL (1 EA per 1 day)
THYQUIDITY	Non – Preferred	
TIROSINT	Non – Preferred	
TIROSINT-SOL	Non – Preferred	
UNITHROID	Preferred	QL (1 EA per 1 day)
<b>*Toxoids* - Biological Agents</b>		
<b><i>*Toxoid Combinations*** - Vaccines</i></b>		
ADACEL	Preferred	AL (Min 19 Years)
BOOSTRIX	Preferred	AL (Min 19 Years)
INFANRIX	Preferred	AL (Min 19 Years)
TDVAX	Preferred	AL (Min 19 Years)
<b>*Ulcer Drugs/Antispasmodics/Anticholinergics* - Drugs For The Stomach</b>		
<b><i>*Anticholinergic Combinations*** - Drugs For Stomach Cramps</i></b>		
<i>belladonna alkaloids-opium</i>	Preferred	
<i>chlordiazepoxide-clidinium</i>	Non – Preferred	
LIBRAX	Non – Preferred	
<b><i>*Antispasmodics*** - Drugs For Stomach Cramps</i></b>		
<i>dicyclomine hcl</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Belladonna Alkaloids*** - Drugs For Stomach Cramps</b>		
<i>hyoscyamine sulfate</i>	Preferred	
<i>hyoscyamine sulfate er</i>	Preferred	
<i>oscimin</i>	Preferred	
<b>LEVSIN</b>	Non – Preferred	
<b>LEVSIN/SL</b>	Non – Preferred	
<b>NULEV</b>	Preferred	
<b>*H-2 Antagonists*** - Drugs For Ulcers And Stomach Acid</b>		
<i>cimetidine</i>	Preferred	QL (2 EA per 1 day)
<i>famotidine oral suspension reconstituted</i>	Preferred	
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	
<i>famotidine tablet 40 mg oral</i>	Preferred	
<i>famotidine tablet 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>nizatidine</i>	Preferred	
<b>PEPCID</b>	Non – Preferred	
<b>*Misc. Anti-Ulcer*** - Drugs For Ulcers And Stomach Acid</b>		
<i>sucralfate</i>	Preferred	
<b>CARAFATE ORAL SUSPENSION</b>	Preferred	
<b>CARAFATE ORAL TABLET</b>	Non – Preferred	
<b>*Proton Pump Inhibitor-Antacid Combinations*** - Drugs For Ulcers And Stomach Acid</b>		
<i>omeprazole-sodium bicarbonate</i>	Non – Preferred	
<b>KONVOMEF</b>	Non – Preferred	
<b>ZEGERID</b>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid</b>		
<i>dexlansoprazole capsule delayed release 30 mg oral</i>	Non – Preferred	
<i>dexlansoprazole capsule delayed release 30 mg oral</i>	Non – Preferred	AL (Max 20 Years)
<i>dexlansoprazole capsule delayed release 60 mg oral</i>	Non – Preferred	
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Non – Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Non – Preferred	
<i>esomeprazole magnesium capsule delayed release 40 mg oral</i>	Non – Preferred	
<i>esomeprazole magnesium oral packet</i>	Non – Preferred	
<i>lansoprazole oral capsule delayed release</i>	Non – Preferred	
<i>lansoprazole oral tablet delayed release dispersible</i>	Preferred	
<i>omeprazole capsule delayed release 10 mg oral</i>	Preferred	
<i>omeprazole capsule delayed release 10 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>omeprazole capsule delayed release 20 mg oral</i>	Preferred	
<i>omeprazole capsule delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>omeprazole capsule delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>omeprazole capsule delayed release 40 mg oral</i>	Preferred	
<i>pantoprazole sodium oral packet</i>	Non – Preferred	
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)

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<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Preferred	
<i>rabeprazole sodium</i>	Non – Preferred	QL (2 EA per 1 day)
<b>ACIPHEX</b>	Non – Preferred	QL (2 EA per 1 day)
<b>DEXILANT</b>	Non – Preferred	
<b>FIRST PANTOPRAZOLE</b>	Non – Preferred	
<b>NEXIUM</b>	Non – Preferred	
<b>PREVACID</b>	Non – Preferred	QL (2 EA per 1 day)
<b>PREVACID SOLUTAB</b>	Non – Preferred	
<b>PRILOSEC</b>	Non – Preferred	
<b>PROTONIX ORAL PACKET</b>	Non – Preferred	
<b>PROTONIX TABLET DELAYED RELEASE 20 MG ORAL</b>	Non – Preferred	QL (1 EA per 1 day)
<b>PROTONIX TABLET DELAYED RELEASE 40 MG ORAL</b>	Non – Preferred	QL (2 EA per 1 day)
<b><i>*Quaternary Anticholinergics*** - Drugs For Stomach Cramps</i></b>		
<i>glycopyrrolate</i>	Preferred	
<i>methscopolamine bromide</i>	Non – Preferred	
<b>CUVPOSA</b>	Non – Preferred	
<b>GLYCATE</b>	Non – Preferred	
<b>ROBINUL</b>	Non – Preferred	
<b>ROBINUL-FORTE</b>	Non – Preferred	
<b><i>*Ulcer Anti-Infective W/ Bismuth Combinations*** - Drugs For Ulcers And Stomach Acid</i></b>		
<i>bis subcit-metronid-tetracyc</i>	Non – Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PYLERA</b>	Non – Preferred	
<b>*Ulcer Anti-Infective W/ Proton Pump Inhibitors*** - Drugs For Ulcers And Stomach Acid</b>		
<i>amoxicill-clarithro-lansopraz</i>	Non – Preferred	
<b>OMECLAMOX-PAK</b>	Non – Preferred	
<b>TALICIA</b>	Non – Preferred	
<b>*Ulcer Drugs - Prostaglandins*** - Drugs For Ulcers And Stomach Acid</b>		
<i>misoprostol</i>	Preferred	
<b>CYTOTEC</b>	Non – Preferred	
<b>*Urinary Antispasmodics* - Drugs For The Urinary System</b>		
<b>*Urinary Antispasmodic - Antimuscarinic (Anticholinergic)*** - Drugs For The Bladder</b>		
<i>darifenacin hydrobromide er</i>	Non – Preferred	
<i>fesoterodine fumarate er</i>	Non – Preferred	
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>oxybutynin chloride oral solution</i>	Preferred	QL (20 ML per 1 day)
<i>oxybutynin chloride tablet 2.5 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>oxybutynin chloride tablet 5 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>solifenacin succinate tablet 10 mg oral</i>	Preferred	
<i>solifenacin succinate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>solifenacin succinate tablet 5 mg oral</i>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>solifenacin succinate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day)
<i>tolterodine tartrate</i>	Non – Preferred	
<i>tolterodine tartrate er</i>	Non – Preferred	
<i>tropium chloride</i>	Non – Preferred	
<i>tropium chloride er</i>	Non – Preferred	
<b>DETROL</b>	Non – Preferred	
<b>DETROL LA</b>	Non – Preferred	
<b>GELNIQUE</b>	Non – Preferred	
<b>OXYTROL</b>	Non – Preferred	
<b>TOVIAZ</b>	Non – Preferred	
<b>VESICARE</b>	Non – Preferred	
<b>VESICARE LS</b>	Non – Preferred	
<b>*Urinary Antispasmodics - Beta-3 Adrenergic Agonists*** - Drugs For The Bladder</b>		
<b>GEMTESA</b>	Non – Preferred	
<b>MYRBETRIQ</b>	Non – Preferred	
<b>*Urinary Antispasmodics - Cholinergic Agonists*** - Drugs For The Bladder</b>		
<i>bethanechol chloride</i>	Preferred	
<b>*Urinary Antispasmodics - Direct Muscle Relaxants*** - Drugs For The Bladder</b>		
<i>flavoxate hcl</i>	Non – Preferred	
<b>*Vaccines* - Biological Agents</b>		
<b>*Bacterial Vaccines*** - Vaccines</b>		
<b>BEXSERO</b>	Preferred	AL (Min 19 Years)
<b>MENVEO</b>	Preferred	AL (Min 19 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PNEUMOVAX 23</b>	Preferred	AL (Min 19 Years)
<b>PREVNAR 13</b>	Preferred	AL (Min 19 Years)
<b>PREVNAR 20</b>	Preferred	AL (Min 19 Years)
<b>TRUMENBA</b>	Preferred	AL (Min 19 Years)
<b>VAXNEUVANCE</b>	Preferred	AL (Min 19 Years)
<b>*Viral Vaccine Combinations*** - Vaccines</b>		
<b>TWINRIX</b>	Preferred	AL (Min 19 Years)
<b>*Viral Vaccines*** - Vaccines</b>		
<i>prehevbrio</i>	Preferred	AL (Min 19 Years)
<b>AFLURIA QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>COMIRNATY</b>	Preferred	AL (Min 3 Years)
<b>ENGERIX-B</b>	Preferred	AL (Min 19 Years)
<b>FLUAD QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>FLUARIX QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>FLUBLOK QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>FLULAVAL QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>FLUMIST QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>FLUZONE HIGH-DOSE QUADRIVALENT</b>	Preferred	AL (Min 65 Years)
<b>FLUZONE QUADRIVALENT</b>	Preferred	AL (Min 14 Years)
<b>GARDASIL 9</b>	Preferred	AL (Min 19 Years and Max 45 Years)
<b>HAVRIX</b>	Preferred	AL (Min 19 Years)
<b>HEPLISAV-B</b>	Preferred	AL (Min 19 Years)
<b>RECOMBIVAX HB</b>	Preferred	AL (Min 19 Years)
<b>VAQTA</b>	Preferred	AL (Min 19 Years)
<b>VARIVAX</b>	Preferred	AL (Min 19 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Vaginal And Related Products* - Drugs For Women</b>		
<b><i>*Imidazole-Related Antifungals*** - Drugs For Infections</i></b>		
<i>clotrimazole 3</i>	Preferred	OTC
<i>miconazole 3</i>	Preferred	QL (3 EA Max Qty Per Fill Retail)
<i>terconazole</i>	Preferred	
<b>GYNAZOLE-1</b>	Non – Preferred	
<b><i>*Miscellaneous Vaginal Combinations*** - Drugs For Infections</i></b>		
<b>TRIMO-SAN</b>	Non – Preferred	
<b><i>*Miscellaneous Vaginal Products*** - Drugs For Women</i></b>		
<b>INTRAROSA</b>	Non – Preferred	
<b><i>*Vaginal Anti-Infectives*** - Drugs For Infections</i></b>		
<i>clindamycin phosphate</i>	Preferred	
<i>metronidazole</i>	Preferred	
<b>CLEOCIN VAGINAL CREAM</b>	Non – Preferred	
<b>CLEOCIN VAGINAL SUPPOSITORY</b>	Preferred	
<b>CLINDESSE</b>	Non – Preferred	
<b>NUVESSA</b>	Non – Preferred	
<b>VANAZOLE</b>	Preferred	
<b><i>*Vaginal Contraceptive Ph Modulator - Combinations*** - Drugs For Women</i></b>		
<b>PHEXXI</b>	Preferred	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*Vaginal Estrogens*** - Drugs For Women</b>		
<i>estradiol vaginal cream</i>	Preferred	
<i>estradiol vaginal tablet</i>	Non – Preferred	
<b>ESTRACE</b>	Non – Preferred	
<b>FEMRING</b>	Non – Preferred	
<b>IMVEXXY MAINTENANCE PACK</b>	Non – Preferred	
<b>IMVEXXY STARTER PACK</b>	Non – Preferred	
<b>PREMARIN</b>	Preferred	QL (60 GM per 30 days)
<b>VAGIFEM</b>	Non – Preferred	
<b>YUVAFEM</b>	Non – Preferred	
<b>*Vaginal Progestins*** - Drugs For Women</b>		
<b>CRINONE</b>	Non – Preferred	
<b>ENDOMETRIN</b>	Preferred	
<b>*Vasopressors* - Drugs For The Heart</b>		
<b>*Anaphylaxis Therapy Agents*** - Drugs For Serious Allergic Reaction</b>		
<i>epinephrine solution auto-injector 0.15 mg/0.15ml injection</i>	Preferred	QL (4 UNIT per 365 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml injection</i>	Preferred	QL (4 EA per 365 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml injection</i>	Preferred	QL (4 UNIT per 365 days)
<b>AUVI-Q SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML INJECTION</b>	Preferred	
<b>AUVI-Q SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML INJECTION</b>	Preferred	QL (4 EA per 365 days)
<b>AUVI-Q SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION</b>	Preferred	QL (4 EA per 365 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EPIPEN 2-PAK	Non – Preferred	QL (4 UNIT per 365 days)
EPIPEN JR 2-PAK	Non – Preferred	QL (4 EA per 365 days)
<b><i>*Neurogenic Orthostatic Hypotension (Noh) - Agents*** - Drugs For Serious Allergic Reaction</i></b>		
<i>droxidopa</i>	Non – Preferred	
NORTHERA	Non – Preferred	
<b><i>*Vasopressors*** - Drugs For Serious Allergic Reaction</i></b>		
<i>midodrine hcl</i>	Preferred	
<b>*Vitamins* - Drugs For Nutrition</b>		
<b><i>*Vitamin B-3*** - Drugs For Nutrition</i></b>		
<i>niacin</i>	Preferred	OTC
<i>niacin er</i>	Preferred	OTC
<b><i>*Vitamin D*** - Drugs For Nutrition</i></b>		
<i>ergocalciferol oral capsule</i>	Preferred	
<i>ergocalciferol oral solution</i>	Preferred	OTC
<i>vitamin d</i>	Preferred	OTC
<i>vitamin d (ergocalciferol)</i>	Preferred	
<b><i>*Vitamin K*** - Drugs For Nutrition</i></b>		
<i>phytonadione</i>	Preferred	

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