



Essential Drug List

Drug list — Four Tier Drug Plan California DMHC Fully Insured

Your prescription benefit comes with a drug list, which is also called a formulary. This list is made up of brand-name and generic prescription drugs approved by the U.S. Food & Drug Administration (FDA).

The following is a list of plan names to which this formulary may apply. Additional plans may be applicable. **If you are a current Anthem member with questions about your pharmacy benefits, we're here to help. Just call us at the Pharmacy Member Services number on your ID card.**

2024 Essential Drug List Plan Names

Anthem Advantage HMO 20 or 40/500 3 day/250 OP	Anthem EPO 1000/20/40/20	Anthem Premier HMO 10/100% Vivity
Anthem Classic Choice HMO 10/30	Anthem EPO 1000/20/40/20 Blue Connection	Anthem Premier HMO 20/100%
Anthem Classic Choice HMO 10/30 Priority Select HMO	Anthem EPO 2000/25/50/20	Anthem Premier HMO 20/100% Priority Select HMO
Anthem Classic Choice HMO 10/30 Select HMO	Anthem EPO 2000/25/50/20 Blue Connection	Anthem Premier HMO 20/100% Select HMO
Anthem Classic HMO 10/30/250 admit/125 OP	Anthem EPO 250/20/40/20	Anthem Premier HMO 20/100% Vivity
Anthem Classic HMO 10/30/250 admit/125 OP Priority Select HMO	Anthem EPO 250/20/40/20 Blue Connection	Anthem Value Ded HMO 1000/25/40/25%
Anthem Classic HMO 10/30/250 admit/125 OP Select HMO	Anthem EPO 3000/25/50/20	Anthem Value Ded HMO 1000/25/40/25% Priority Select HMO
Anthem Classic HMO 10/30/250 admit/125 OP Vivity	Anthem EPO 3000/25/50/20 Blue Connection	Anthem Value Ded HMO 1000/25/40/25% Select HMO
Anthem Classic HMO 20/40/250 admit/125 OP	Anthem EPO 750/20/40/20	Anthem Value Ded HMO 1500/25/50/25%
Anthem Classic HMO 20/40/250 admit/125 OP Priority Select HMO	Anthem EPO 750/20/40/20 Blue Connection	Anthem Value Ded HMO 1500/25/50/25% Priority Select HMO
Anthem Classic HMO 20/40/250 admit/125 OP Select HMO	Anthem Exclusive Classic PPO 20/250 3 day/125 OP	Anthem Value Ded HMO 1500/25/50/25% Select HMO
Anthem Classic HMO 20/40/250 admit/125 OP Vivity	Anthem Exclusive Classic PPO 20/250 admit/125 OP	Anthem Value Ded HMO 2000/30/60/25%
Anthem Classic HMO 20/40/500 admit/250 OP	Anthem Exclusive Value PPO 30/30	Anthem Value Ded HMO 2000/30/60/25% Priority Select HMO
Anthem Classic HMO 20/40/500 admit/250 OP Priority Select HMO	Anthem High Performance EPO 1000/35/70/4000	Anthem Value Ded HMO 2000/30/60/25% Select HMO
Anthem Classic HMO 20/40/500 admit/250 OP Select HMO	Anthem High Performance EPO 2000/40/80/6000	Anthem Value Ded HMO 250/20/40/10%
Anthem Classic HMO 20/40/500 admit/250 OP Vivity	Anthem High Performance EPO 25/50/3000	Anthem Value Ded HMO 250/20/40/10% Priority Select HMO
Anthem Classic HMO 30/50/500 admit/250 OP	Anthem High Performance EPO 35/70/5000	Anthem Value Ded HMO 250/20/40/10% Select HMO
Anthem Classic HMO 30/50/500 admit/250 OP Priority Select HMO	Anthem High Performance EPO 40/80/7000	Anthem Value Ded HMO 500/20/40/20%
Anthem Classic HMO 30/50/500 admit/250 OP Select HMO	Anthem High Performance EPO 500/25/50/2500	Anthem Value Ded HMO 500/20/40/20% Priority Select HMO
Anthem Classic HMO 30/50/500 admit/250 OP Vivity	Anthem High Performance EPO HSA 3200/25/75/5000	Anthem Value Ded HMO 500/20/40/20% Select HMO
Anthem Classic HMO 40/60/750 admit/375 OP	Anthem High Performance EPO HSA 4000/25/75/6500	Anthem Value Ded HMO 750/25/40/25%
Anthem Classic HMO 40/60/750 admit/375 OP Priority Select HMO	Anthem PPO HIA Plus 3000/0	Anthem Value Ded HMO 750/25/40/25% Priority Select HMO

Anthem Classic HMO 40/60/750 admit/375 OP Select HMO	Anthem PPO HIA Plus 3000/0 Select PPO	Anthem Value Ded HMO 750/25/40/25% Select HMO
Anthem Classic HMO 40/60/750 admit/375 OP Vivity	Anthem PPO HIA Plus Copay 1000/30/20	Anthem Value HMO 20/40/20%
Anthem Classic PPO 1000/35/55/20	Anthem PPO HIA Plus Copay 1000/30/20 Select PPO	Anthem Value HMO 20/40/20% Priority Select HMO
Anthem Classic PPO 1000/35/55/20 Select PPO	Anthem PPO HIA Plus Copay 2000/30/20	Anthem Value HMO 20/40/20% Select HMO
Anthem Classic PPO 1500/40/60/20	Anthem PPO HIA Plus Copay 2000/30/20 Select PPO	Anthem Value HMO 20/40/250 3 day
Anthem Classic PPO 1500/40/60/20 Select PPO	Anthem PPO HRA 3000/0	Anthem Value HMO 20/40/250 3 day Priority Select HMO
Anthem Classic PPO 250/20/40/10	Anthem PPO HRA 3000/0 Select PPO	Anthem Value HMO 20/40/250 3 day Select HMO
Anthem Classic PPO 250/20/40/10 Select PPO	Anthem PPO HRA Copay 2000/30/20	Anthem Value HMO 20/40/250 3 day Vivity
Anthem Classic PPO 250/20/40/20	Anthem PPO HRA Copay 2000/30/20 Select PPO	Anthem Value HMO 20/40/250 3 day/20%
Anthem Classic PPO 250/20/40/20 Select PPO	Anthem PPO HSA 3200/0	Anthem Value HMO 20/40/250 3 day/20% Priority Select HMO
Anthem Classic PPO 500/20/40/10	Anthem PPO HSA 3200/0 Select PPO	Anthem Value HMO 20/40/250 3 day/20% Select HMO
Anthem Classic PPO 500/20/40/10 Select PPO	Anthem PPO HSA 3200/20	Anthem Value HMO 30/50/30%
Anthem Classic PPO 500/20/40/20	Anthem PPO HSA 3200/20 Select PPO	Anthem Value HMO 30/50/30% Priority Select HMO
Anthem Classic PPO 500/20/40/20 Select PPO	Anthem PPO HSA 3500/20	Anthem Value HMO 30/50/30% Select HMO
Anthem Classic PPO 500/30/50/20	Anthem PPO HSA 3500/20 Select PPO	Anthem Value HMO 30/50/500 3 day
Anthem Classic PPO 500/30/50/20 Select PPO	Anthem PPO HSA 4000/20	Anthem Value HMO 30/50/500 3 day Priority Select HMO
Anthem Classic PPO 750/30/50/20	Anthem PPO HSA 4000/20 Select PPO	Anthem Value HMO 30/50/500 3 day Select HMO
Anthem Classic PPO 750/30/50/20 Select PPO	Anthem PPO HSA 4500/20	Anthem Value HMO 30/50/500 3 day Vivity
Anthem Elements Choice HMO 1500	Anthem PPO HSA 4500/20 Select PPO	Anthem Value HMO 30/50/500 3 day/20%
Anthem Elements Choice HMO 1500 Priority Select HMO	Anthem PPO HSA 5000/20	Anthem Value HMO 30/50/500 3 day/20% Priority Select HMO
Anthem Elements Choice HMO 1500 Select HMO	Anthem PPO HSA 5000/20 Select PPO	Anthem Value HMO 30/50/500 3 day/20% Select HMO
Anthem Elements Choice HMO 3000	Anthem PPO HSA/H 1600/3200/4000 10/30	Anthem Value HMO 35/55/750 3 day
Anthem Elements Choice HMO 3000 Priority Select HMO	Anthem PPO HSA/H 1600/3200/4000 10/30 Select PPO	Anthem Value HMO 35/55/750 3 day Priority Select HMO
Anthem Elements Choice HMO 3000 Select HMO	Anthem PPO HSA/H 1600/3200/4000 20/40	Anthem Value HMO 35/55/750 3 day Select HMO
Anthem Elements Choice HMO 5900	Anthem PPO HSA/H 1600/3200/4000 20/40 Select PPO	Anthem Value HMO 35/55/750 3 day Vivity
Anthem Elements Choice HMO 5900 Priority Select HMO	Anthem PPO HSA/H 2000/3200/5000 10/30	Anthem Value HMO 40/60/1000 3 day
Anthem Elements Choice HMO 5900 Select HMO	Anthem PPO HSA/H 2000/3200/5000 10/30 Select PPO	Anthem Value HMO 40/60/1000 3 day Priority Select HMO
Anthem Elements Choice HSA 6100/0	Anthem PPO HSA/H 2000/3200/5000 20/40	Anthem Value HMO 40/60/1000 3 day Select HMO
Anthem Elements Choice HSA 6100/0 Select PPO	Anthem PPO HSA/H 2000/3200/5000 20/40 Select PPO	Anthem Value HMO 40/60/1000 3 day Vivity
Anthem Elements Choice PPO 6000	Anthem Premier HMO 10/100%	Anthem Value HMO 40/60/750 3 day/20%
Anthem Elements Choice PPO 6000 Select PPO	Anthem Premier HMO 10/100% Priority Select HMO	Anthem Value HMO 40/60/750 3 day/20% Priority Select HMO
Anthem EPO 0/20/40/0	Anthem Premier HMO 10/100% Select HMO	Anthem Value HMO 40/60/750 3 day/20% Select HMO
Anthem EPO 0/20/40/20		

2025 Essential Drug List Plan Names

Anthem Blue Connection EPO 1000/20/40/20	Anthem Priority Select HMO Value Ded 1000/25/40/25%	Anthem Select HMO Value 40/60/1000 3 day
Anthem Blue Connection EPO 2000/25/50/20	Anthem Priority Select HMO Value Ded 1500/25/50/25%	Anthem Select HMO Value 40/60/750 3 day/20%
Anthem Blue Connection EPO 250/20/40/20	Anthem Priority Select HMO Value Ded 2000/30/60/25%	Anthem Select HMO Value Ded 1000/25/40/25%
Anthem Blue Connection EPO 3000/25/50/20	Anthem Priority Select HMO Value Ded 250/20/40/10%	Anthem Select HMO Value Ded 1500/25/50/25%
Anthem Blue Connection EPO 750/20/40/20	Anthem Priority Select HMO Value Ded 500/20/40/20%	Anthem Select HMO Value Ded 2000/30/60/25%
Anthem CaliforniaCare HMO Advantage 20 or 40/500 3 day/250 OP	Anthem Priority Select HMO Value Ded 750/25/40/25%	Anthem Select HMO Value Ded 250/20/40/10%
Anthem CaliforniaCare HMO Classic 10/30/250 admit/125 OP	Anthem Prudent Buyer EPO 0/20/40/0	Anthem Select HMO Value Ded 500/20/40/20%
Anthem CaliforniaCare HMO Classic 20/40/250 admit/125 OP	Anthem Prudent Buyer EPO 0/20/40/20	Anthem Select HMO Value Ded 750/25/40/25%
Anthem CaliforniaCare HMO Classic 20/40/500 admit/250 OP	Anthem Prudent Buyer EPO 1000/20/40/20	Anthem Select PPO Classic 1000/35/55/20
Anthem CaliforniaCare HMO Classic 30/50/500 admit/250 OP	Anthem Prudent Buyer EPO 2000/25/50/20	Anthem Select PPO Classic 1500/40/60/20
Anthem CaliforniaCare HMO Classic 40/60/750 admit/375 OP	Anthem Prudent Buyer EPO 250/20/40/20	Anthem Select PPO Classic 250/20/40/20
Anthem CaliforniaCare HMO Classic Choice 10/30	Anthem Prudent Buyer EPO 3000/25/50/20	Anthem Select PPO Classic 500/20/40/10
Anthem CaliforniaCare HMO Elements Choice 1500	Anthem Prudent Buyer EPO 750/20/40/20	Anthem Select PPO Classic 500/20/40/20
Anthem CaliforniaCare HMO Elements Choice 3000	Anthem Prudent Buyer PPO Classic 1000/35/55/20	Anthem Select PPO Classic 500/30/50/20
Anthem CaliforniaCare HMO Elements Choice 5900	Anthem Prudent Buyer PPO Classic 1500/40/60/20	Anthem Select PPO Classic 750/30/50/20
Anthem CaliforniaCare HMO Premier 10/100%	Anthem Prudent Buyer PPO Classic 250/20/40/10	Anthem Select PPO Classic PPO 250/20/40/10
Anthem CaliforniaCare HMO Premier 20/100%	Anthem Prudent Buyer PPO Classic 250/20/40/20	Anthem Select PPO Elements Choice 6000
Anthem CaliforniaCare HMO Value 20/40/20%	Anthem Prudent Buyer PPO Classic 500/20/40/10	Anthem Select PPO Elements Choice HSA 6100/0
Anthem CaliforniaCare HMO Value 20/40/250 3 day	Anthem Prudent Buyer PPO Classic 500/20/40/20	Anthem Select PPO HIA Plus 3000/0
Anthem CaliforniaCare HMO Value 20/40/250 3 day/20%	Anthem Prudent Buyer PPO Classic 500/30/50/20	Anthem Select PPO HIA Plus Copay 1000/30/20
Anthem CaliforniaCare HMO Value 30/50/30%	Anthem Prudent Buyer PPO Classic 750/30/50/20	Anthem Select PPO HIA Plus Copay 2000/30/20
Anthem CaliforniaCare HMO Value 30/50/500 3 day	Anthem Prudent Buyer PPO Elements Choice 6000	Anthem Select PPO HRA 3000/0
Anthem CaliforniaCare HMO Value 30/50/500 3 day/20%	Anthem Prudent Buyer PPO Elements Choice HSA 6100/0	Anthem Select PPO HRA Copay 2000/30/20
Anthem CaliforniaCare HMO Value 35/55/750 3 day	Anthem Prudent Buyer PPO Exclusive Classic 20/250 3 day/125 OP	Anthem Select PPO HSA 3300/0
Anthem CaliforniaCare HMO Value 40/60/1000 3 day	Anthem Prudent Buyer PPO Exclusive Classic 20/250 admit/125 OP	Anthem Select PPO HSA 3300/20
Anthem CaliforniaCare HMO Value 40/60/750 3 day/20%	Anthem Prudent Buyer PPO Exclusive Value 30/30	Anthem Select PPO HSA 3500/20
Anthem CaliforniaCare HMO Value Ded 1000/25/40/25%	Anthem Prudent Buyer PPO HIA Plus 3000/0	Anthem Select PPO HSA 4000/20
Anthem CaliforniaCare HMO Value Ded 1500/25/50/25%	Anthem Prudent Buyer PPO HIA Plus Copay 1000/30/20	Anthem Select PPO HSA 4500/20

Anthem CaliforniaCare HMO Value Ded 2000/30/60/25%	Anthem Prudent Buyer PPO HIA Plus Copay 2000/30/20	Anthem Select PPO HSA 5000/20
Anthem CaliforniaCare HMO Value Ded 250/20/40/10%	Anthem Prudent Buyer PPO HRA 3000/0	Anthem Select PPO HSA/H 1650/3300/4100 10/30
Anthem CaliforniaCare HMO Value Ded 500/20/40/20%	Anthem Prudent Buyer PPO HRA Copay 2000/30/20	Anthem Select PPO HSA/H 1650/3300/4100 10/30
Anthem CaliforniaCare HMO Value Ded 750/25/40/25%	Anthem Prudent Buyer PPO HSA 3300/0	Anthem Select PPO HSA/H 1650/3300/4100 20/40
Anthem High Performance EPO 1000/35/70/4000	Anthem Prudent Buyer PPO HSA 3300/20	Anthem Select PPO HSA/H 1650/3300/4100 20/40
Anthem High Performance EPO 2000/40/80/6000	Anthem Prudent Buyer PPO HSA 3500/20	Anthem Select PPO HSA/H 2000/3300/5000 10/30
Anthem High Performance EPO 25/50/3000	Anthem Prudent Buyer PPO HSA 4000/20	Anthem Select PPO HSA/H 2000/3300/5000 10/30
Anthem High Performance EPO 35/70/5000	Anthem Prudent Buyer PPO HSA 4500/20	Anthem Select PPO HSA/H 2000/3300/5000 20/40
Anthem High Performance EPO 40/80/7000	Anthem Prudent Buyer PPO HSA 5000/20	Anthem Select PPO HSA/H 2000/3300/5000 20/40
Anthem High Performance EPO 500/25/50/2500	Anthem Prudent Buyer PPO HSA/H 1650/3300/4100 10/30	Anthem Vivity HMO Classic 10/30/250 admit/125 OP
Anthem High Performance EPO HSA 3300/25/75/5000	Anthem Prudent Buyer PPO HSA/H 1650/3300/4100 10/30	Anthem Vivity HMO Classic 20/40/250 admit/125 OP
Anthem High Performance EPO HSA 4000/25/75/6500	Anthem Prudent Buyer PPO HSA/H 1650/3300/4100 20/40	Anthem Vivity HMO Classic 20/40/500 admit/250 OP
Anthem Link Virtual First High Performance EPO 2000/50/75/5000	Anthem Prudent Buyer PPO HSA/H 1650/3300/4100 20/40	Anthem Vivity HMO Classic 30/50/500 admit/250 OP
Anthem Link Virtual First High Performance EPO 3500/50/75/6500	Anthem Prudent Buyer PPO HSA/H 2000/3300/5000 10/30	Anthem Vivity HMO Classic 40/60/750 admit/375 OP
Anthem Link Virtual First High Performance EPO 6000/50/75/9100	Anthem Prudent Buyer PPO HSA/H 2000/3300/5000 10/30	Anthem Vivity HMO Elements Choice 1500
Anthem Priority Select HMO Classic 10/30/250 admit/125 OP	Anthem Prudent Buyer PPO HSA/H 2000/3300/5000 20/40	Anthem Vivity HMO Elements Choice 3000
Anthem Priority Select HMO Classic 20/40/250 admit/125 OP	Anthem Prudent Buyer PPO HSA/H 2000/3300/5000 20/40	Anthem Vivity HMO Elements Choice 5900
Anthem Priority Select HMO Classic 20/40/500 admit/250 OP	Anthem Select HMO Classic 10/30/250 admit/125 OP	Anthem Vivity HMO Premier 10/100%
Anthem Priority Select HMO Classic 30/50/500 admit/250 OP	Anthem Select HMO Classic 20/40/250 admit/125 OP	Anthem Vivity HMO Premier 20/100%
Anthem Priority Select HMO Classic 40/60/750 admit/375 OP	Anthem Select HMO Classic 20/40/500 admit/250 OP	Anthem Vivity HMO Value 20/40/20%
Anthem Priority Select HMO Classic Choice 10/30	Anthem Select HMO Classic 30/50/500 admit/250 OP	Anthem Vivity HMO Value 20/40/250 3 day
Anthem Priority Select HMO Elements Choice 1500	Anthem Select HMO Classic 40/60/750 admit/375 OP	Anthem Vivity HMO Value 20/40/250 3 day/20%
Anthem Priority Select HMO Elements Choice 3000	Anthem Select HMO Classic Choice 10/30	Anthem Vivity HMO Value 30/50/30%
Anthem Priority Select HMO Elements Choice 5900	Anthem Select HMO Elements Choice 1500	Anthem Vivity HMO Value 30/50/500 3 day
Anthem Priority Select HMO Premier 10/100%	Anthem Select HMO Elements Choice 3000	Anthem Vivity HMO Value 30/50/500 3 day/20%
Anthem Priority Select HMO Premier 20/100%	Anthem Select HMO Elements Choice 5900	Anthem Vivity HMO Value 35/55/750 3 day
Anthem Priority Select HMO Value 20/40/20%	Anthem Select HMO Premier 10/100%	Anthem Vivity HMO Value 40/60/1000 3 day
Anthem Priority Select HMO Value 20/40/250 3 day	Anthem Select HMO Premier 20/100%	Anthem Vivity HMO Value 40/60/750 3 day/20%

Anthem Priority Select HMO Value 20/40/250 3 day/20%	Anthem Select HMO Value 20/40/20%	Anthem Vivity HMO Value Ded 1000/25/40/25%
Anthem Priority Select HMO Value 30/50/30%	Anthem Select HMO Value 20/40/250 3 day	Anthem Vivity HMO Value Ded 1500/25/50/25%
Anthem Priority Select HMO Value 30/50/500 3 day	Anthem Select HMO Value 20/40/250 3 day/20%	Anthem Vivity HMO Value Ded 2000/30/60/25%
Anthem Priority Select HMO Value 30/50/500 3 day/20%	Anthem Select HMO Value 30/50/30%	Anthem Vivity HMO Value Ded 250/20/40/10%
Anthem Priority Select HMO Value 35/55/750 3 day	Anthem Select HMO Value 30/50/500 3 day	Anthem Vivity HMO Value Ded 500/20/40/20%
Anthem Priority Select HMO Value 40/60/1000 3 day	Anthem Select HMO Value 30/50/500 3 day/20%	Anthem Vivity HMO Value Ded 750/25/40/25%
Anthem Priority Select HMO Value 40/60/750 3 day/20%	Anthem Select HMO Value 35/55/750 3 day	

Here are a few things to remember:

- You can view and search our current drug lists when you visit anthem.com/ca and choose Prescription Benefits. Please note: The formulary is subject to change and all previous versions of the formulary are no longer in effect.
- Additional tools and resources are available for current Anthem members to view the most up-to-date list of drugs for your plan - including drugs that have been added, generic drugs and more – by logging in at anthem.com/ca/pharmacy-information/select-your-state or anthem.com/ca/pharmacy-information/drug-list-formulary.
- Your coverage has limitations and exclusions, which means there are certain rules about what's covered by your plan and what isn't. Already a member? You can view your Certificate/Evidence of Coverage or your Summary Plan Description by logging in at anthem.com/ca and go to **My Plan ->Benefits-> Plan Documents**.
- You and your doctor can use this list as a guide to choose drugs that are best for you. Drugs that aren't on this list may not be covered by your plan and may cost you more out of pocket. To help you see how the drug list works with your drug benefit, we've included some frequently asked questions (FAQ) in this document about how the list is set up and what to do if a drug you take isn't on it.

Essential Drug List

Four-Tier

Table of Contents

INFORMATIONAL SECTION	8
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS FOR THE NERVOUS SYSTEM	18
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS	20
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER	21
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER	23
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER	24
ANDROGENS-ANABOLIC - HORMONES	26
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS	27
ANTHELMINTICS - DRUGS FOR INFECTIONS	27
ANTIANGINAL AGENTS - DRUGS FOR THE HEART	27
ANTIANKXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	28
ANTIARRHYTHMICS - DRUGS FOR THE HEART	28
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS	29
ANTICOAGULANTS - DRUGS FOR THE BLOOD	32
ANTICONVULSANTS - DRUGS FOR THE NERVOUS SYSTEM	33
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM	36
ANTIDIABETICS - HORMONES	39
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH	43
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING	43
ANTIEMETICS - DRUGS FOR THE STOMACH	44
ANTIFUNGALS - DRUGS FOR INFECTIONS	45
ANTIHISTAMINES - DRUGS FOR THE LUNGS	45
ANTIHYPERLIPIDEMICS - DRUGS FOR THE HEART	46
ANTIHYPERTENSIVES - DRUGS FOR THE HEART	48
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS	51
ANTIMALARIALS - DRUGS FOR INFECTIONS	53
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES	53
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS	53
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER	53
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM	60
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM	61
ANTIVIRALS - DRUGS FOR INFECTIONS	64
BETA BLOCKERS - DRUGS FOR THE HEART	67
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART	69
CARDIOTONICS - DRUGS FOR THE HEART	70
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART	71
CEPHALOSPORINS - DRUGS FOR INFECTIONS	72
CONTRACEPTIVES - DRUGS FOR WOMEN	73
CORTICOSTEROIDS - HORMONES	79
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS	80
DERMATOLOGICALS - DRUGS FOR THE SKIN	81
DIGESTIVE AIDS - DRUGS FOR THE STOMACH	87
DIURETICS - DRUGS FOR THE HEART	88
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES	89
ESTROGENS - HORMONES	92
FLUOROQUINOLONES - DRUGS FOR INFECTIONS	92
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH	93
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER	95
GENTOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM	95
GOUT AGENTS - DRUGS FOR PAIN AND FEVER	96
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD	96
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION	98
HEMOSTATICS - DRUGS FOR THE BLOOD	99
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM	99
LAXATIVES - DRUGS FOR THE STOMACH	100
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER	101
MACROLIDES - DRUGS FOR INFECTIONS	101
MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT	102

MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM.....	104
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION.....	105
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS.....	107
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT.....	108
MULTIVITAMINS - DRUGS FOR NUTRITION.....	109
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES.....	111
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE.....	111
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES.....	112
NUTRIENTS - DRUGS FOR NUTRITION.....	112
OPHTHALMIC AGENTS - DRUGS FOR THE EYE.....	112
OTIC AGENTS - DRUGS FOR THE EAR.....	116
OXYTOCICS - HORMONES.....	116
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS.....	116
PENICILLINS - DRUGS FOR INFECTIONS.....	117
PROGESTINS - HORMONES.....	118
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM.....	118
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS.....	122
SULFONAMIDES - DRUGS FOR INFECTIONS.....	122
TETRACYCLINES - DRUGS FOR INFECTIONS.....	122
THYROID AGENTS - HORMONES.....	123
TOXOIDS - BIOLOGICAL AGENTS.....	123
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH.....	124
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM.....	125
VACCINES - BIOLOGICAL AGENTS.....	126
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN.....	129
VASOPRESSORS - DRUGS FOR THE HEART.....	129
VITAMINS - DRUGS FOR NUTRITION.....	130



Essential Drug List – Informational Section

Definitions

“**\$0**” next to a drug means this is a preventive drug. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

“**BRAND name drug**” means a drug that is marketed under a proprietary, trademark-protected name. A BRAND name drug is listed in this formulary in all CAPITAL letters.

“**Coinsurance**” means a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“**Copayment**” means a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“**Deductible**” means the amount an enrollee pays for covered health care benefits before the enrollee’s health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

“**Dose Optimization (DO)**” means dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

“**Drug Tier**” is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan’s prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee’s portion of the cost for the drug.

“**Enrollee**” is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this this formulary template shall also include subscriber as defined in this section below.

“**Exception request**” is a request for coverage of a prescription drug. If an enrollee, his or her designee or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee’s condition.

“**Exigent circumstances**” means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

“**Formulary**” or “**prescription drug list**” is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

“**Generic drug**” is the same drug as its BRAND name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.

“**Limited Distribution (LD)**” means limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

“**Medically Necessary**” means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

“**Nonformulary drug**” is a prescription drug that is not listed on the health plan’s formulary.

“**Oral Chemotherapy (OC)**” Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.



“Out-of-pocket costs” are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

“Prescribing provider” is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

“Prescription” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription drug” is a drug that is prescribed by the enrollee’s prescribing provider and requires a prescription under applicable law.

“Prior Authorization (PA)” is a health plan’s requirement that the enrollee or the enrollee’s prescribing provider obtain the health plan’s authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“Quantity limit (QL)” means a restriction on the number of doses of a prescription drug covered by a health insurance product during a specific time period, or any other limitation on the quantity of a drug that is covered.

“Specialty Drugs (SP)” means specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

“Step therapy (ST)” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee’s medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee’s prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

“Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.



Frequently Asked Questions

How do I know what drugs are covered under my benefits?

This is a complete listing of all the drugs on the drug list. But, it's possible a drug(s) on this list may not be covered, depending on your plan's design.

Your pharmacy benefit covers prescription drugs, including Specialty Drugs, that may be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. Benefits that are administered to you in your provider's office are typically covered under your medical benefit. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables and any drug that must be administered by a Provider.

How can I find a drug on the list?

(A) A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the BRAND name or **generic** name of the drug in the alphabetical index; and

(B) If a **generic** equivalent for a BRAND name drug is not available on the market or is not covered, the drug will not be separately listed by its **generic** name.

You can search the PDF drug list by:

- Drug name, using Ctrl + F on your keyboard, then type in the name of the drug you're looking for.
- Drug class, using the categories listed in alphabetical order.

How are drugs shown on the list?

- A drug is listed alphabetically by its BRAND name and **generic** names in the therapeutic category and class to which it belongs;
- The **generic** name for a BRAND name drug is included after the BRAND name in parentheses and all **bold and italicized lowercase** letters;

PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS TYPE - DRUGS FOR SEVERE MENTAL DISORDERS
<i>NUEDEXTA ORAL CAPSULE (dextromethorphan)</i>

- If a **generic** equivalent for a BRAND name drug is both available and covered, the **generic** drug will be listed separately from the BRAND name drug in all **bold and italicized lowercase letters**; and

AMINOPENICILLIN ANTIBIOTIC - ANTIBIOTICS
<i>amoxicillin oral capsule</i>

- If a **generic** drug is marketed under a proprietary, trademark-protected BRAND name, the BRAND name will be listed after the **generic** name in parentheses and regular typeface with the first letter of each word capitalized.

<i>levonorgestrel-ethinyl estrad (Portia 28 Oral Tablet)</i>

The "Under Coverage Requirements and Limits" section will indicate if you need preapproval before you can take the drug (called prior authorization or PA), or if you need to try other drugs first for your treatment (called step therapy or ST).

Note: The presence of a prescription drug on the formulary does not guarantee that your doctor will prescribe that prescription drug for a particular medical condition.



What are my options for getting my prescriptions?

You have plenty of choices about how and where to get your prescription medicines, including local pharmacies in your plan, convenient home delivery or specialty pharmacies.

Local pharmacies

Your plan includes local pharmacies at major retail chains, such as CVS, Walmart, Target, and Kroger. You'll save the most money when you use one of these pharmacies.

To find a pharmacy near you:

1. Log in at [anthem.com/ca](https://www.anthem.com/ca).
2. Choose Find a Pharmacy.
3. Enter your ZIP code.

CarelonRx Pharmacy

For medications you take regularly, have your prescriptions delivered to your home with CarelonRx Pharmacy. Current Anthem members can get started at [anthem.com/ca](https://www.anthem.com/ca) and go to the "Pharmacy Benefits" page. You can also log in to our Sydney Health mobile app and select "Pharmacy". Register your member account if you haven't already. Go to "View Prescriptions" and follow the guided steps to switch to CarelonRx Pharmacy. Shipping is always free. Call the CarelonRx Pharmacy Contact Center at 833-396-0309 or use the live chat feature on Sydney Health or [anthem.com/ca](https://www.anthem.com/ca) for assistance.

Specialty pharmacy

If you have a complex or chronic condition treated with specialty medication — one that may need special handling or is given by injection or infusion — you'll need to get it through our specialty pharmacy. Your doctor will send the prescription to our specialty pharmacy for you, and it will be delivered to your home or your doctor's office if it needs to be administered by a doctor.

Current Anthem members can find out more by logging in at [anthem.com/ca](https://www.anthem.com/ca) and choose Prescription Benefits or call 833-203-1739. For more details about your coverage, you can call the phone number on your member ID card.

What if my drug isn't on the list?

Drugs not listed on the formulary are called non-formulary drugs. We understand that only you and your doctor know what is best for you. If you want to take a drug that's not on the drug list, you may have to pay the full cost for it. You can also talk to your doctor or pharmacist to see if there's another drug covered by your plan that will work just as well, or if generic or OTC drugs are an option. Only you and your doctor can decide what drugs are right for you. If it is determined that a non-formulary drug is medically appropriate and necessary, that drug will be covered under the terms of your benefits.

If a drug you're taking isn't covered, your doctor can ask us to review the coverage. This process is called preapproval or prior authorization.

Your doctor can get the process started by completing an electronic Prior Authorization, calling the Member Services number on the back of your member ID card or by downloading a prior authorization form from our website and submitting it. If your request is approved, the amount you pay for the drug will depend on your plan's benefit.

There are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermyeds.com/main/partners/anthem>.
2. Log in at [anthem.com/ca](https://www.anthem.com/ca) and choose **Pharmacy**.
 - o Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
 - o Choose the correct medication strength and form.
 - o Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
 - o Your doctor [completes and faxes the form](#) to us at 844-474-3347.
3. Calling Member Services number on the back of your member ID card.

If the contraceptive you are taking is not on the formulary, your doctor can contact us if it is medically necessary because the preferred contraceptives are inappropriate for you, and we will waive your cost share.

Once we receive all the needed supporting information, we will approve or deny the exception request based on medical necessity.

If we fail to respond to a completed prior authorization or exception request within 24 hours of receiving a request based on exigent circumstances, we will provide coverage, including refills for the duration of the exigency.



If we fail to respond to a completed prior authorization or exception request within 72 hours of receiving a non-urgent request, we will provide coverage, including refills for the duration of the prescription.

We will notify you or your authorized representative and prescribing provider about a completed prior authorization or step therapy exception within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests.

You may also contact Member Services, 24 hours a day, 7 days a week. If you wish to have a non-formulary drug that your doctor determines not to be medically necessary, you may file a grievance with Member Services by calling 1-800-365-0609 or 1-866-333-4823 (TDD line if you have hearing or speech loss). If the Prior Authorization Center concludes the prescription claim should be denied, members and their doctors will get letters that explain the appeals and/or grievance process.

If you are currently taking the drug and it was approved by your previous health plan or by us, we will not require you to try other drugs first. If the drug is safe and effective for your condition, we will continue to cover it.

Who decides what drugs are on the list?

The drugs on the list are reviewed through our Pharmacy and Therapeutics (P&T) process. In this process, a group of independent doctors, pharmacists and other health care professionals decides which drugs we include on our lists. This group meets regularly to look at new and existing drugs and recommends drugs based on how safe they are, how well they work and the value they offer our members.

What is a specialty drug and how do I get them?

If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered. Specialty drugs come in many forms like pills, liquids, injections (shots), infusions or inhalers and may need special storage and handling. Typically benefits for specialty drugs that are self-administered will be covered under the pharmacy benefit. Benefits for specialty drugs that are administered to you in your provider's office are typically covered under your medical benefit. If you use pharmacies that are not in the network, your medicine may not be covered and you may have to pay the full cost. For more details about your coverage, you can call the phone number on your member ID card.

Does the drug list change, and how will I know if it does?

Drugs on our list are reviewed and updated on a monthly basis. Sometimes, drugs are added, removed, change tiers or have updated requirements. The changes will usually go into effect the first day of the month. But don't worry, we'll let you know if a drug you take is taken off the list and, in some cases, if a drug you take is moved to a higher tier.

You can always check the drug list to make sure medicines you take are still on it. You'll find the most up-to-date drug list when you log in at anthem.com/ca.

What kind of drugs can I find on the formulary?

We cover FDA-approved preventive care drugs with zero cost share in compliance with the Affordable Care Act (ACA) and California state regulations. Your doctor may need to write a prescription for these preventive services to be covered by your plan, even if they are listed as over-the-counter. The availability or coverage of these medications without cost-sharing may be subject to criteria established by the health plan.

We cover FDA-approved equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program authorized by the State's Diabetes Control Project within the Bureau of Health.

What drugs can I find in each tier?

We place drugs on different tiers based on how well they work to improve health, whether there are over-the-counter (OTC) options and their costs compared to other drugs used for the same type of treatment. The lower the tier, the lower your share of the cost. Here's a breakdown of the tiers in your plan:

- Tier 1 drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Some plans split Tier 1 into Tier 1a and Tier 1b:
 - Tier 1a drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.
 - Tier 1b drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.



- Tier 2 drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have the highest cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs that were recently approved by the FDA or specialty drugs that are used to treat serious, long-term health conditions and that may need special handling.
- Tier 4 drugs have the highest cost share and usually include specialty BRAND and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

How will I know if my drug is covered and how much will it cost?

You can go online and with the [Price a Medication](#) tool, get pharmacy-specific drug coverage details and pricing from a number of local retail pharmacies in your zip code.

Note: For oral chemotherapy drugs - Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

How does Anthem promote safety?

When you go to a pharmacy, the pharmacist will get an electronic message from Anthem if a drug needs prior authorization, requires step therapy or has a limit on the amount that can be given. Here's a closer look at all of the programs we've put into place to help make sure you get the care you need, while helping to keep you safe.

Our clinical edit programs are:

- Prior authorization, which requires you to get approval before taking a medicine. This helps make sure a drug is used properly and focuses on drugs that may have:
 - Risk of side effects.
 - Risk of harmful effects when taken with other drugs.
 - Potential for incorrect use or abuse.
 - Rules for use with certain conditions.
- Step therapy, which requires that other drugs be tried first. It focuses on whether a drug is right for your condition.
- Dose optimization, which involves changing from taking a dose twice a day to once a day, when medically appropriate. Taking fewer doses may lower your costs; a single higher dose of a drug taken once a day may cost less than a lower dose taken twice a day.
- Quantity Limits impose a limit on the amount in a prescription and how often it can be refilled.
 - If a refill request is submitted too soon or the doctor prescribes an amount that's higher than what is allowed, the drug won't be covered at that time.
 - If there are medical reasons to prescribe the drug as originally dosed, the doctor can ask for review by our Prior Authorization Center.

Also, if you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered.

What is Prior Authorization? How does it work?

Prior Authorization is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

Your doctor can get the process started by completing an electronic Prior Authorization, calling the Member Services number on the back of your member ID card or by downloading a prior authorization form from our website and submitting it. If your request is approved, the amount you pay for the drug will depend on your plan's benefit.



There are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermyeds.com/main/partners/anthem>.
2. Log in at anthem.com/ca and choose **Pharmacy**.
 - o Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
 - o Choose the correct medication strength and form.
 - o Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
 - o Your doctor completes and faxes the form to us at 844-474-3347.
3. Calling Member Services number on the back of your member ID card.

Once we receive all the needed supporting information, we will approve or deny the exception request based on medical necessity.

If we fail to respond to a completed prior authorization or exception request within 24 hours of receiving a request based on exigent circumstances, we will provide coverage, including refills for the duration of the exigency.

If we fail to respond to a completed prior authorization or exception request within 72 hours of receiving a non-urgent request, we will provide coverage, including refills for the duration of the prescription.

We will notify you or your authorized representative and prescribing provider about a completed prior authorization or step therapy exception within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests.

You may also contact Member Services, 24 hours a day, 7 days a week. If you wish to have a non-formulary drug that your doctor determines not to be medically necessary, you may file a grievance with Member Services by calling 1-800-365-0609 or 1-866-333-4823 (TDD line if you have hearing or speech loss). If the Prior Authorization Center concludes the prescription claim should be denied, members and their doctors will get letters that explain the appeals and/or grievance process.

If you are currently taking the drug and it was approved by your previous health plan or by us, we will not require you to try other drugs first. If the drug is safe and effective for your condition, we will continue to cover it.

What is Step Therapy? How does it work?

Step therapy requires trying other drugs before certain medications may be covered. The pharmacy will let you know if step therapy is required, and you must first try the drug or treatment included in the program. If the drug or treatment does not treat the condition well, the doctor can contact our Prior Authorization Center to ask that we approve the original drug.

There are a few options for your doctor to start the Step Therapy (ST) exception process:

1. Submit an electronic PA request by going to <https://www.covermyeds.com/main/partners/anthem>.
2. Log in at anthem.com/ca and choose **Pharmacy**.
 - o Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
 - o Choose the correct medication strength and form.
 - o Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
 - o Your doctor completes and faxes the form to us at 844-474-3347.
3. Calling Member Services number on the back of your member ID card.

Once we receive all the needed supporting information, we will approve or deny the exception request based on medical necessity.

If we fail to respond to a completed step therapy exception request within 24 hours of receiving a request based on exigent circumstances, we will provide coverage, including refills for the duration of the exigency.

If we fail to respond to a completed step therapy exception request within 72 hours of receiving a non-urgent request, we will provide coverage, including refills for the duration of the prescription.

We will notify you or your authorized representative and prescribing provider about a completed prior authorization or step therapy exception within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests.

In circumstances where an enrollee is changing plans, we will not require the enrollee to repeat step therapy when they are already being treated for a medical condition by a prescription drug, provided that the drug is appropriately prescribed and considered safe and effective for the enrollee's condition.

If we have previously approved coverage of the drug for your medical condition, and your provider continues to prescribe for the medical condition, provided the drug is appropriately prescribed and safe and effective for your condition, we will not exclude coverage of the drug.



Rights Available to Members

If you don't agree with a coverage decision, you have the right to ask for a grievance (also known as an appeal). Unless your benefits booklet states otherwise, you must ask for a grievance within 180 calendar days from the date you get the coverage decision letter. Your provider, or any other person you choose (authorized representative), may ask for a grievance on your behalf. A person of your choice may also help you during the grievance process. You need to let us know, in writing, if you want someone to help or represent you.

How do I ask for an urgent (expedited) grievance?

An urgent grievance is available if you haven't had services (pre-service) or if you are currently getting services (concurrent care) and you, or your health care provider, believe that your condition could involve an imminent and serious threat to your health, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function.

We will let you know the decision within 3 calendar days after we get a qualifying urgent grievance. We will let you know the decision by phone. We will also send you the decision in writing.

You, or any person you choose, can ask for an urgent grievance in writing or by phone:

In writing: Overnight mail

**Grievances and Appeals
21215 Burbank Boulevard
Woodland Hills, CA 91367**

By phone: **1-800-365-0609** or **1-866-333-4823** (TDD line if you have hearing or speech loss)

By fax: **1-855-211-3699**

If you qualify for an urgent grievance, you may ask for an independent medical review (IMR) with the Department of Managed Health Care (the department) instead of, or at the same time as, asking for an urgent grievance with your health plan. Details about IMR are included in this document (see "If I don't agree with the grievance decision, what other rights do I have?").

How do I ask for a standard (not expedited) grievance?

You, or any person you choose, can ask for a standard grievance in writing, by phone or online at www.anthem.com/ca.

In writing: **Grievances and Appeals
P.O. Box 4310**

Woodland Hills, CA 91365-4310

By phone: **1-800-365-0609** or **866-333-4823** (TDD line for the hearing and speech impaired)

By fax: **1-877-551-6183**

We will send a written decision within 30 calendar days from the date we get the grievance. Our response will have reasons for the decision and references to the plan provisions on which the decision was based. However, grievances received over the phone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, will not receive a written response.

Can I get copies of documents for my records?

Of course! You can call us or send a letter to ask for free copies of all documents, including the actual benefit provision, guideline, protocol or other similar criterion this decision was based on.

Can I get diagnosis and treatment codes?

You can! Just call us to ask for them. You can also ask for descriptions of the codes, if they are available.

What should my grievance include?

Include, if available, the following information:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree; and
- The specific reason(s) why you don't agree with the decision.

You have the right, and we encourage you, to give us written comments, documents, and other relevant information with your grievance.



How will my grievance be handled?

The appropriate administrative and/or clinical specialists will review your grievance. All relevant information submitted by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. We may contact any providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial decision. They also will not be a subordinate of the person who made the initial decision.

If I don't agree with the grievance decision, what other rights do I have?

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

You may ask for an IMR immediately without going through your health plan's grievance process if:

- Your disputed health care service involves experimental or investigational treatment; or
- The department decides that an earlier review is warranted; or
- There is an imminent or serious threat to your health that requires an urgent (expedited) review of your case.

We will help you with the application process if an urgent review of your case is warranted. You can find the application and instructions online at www.dmhc.ca.gov (the department's website). IMR is free to you. There aren't any filing fees either.

If we deny your grievance, we will give you more details about dispute resolution options available to you. You may also refer to your benefits booklet or call Member Services at the phone number on your member ID card for details about the entire grievance process.

A note about opioid analgesics. The member cost share for certain abuse-deterrent opioid analgesics may be lower in some states because of laws in those states. Opioid analgesics are a type of painkiller. In response to the global opioid epidemic, the U.S. Food and Drug Administration (FDA) has encouraged drug manufacturers to develop opioids with properties that help deter their misuse and abuse.

Drug(s) may be excluded from the list based on your plan's benefit design.

KEY

Here are some terms and notes you'll find on the drug list.

BRAND name drugs are in **UPPER CASE**, plain type.

generic drugs are in lower case, italic bold type.

\$0 = preventive drugs. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

BE = benefit exclusion. This drug may not be covered depending on your plans design. To find out if your drug is covered, log into your member portal or use the Sydney app to [Price a Medication](#) and refer to your plan documents.

DO = dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

LD = limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

OC = oral chemotherapy. These drugs after deductible shall not exceed \$200 per an individual prescription for up to a 30 day supply.

PA = prior authorization. You may need to get benefits approved before certain prescriptions can be filled.

QL = quantity limits. There are limits on the amount of medicine covered within a certain amount of time.

SP = specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

ST = step therapy. You may need to use another recommended drug first before a prescribed drug is covered.

Tier 1 = drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions.

Tier 1a = drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 1b = drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.

Tier 2 = drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.

Tier 3 = drugs have a higher cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition.

Tier 4 = Tier 4 drugs have a higher cost share and usually include preferred specialty brand and generic drugs.

Four-Tier

CURRENT AS OF 10/1/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>clonidine hcl er oral tablet extended release 12 hour</i>	1 or 1b*	PA
<i>guanfacine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA
*ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>atomoxetine hcl oral capsule</i>	1 or 1b*	PA
*AMPHETAMINE MIXTURES*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	1 or 1b*	PA; DO
<i>amphetamine-dextroamphetamine oral tablet 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>amphet-dextroamphet 3-bead er oral capsule extended release 24 hour</i>	2	PA; QL (1 capsule per 1 day)
*AMPHETAMINES*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>amphetamine sulfate oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>amphetamine sulfate oral tablet 5 mg</i>	1 or 1b*	DO
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg</i>	1 or 1b*	PA; QL (4 capsules per 1 day)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg</i>	1 or 1b*	PA; DO
<i>dextroamphetamine sulfate oral solution</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>dextroamphetamine sulfate oral tablet 10 mg, 7.5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>dextroamphetamine sulfate oral tablet 15 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>dextroamphetamine sulfate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>dextroamphetamine sulfate oral tablet 20 mg, 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	2	PA; DO
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	2	PA; QL (1 capsule per 1 day)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	2	PA; DO
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	2	PA; QL (1 tablet per 1 day)
<i>procentra oral solution</i>	1 or 1b*	PA; QL (60 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zenzedi oral tablet 10 mg, 7.5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>zenzedi oral tablet 15 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>zenzedi oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>zenzedi oral tablet 20 mg, 30 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
*ANALEPTICS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>caffeine citrate oral solution</i>	2	
*ANOREXIANTS NON-AMPHETAMINE*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>benzphetamine hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
<i>diethylpropion hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
<i>diethylpropion hcl oral tablet</i>	1 or 1b*	PA; BE; QL (3 tablets per 1 day)
<i>phendimetrazine tartrate oral tablet</i>	1 or 1b*	PA; BE; QL (6 tablets per 1 day)
<i>phentermine hcl oral capsule</i>	1 or 1b*	PA; BE; QL (1 capsule per 1 day)
<i>phentermine hcl oral tablet 37.5 mg</i>	1 or 1b*	PA; BE; QL (1 tablet per 1 day)
*ANTI-OBESITY - GIP & GLP-1 RECEPTOR AGONISTS*** - DRUGS FOR THE NERVOUS SYSTEM		
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide-weight management</i>)	3	PA; BE; QL (1 pen per 1 week)
*HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS*** - DRUGS FOR SLEEP DISORDER		
WAKIX ORAL TABLET 17.8 MG (<i>pitolisant hcl</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
WAKIX ORAL TABLET 4.45 MG (<i>pitolisant hcl</i>)	4	PA; LD; DO; SP
*LIPASE INHIBITORS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>orlistat oral capsule</i>	2	PA; BE; QL (3 capsules per 1 day)
*STIMULANTS - MISC.*** - DRUGS FOR ATTENTION DEFICIT DISORDER		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	PA; QL (1 tablet per 1 day)
<i>armodafinil oral tablet 50 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg</i>	1 or 1b*	ST; DO
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg</i>	1 or 1b*	ST; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 30 mg, 35 mg, 40 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 5 mg</i>	1 or 1b*	PA; DO
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg</i>	1 or 1b*	PA; QL (2 capsules per 1 day)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	1 or 1b*	PA; QL (2 tablets per 1 day)
<i>methylphenidate hcl er (osm) oral tablet extended release 45 mg, 54 mg, 63 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
METHYLPHENIDATE HCL ER (OSM) ORAL TABLET EXTENDED RELEASE 72 MG	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er (xr) oral capsule extended release 24 hour 40 mg, 50 mg, 60 mg</i>	1 or 1b*	PA; QL (1 capsule per 1 day)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate hcl oral tablet 20 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 10 mg</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>methylphenidate hcl oral tablet chewable 2.5 mg</i>	1 or 1b*	ST; DO
<i>methylphenidate hcl oral tablet chewable 5 mg</i>	1 or 1b*	PA; DO
<i>methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr</i>	2	ST; DO
<i>methylphenidate transdermal patch 20 mg/9hr, 30 mg/9hr</i>	2	ST; QL (1 patch per 1 day)
<i>modafinil oral tablet 100 mg</i>	2	PA; DO
<i>modafinil oral tablet 200 mg</i>	2	PA; QL (1 tablet per 1 day)
AMINOGLYCOSIDES - DRUGS FOR INFECTIONS		
*AMINOGLYCOSIDES*** - ANTIBIOTICS		
<i>amikacin sulfate injection solution</i>	2	
<i>gentamicin in saline intravenous solution</i>	2	
<i>gentamicin sulfate injection solution</i>	2	
<i>neomycin sulfate oral tablet</i>	1 or 1a*	
<i>streptomycin sulfate intramuscular solution reconstituted</i>	1 or 1b*	
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	4	QL (224 mL per 28 days); SP
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	4	QL (10 mL per 1 day); SP
<i>tobramycin sulfate injection solution 1.2 gm/30ml</i>	2	QL (900 mL per 30 days)
<i>tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml</i>	2	QL (180 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tobramycin sulfate injection solution 2 gm/50ml</i>	2	QL (1500 mL per 30 days)
<i>tobramycin sulfate injection solution reconstituted</i>	2	QL (30 vials per 30 days)
ANALGESICS - ANTI-INFLAMMATORY - DRUGS FOR PAIN AND FEVER		
*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
RINVOQ LQ ORAL SOLUTION (<i>upadacitinib</i>)	4	PA; QL (12 mL per 1 day); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>upadacitinib</i>)	4	PA; QL (1 tablet per 1 day); SP
XELJANZ ORAL SOLUTION (<i>tofacitinib citrate</i>)	4	PA; QL (10 mL per 1 day); SP
XELJANZ ORAL TABLET (<i>tofacitinib citrate</i>)	4	PA; QL (2 tablets per 1 day); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>tofacitinib citrate</i>)	4	PA; QL (1 tablet per 1 day); SP
*ANTIRHEUMATIC ANTIMETABOLITES*** - ARTHRITIS AND PAIN DRUGS		
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>methotrexate anti-rheumatic</i>)	4	PA; QL (4 auto-injector per 28 days); SP
*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS		
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab</i>)	4	PA; QL (2 pens per 28 days); SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab</i>)	4	PA; QL (2 pens per 28 days (QL exception needed for all 80 mg doses)); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>adalimumab</i>)	4	PA; QL (2 syringes per 28 days); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	4	PA; QL (1 kit per 1 one-time fill); SP
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab</i>)	4	PA; QL (1 kit per 1 one-time fill); SP
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	4	PA; QL (2 pens per 28 days); SP
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab-ryvk</i>)	4	PA; QL (2 pens per 28 days (QL exception needed for all 80 mg doses)); SP
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT (<i>adalimumab-ryvk</i>)	4	PA; QL (2 pens per 28 days); SP
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT (<i>adalimumab-ryvk</i>)	4	PA; QL (2 syringes per 28 days); SP
SIMPONI ARIA INTRAVENOUS SOLUTION (<i>golimumab</i>)	4	PA; SP
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>golimumab</i>)	4	PA; QL (1 pen per 28 days); SP
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>golimumab</i>)	4	PA; QL (1 syringe per 28 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	2	QL (2 capsules per 1 day)
<i>celecoxib oral capsule 400 mg</i>	2	QL (1 capsule per 1 day)
*GOLD COMPOUNDS*** - ARTHRITIS AND PAIN DRUGS		
RIDAURA ORAL CAPSULE (<i>auranofin</i>)	2	QL (3 capsules per 1 day)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg</i>	2	QL (4 tablets per 1 day)
<i>diclofenac-misoprostol oral tablet delayed release 75-0.2 mg</i>	2	QL (2 tablets per 1 day)
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*** - ARTHRITIS AND PAIN DRUGS		
<i>diclofenac potassium oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium er oral tablet extended release 24 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 25 mg</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>ec-naproxen oral tablet delayed release</i>	1 or 1b*	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>etodolac er oral tablet extended release 24 hour 600 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>etodolac oral capsule 200 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>etodolac oral capsule 300 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>etodolac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>flurbiprofen oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>flurbiprofen oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>ibu oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>indomethacin er oral capsule extended release</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>indomethacin oral capsule 25 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>indomethacin oral capsule 50 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>ketoprofen er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>ketorolac tromethamine injection solution 15 mg/ml</i>	2	QL (4 ML per 30 days)
KETOROLAC TROMETHAMINE INJECTION SOLUTION 30 MG/ML	2	QL (2 mL per 30 days)
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	2	QL (2 mL per 30 days)
<i>ketorolac tromethamine oral tablet</i>	1 or 1a*	QL (20 tablets per 30 days)
<i>meclofenamate sodium oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>mefenamic acid oral capsule</i>	1 or 1b*	QL (29 capsule per 1 fill)
<i>meloxicam oral tablet 15 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>meloxicam oral tablet 7.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nabumetone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>nabumetone oral tablet 750 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>naproxen dr oral tablet delayed release</i>	1 or 1b*	
<i>naproxen oral tablet 250 mg, 375 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen oral tablet 500 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>naproxen oral tablet delayed release</i>	1 or 1b*	
<i>naproxen sodium oral tablet 275 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>naproxen sodium oral tablet 550 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxaprozin oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>piroxicam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>sulindac oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>tolmetin sodium oral capsule</i>	2	Effective 01/01/2026: NF; QL (3 capsules per 1 day)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
OTEZLA ORAL TABLET (<i>apremilast</i>)	4	PA; QL (2 tablets per 1 day); SP
OTEZLA ORAL TABLET THERAPY PACK (<i>apremilast</i>)	4	PA; QL (1 pack per 1 one-time fill); SP
*PYRIMIDINE SYNTHESIS INHIBITORS*** - ARTHRITIS AND PAIN DRUGS		
<i>leflunomide oral tablet</i>	2	QL (1 tablet per 1 day)
*SELECTIVE COSTIMULATION MODULATORS*** - ARTHRITIS AND PAIN DRUGS		
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>abatacept</i>)	4	PA; QL (4 Syringes per 28 days); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>abatacept</i>)	4	PA; QL (4 syringes per 28 days); SP
*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS*** - ARTHRITIS AND PAIN DRUGS		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE (<i>etanercept</i>)	4	PA; QL (4 cartridge per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION (<i>etanercept</i>)	4	PA; QL (8 injections per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (<i>etanercept</i>)	4	PA; QL (8 syringes per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (<i>etanercept</i>)	4	PA; QL (4 syringes per 28 days); SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>etanercept</i>)	4	PA; QL (4 pens per 28 days); SP
ANALGESICS - NONNARCOTIC - DRUGS FOR PAIN AND FEVER		
*ANALGESICS OTHER*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANALGESICS-SEDATIVES*** - ARTHRITIS AND PAIN DRUGS		
<i>bac (butalbital-acetamin-caff) oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-acetaminophen oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-apap-caffeine oral capsule 50-300-40 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-apap-caffeine oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>butalbital-aspirin-caffeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tencon oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*SALICYLATES*** - ARTHRITIS AND PAIN DRUGS		
<i>diflunisal oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
ANALGESICS - OPIOID - DRUGS FOR PAIN AND FEVER		
*CODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>acetaminophen-codeine oral solution</i>	1 or 1a*	AL; QL (90 mL per 1 day)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	1 or 1a*	AL; QL (6 tablets per 1 day)
<i>acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg</i>	1 or 1a*	AL; QL (6 tablet per 1 day)
<i>ascomp-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg</i>	1 or 1b*	AL; QL (6 capsules per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
<i>butalbital-asa-caff-codeine oral capsule</i>	1 or 1b*	AL; QL (6 capsule per 1 day)
*DIHYDROCODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>apap-caff-dihydrocodeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>trezix oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
*HYDROCODONE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15ml, 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	1 or 1b*	QL (90 mL per 1 day)
<i>hydrocodone-acetaminophen oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-ibuprofen oral tablet</i>	1 or 1b*	QL (5 tablets per 1 day)
*OPIOID AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
<i>codeine sulfate oral tablet 30 mg</i>	2	AL; QL (6 tablets per 1 day)
FENTANYL CITRATE (PF) INJECTION SOLUTION 100 MCG/2ML, 250 MCG/5ML	1 or 1b*	
<i>fentanyl citrate (pf) injection solution 1000 mcg/20ml, 2500 mcg/50ml, 500 mcg/10ml</i>	1 or 1b*	
<i>fentanyl transdermal patch 72 hour</i>	2	PA; QL (15 patches per 30 days)
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl er oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>hydromorphone hcl injection solution 4 mg/ml</i>	1 or 1b*	
<i>hydromorphone hcl oral liquid</i>	1 or 1b*	QL (24 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydromorphone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>hydromorphone hcl pf injection solution 50 mg/5ml, 500 mg/50ml</i>	1 or 1b*	
<i>levorphanol tartrate oral tablet 3 mg</i>	2	PA; QL (6 tablets per 1 day)
<i>meperidine hcl injection solution</i>	1 or 1b*	
<i>meperidine hcl oral solution</i>	1 or 1b*	QL (7 days per 1 fill)
<i>meperidine hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>methadone hcl intensol oral concentrate</i>	1 or 1b*	PA; QL (6 mL per 1 day)
<i>methadone hcl oral concentrate</i>	1 or 1b*	PA; QL (6 mL per 1 day)
<i>methadone hcl oral solution</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methadone hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (6 tablet per 1 day)
<i>methadone hcl oral tablet 5 mg</i>	1 or 1b*	PA; QL (6 tablets per 1 day)
<i>methadone hcl oral tablet soluble</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>methadose oral tablet soluble</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>mitigo injection solution</i>	2	
<i>morphine sulfate (concentrate) oral solution 10 mg/0.5ml</i>	1 or 1b*	QL (6 mL per 1 day)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	1 or 1b*	
<i>morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	1 or 1b*	
<i>morphine sulfate er beads oral capsule extended release 24 hour</i>	2	PA; QL (1 capsule per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour</i>	2	PA; QL (2 capsules per 1 day)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg</i>	2	PA; QL (3 tablet per 1 day)
<i>morphine sulfate intravenous solution 10 mg/ml, 2 mg/ml, 4 mg/ml, 8 mg/ml</i>	1 or 1b*	
<i>morphine sulfate oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>morphine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone hcl oral capsule</i>	2	QL (7 days per 1 fill)
<i>oxycodone hcl oral concentrate</i>	2	QL (6 mL per 1 day)
<i>oxycodone hcl oral solution</i>	2	QL (30 mL per 1 day)
<i>oxycodone hcl oral tablet</i>	2	QL (6 tablets per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour</i>	2	PA; QL (2 tablets per 1 day)
<i>oxymorphone hcl oral tablet 10 mg</i>	2	QL (6 tablet per 1 day)
<i>oxymorphone hcl oral tablet 5 mg</i>	2	QL (6 tablets per 1 day)
<i>remifentanil hcl intravenous solution reconstituted</i>	1 or 1b*	
SUFENTANIL CITRATE INTRAVENOUS SOLUTION	1 or 1b*	
<i>tramadol hcl (er biphasic) oral capsule extended release 24 hour</i>	2	PA; QL (1 capsule per 1 day)
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>tramadol hcl er oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>tramadol hcl oral tablet 100 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>tramadol hcl oral tablet 25 mg</i>	2	PA; QL (16 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tramadol hcl oral tablet 50 mg</i>	1 or 1b*	AL; QL (8 tablets per 1 day)
*OPIOID COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>endocet oral tablet 5-325 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
OXYCODONE-ACETAMINOPHEN ORAL SOLUTION 5-325 MG/5ML	1 or 1b*	QL (60 mL per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 5-325 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
*OPIOID PARTIAL AGONISTS*** - ARTHRITIS AND PAIN DRUGS		
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>buprenorphine</i>)	4	LD; QL (4 syringes per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>buprenorphine</i>)	4	LD; QL (1 syringe per 28 days)
<i>buprenorphine hcl injection solution</i>	2	
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	1 or 1b*	QL (12 tablets per 90 days)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1 or 1b*	QL (3 tablets per 90 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1 or 1b*	QL (2 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	1 or 1b*	QL (16 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	1 or 1b*	QL (8 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1 or 1b*	QL (4 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>buprenorphine transdermal patch weekly</i>	2	PA; QL (1 package per 28 days)
<i>butorphanol tartrate injection solution</i>	2	
<i>butorphanol tartrate nasal solution</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>nalbuphine hcl injection solution</i>	2	QL (2 mL per 1 day)
<i>pentazocine-naloxone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*TRAMADOL COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS		
<i>tramadol-acetaminophen oral tablet</i>	1 or 1b*	AL; QL (8 tablet per 1 day)
ANDROGENS-ANABOLIC - HORMONES		
*ANDROGENS*** - DRUGS FOR MEN		
<i>danazol oral capsule 100 mg, 50 mg</i>	2	QL (2 capsules per 1 day)
<i>danazol oral capsule 200 mg</i>	2	QL (4 capsules per 1 day)
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION (<i>testosterone cypionate</i>)	1 or 1b*	PA
<i>testosterone cypionate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone enanthate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)</i>	2	PA; QL (1 bottle per 30 days)
<i>testosterone transdermal gel 10 mg/act (2%)</i>	2	PA; QL (1 pump per 30 days)
<i>testosterone transdermal gel 12.5 mg/act (1%)</i>	2	PA; QL (2 bottles per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	2	PA; QL (1 packet per 1 day)
<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	2	PA; QL (2 packet per 1 day)
<i>testosterone transdermal solution</i>	2	PA; QL (1 pump bottle per 30 days)
XYOSTED SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>testosterone enanthate</i>)	3	PA
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS		
*INTRARECTAL STEROIDS*** - RECTAL PREPARATIONS		
<i>budesonide rectal foam 2 mg</i>	2	QL (4.78 gm per 1 day)
<i>budesonide rectal foam 2 mg/act</i>	2	QL (4.78 grams per 1 day)
<i>hydrocortisone rectal enema</i>	1 or 1b*	
*NITRATE VASODILATING AGENTS*** - RECTAL PREPARATIONS		
<i>nitroglycerin rectal ointment</i>	2	QL (1 unit per 1 day)
*RECTAL ANESTHETIC/STEROIDS*** - RECTAL PREPARATIONS		
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	1 or 1b*	
*RECTAL STEROIDS*** - RECTAL PREPARATIONS		
<i>hydrocortisone (perianal) external cream</i>	1 or 1b*	
PROCTOCORT EXTERNAL CREAM (<i>hydrocortisone</i>)	1 or 1b*	
<i>procto-med hc external cream</i>	1 or 1b*	
<i>proctosol hc external cream</i>	1 or 1b*	
<i>proctozone-hc external cream</i>	1 or 1b*	
ANTHELMINTICS - DRUGS FOR INFECTIONS		
*ANTHELMINTICS*** - DRUGS FOR PARASITES		
<i>albendazole oral tablet</i>	1 or 1b*	PA; QL (4 tablets per 1 day)
<i>ivermectin oral tablet 3 mg</i>	1 or 1b*	QL (9 tablets per 1 fill)
<i>ivermectin oral tablet 6 mg</i>	1 or 1b*	QL (4 tablets per 1 fill)
<i>praziquantel oral tablet</i>	2	
ANTIANGINAL AGENTS - DRUGS FOR THE HEART		
*ANTIANGINALS-OTHER*** - DRUGS FOR ANGINA		
<i>ranolazine er oral tablet extended release 12 hour</i>	2	QL (2 tablets per 1 day)
*NITRATES*** - DRUGS FOR ANGINA		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1 or 1b*	
<i>isosorbide dinitrate oral tablet 40 mg</i>	2	
<i>isosorbide mononitrate er oral tablet extended release 24 hour</i>	1 or 1b*	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	2	
<i>nitroglycerin in d5w intravenous solution</i>	1 or 1b*	
<i>nitroglycerin sublingual tablet sublingual</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nitroglycerin transdermal patch 24 hour</i>	1 or 1b*	
<i>nitroglycerin translingual solution</i>	2	
ANTIANKXIETY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIANKXIETY AGENTS - MISC.*** - DRUGS FOR ANXIETY		
<i>bupirone hcl oral tablet</i>	1 or 1b*	
<i>droperidol injection solution</i>	1 or 1b*	
<i>hydroxyzine hcl intramuscular solution</i>	1 or 1b*	
<i>hydroxyzine hcl oral syrup</i>	1 or 1b*	
<i>hydroxyzine hcl oral tablet</i>	1 or 1b*	
<i>hydroxyzine pamoate oral capsule</i>	1 or 1a*	
<i>meprobamate oral tablet</i>	3	
*BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>alprazolam er oral tablet extended release 24 hour 1 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>alprazolam er oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>alprazolam oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>alprazolam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>alprazolam xr oral tablet extended release 24 hour 1 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>alprazolam xr oral tablet extended release 24 hour 2 mg, 3 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>chlordiazepoxide hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>clorazepate dipotassium oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>diazepam injection solution 10 mg/2ml</i>	1 or 1a*	
<i>diazepam intensol oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral concentrate</i>	1 or 1a*	QL (8 mL per 1 day)
<i>diazepam oral solution</i>	1 or 1a*	
<i>diazepam oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lorazepam injection solution</i>	1 or 1b*	
<i>lorazepam intensol oral concentrate</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral concentrate 2 mg/ml</i>	1 or 1b*	QL (3 mL per 1 day)
<i>lorazepam oral tablet 0.5 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>lorazepam oral tablet 1 mg, 2 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>oxazepam oral capsule</i>	2	QL (4 capsules per 1 day)
ANTIARRHYTHMICS - DRUGS FOR THE HEART		
*ANTIARRHYTHMICS - MISC.*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>adenosine intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTIARRHYTHMICS TYPE I-A*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>disopyramide phosphate oral capsule</i>	2	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR (<i>disopyramide phosphate</i>)	2	
<i>procainamide hcl injection solution</i>	2	
<i>quinidine gluconate er oral tablet extended release</i>	2	
<i>quinidine sulfate oral tablet</i>	1 or 1a*	
*ANTIARRHYTHMICS TYPE I-B*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>lidocaine hcl (cardiac) intravenous solution prefilled syringe 50 mg/5ml</i>	1 or 1b*	
<i>lidocaine hcl (cardiac) pf intravenous solution prefilled syringe 50 mg/5ml</i>	1 or 1b*	
<i>lidocaine in d5w intravenous solution 4-5 mg/ml-%, 8-5 mg/ml-%</i>	1 or 1b*	
<i>mexiletine hcl oral capsule</i>	2	
*ANTIARRHYTHMICS TYPE I-C*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>flecainide acetate oral tablet 100 mg</i>	2	QL (4 tablets per 1 day)
<i>flecainide acetate oral tablet 150 mg</i>	2	QL (2 tablets per 1 day)
<i>flecainide acetate oral tablet 50 mg</i>	2	QL (3 tablets per 1 day)
<i>propafenone hcl er oral capsule extended release 12 hour</i>	2	
<i>propafenone hcl oral tablet</i>	2	
*ANTIARRHYTHMICS TYPE III*** - DRUGS FOR ABNORMAL HEART RHYTHMS		
<i>amiodarone hcl intravenous solution</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 100 mg, 400 mg</i>	1 or 1b*	
<i>amiodarone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>dofetilide oral capsule</i>	4	
<i>ibutilide fumarate intravenous solution</i>	1 or 1b*	
<i>pacerone oral tablet 100 mg</i>	1 or 1b*	
<i>pacerone oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS FOR THE LUNGS		
*ADRENERGIC COMBINATIONS*** - DRUGS FOR ASTHMA/COPD		
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate-vilanterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate</i> (Breynd Inhalation Aerosol)	1 or 1b*	QL (1.03 grams per 1 day)
BREZTRI AEROSPHERE INHALATION AEROSOL (<i>budeson-glycopyrrol-formoterol</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol</i>	1 or 1b*	QL (1.03 grams per 1 day)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION (<i>ipratropium-albuterol</i>)	2	QL (2 inhalers per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	1 or 1b*	QL (1 package per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>ipratropium-albuterol inhalation solution</i>	1 or 1b*	QL (540 mL per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION (<i>tiotropium bromide-olodaterol</i>)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	2	QL (1 inhaler per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	2	QL (2 EA per 1 day)
<i>umeclidinium-vilanterol inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 inhaler per 30 days)
<i>wixela inhub inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 package per 30 days)
*ANTI-IGE MONOCLONAL ANTIBODIES*** - DRUGS FOR ASTHMA/COPD		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	4	PA; LD; QL (4 auto-injectors per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	4	PA; LD; QL (2 auto-injectors per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	4	PA; LD; QL (4 prefilled syringes per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	4	PA; LD; QL (2 prefilled syringes per 28 days); SP
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>omalizumab</i>)	4	PA; LD; QL (4 vials/syringes/autoinjectors per 28 days); SP
*ANTI-INFLAMMATORY AGENTS*** - DRUGS FOR ASTHMA/COPD		
<i>cromolyn sodium inhalation nebulization solution</i>	1 or 1b*	
*BETA ADRENERGICS*** - DRUGS FOR ASTHMA/COPD		
<i>albuterol sulfate hfa inhalation aerosol solution</i>	1 or 1b*	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml</i>	1 or 1b*	QL (180 vials per 30 days)
ALBUTEROL SULFATE INHALATION NEBULIZATION SOLUTION (5 MG/ML) 0.5%	1 or 1b*	QL (180 vials per 30 days)
<i>albuterol sulfate oral syrup</i>	1 or 1b*	
<i>albuterol sulfate oral tablet</i>	1 or 1b*	
<i>arformoterol tartrate inhalation nebulization solution</i>	2	QL (60 vial per 30 days)
<i>formoterol fumarate inhalation nebulization solution</i>	2	QL (120 ML per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	2	QL (90 vials per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	2	QL (90 mL per 30 days)
<i>levalbuterol tartrate inhalation aerosol</i>	1 or 1b*	ST; QL (2 inhalers per 30 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>albuterol sulfate</i>)	2	QL (2 inhalers per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>salmeterol xinafoate</i>)	2	QL (1 inhaler per 30 days)
<i>terbutaline sulfate injection solution</i>	1 or 1b*	
<i>terbutaline sulfate oral tablet</i>	1 or 1b*	
*BRONCHODILATORS - ANTICHOLINERGICS*** - DRUGS FOR ASTHMA/COPD		
ATROVENT HFA INHALATION AEROSOL SOLUTION (<i>ipratropium bromide hfa</i>)	2	QL (2 inhalers per 30 days)
<i>ipratropium bromide inhalation solution</i>	1 or 1b*	QL (300 ML per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION (<i>tiotropium bromide</i>)	2	QL (1 inhaler per 30 days)
<i>tiotropium bromide inhalation capsule</i>	2	QL (1 capsule per 1 day)
*INTERLEUKIN-5 ANTAGONISTS (IGG1 KAPPA)*** - DRUGS FOR ASTHMA/COPD		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>benralizumab</i>)	4	PA; LD; QL (1 autoinjector per 8 weekss); SP
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (<i>benralizumab</i>)	4	PA; LD; QL (1 syringe per 8 weeks); SP
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (<i>benralizumab</i>)	4	PA; LD; QL (1 syringes per 8 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>mepolizumab</i>)	4	PA; LD; QL (1 autoinjector per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	4	PA; LD; QL (1 syringe per 4 weekss); SP
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	4	PA; LD; QL (1 injection per 28 days); SP
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>mepolizumab</i>)	4	PA; LD; QL (1 injections per 28 days); SP
*LEUKOTRIENE RECEPTOR ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD		
<i>montelukast sodium oral packet</i>	1 or 1b*	QL (1 packet per 1 day)
<i>montelukast sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>montelukast sodium oral tablet chewable</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zafirlukast oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS*** - DRUGS FOR ASTHMA/COPD		
<i>roflumilast oral tablet</i>	2	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*STEROID INHALANTS*** - DRUGS FOR ASTHMA/COPD		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>fluticasone furoate</i>)	2	QL (1 inhaler per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1 or 1b*	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1 or 1b*	QL (60 ML per 30 days)
<i>fluticasone furoate ellipta inhalation aerosol powder breath activated</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 50 mcg/act</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcg/act</i>	2	QL (4 inhalers per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 44 mcg/act</i>	2	QL (1 inhaler per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 220 mcg/act</i>	2	QL (2 inhalers per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (1 inhaler per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	2	QL (2 inhalers per 30 days)
*THYMIC STROMAL LYMPHOPOIETIN (TSLP) ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD		
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tezepelumab-ekko</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>tezepelumab-ekko</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
*XANTHINES*** - DRUGS FOR ASTHMA/COPD		
<i>aminophylline intravenous solution</i>	1 or 1b*	
ELIXOPHYLLIN ORAL ELIXIR (<i>theophylline</i>)	1 or 1b*	QL (112.5 mL per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG (<i>theophylline</i>)	2	QL (4 tablets per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG (<i>theophylline</i>)	2	QL (3 capsules per 1 day)
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 400 MG (<i>theophylline</i>)	2	QL (2 capsules per 1 day)
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>theophylline er oral tablet extended release 12 hour 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>theophylline oral elixir</i>	1 or 1b*	QL (112.5 mL per 1 day)
<i>theophylline oral solution</i>	1 or 1b*	QL (112.5 mL per 1 day)
ANTICOAGULANTS - DRUGS FOR THE BLOOD		
*COUMARIN ANTICOAGULANTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>jantoven oral tablet</i>	1 or 1a*	
<i>warfarin sodium oral tablet</i>	1 or 1a*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*DIRECT FACTOR XA INHIBITORS*** - DRUGS TO PREVENT BLOOD CLOTS		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (<i>apixaban</i>)	2	QL (74 tablets per 365 days)
ELIQUIS ORAL TABLET 2.5 MG (<i>apixaban</i>)	2	QL (2 tablets per 1 day)
ELIQUIS ORAL TABLET 5 MG (<i>apixaban</i>)	2	QL (74 tablets per 30 days)
<i>rivaroxaban oral suspension reconstituted</i>	2	QL (20 mL per 1 day)
<i>rivaroxaban oral tablet</i>	2	QL (2 tablets per 1 day)
XARELTO ORAL SUSPENSION RECONSTITUTED (<i>rivaroxaban</i>)	2	QL (20 mL per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG (<i>rivaroxaban</i>)	2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (<i>rivaroxaban</i>)	2	QL (2 tablets per 1 day)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK (<i>rivaroxaban</i>)	2	QL (1 pack per 365 days)
*HEPARINS AND HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>bd heparin posiflush intravenous solution</i>	2	
<i>heparin (porcine) in nacl intravenous solution 1000-0.9 ut/500ml-%, 2000-0.9 unit/l-%</i>	2	
<i>heparin na (pork) lock flsh pf intravenous solution</i>	2	
<i>heparin sod (porcine) in d5w intravenous solution 40-5 unit/ml-%</i>	2	
<i>heparin sod (pork) lock flush intravenous solution</i>	2	
<i>heparin sodium (porcine) injection solution</i>	2	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml</i>	2	
*LOW MOLECULAR WEIGHT HEPARINS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>enoxaparin sodium injection solution</i>	1 or 1b*	QL (30 syringes per 30 days)
<i>enoxaparin sodium injection solution prefilled syringe</i>	1 or 1b*	QL (2 syringes per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML (<i>dalteparin sodium</i>)	3	QL (8 mL per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	3	QL (6 vials per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dalteparin sodium</i>)	3	QL (30 syringes per 30 days)
*SYNTHETIC HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS		
<i>fondaparinux sodium subcutaneous solution</i>	1 or 1b*	QL (30 syringes per 30 days)
ANTICONSULSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*AMPA GLUTAMATE RECEPTOR ANTAGONISTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>perampanel oral tablet</i>	2	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTICONVULSANTS - BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>clobazam oral suspension 2.5 mg/ml</i>	2	QL (16 mL per 1 day)
<i>clobazam oral tablet</i>	2	QL (2 tablets per 1 day)
<i>clonazepam oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>clonazepam oral tablet dispersible</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>diazepam rectal gel</i>	1 or 1b*	QL (2 syringes per 1 fill)
*ANTICONVULSANTS - MISC.*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>carbamazepine er oral capsule extended release 12 hour 300 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>carbamazepine er oral tablet extended release 12 hour 400 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carbamazepine oral suspension</i>	1 or 1b*	QL (50 mL per 1 day)
<i>carbamazepine oral tablet</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>carbamazepine oral tablet chewable 100 mg</i>	1 or 1b*	QL (10 tablets per 1 day)
<i>carbamazepine oral tablet chewable 200 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
EPIDIOLEX ORAL SOLUTION (<i>cannabidiol</i>)	4	PA; LD; SP
<i>eslicarbazepine acetate oral tablet 200 mg, 400 mg</i>	2	DO
<i>eslicarbazepine acetate oral tablet 600 mg, 800 mg</i>	2	QL (2 tablets per 1 day)
<i>gabapentin oral capsule</i>	1 or 1b*	DO
<i>gabapentin oral solution</i>	2	QL (72 mL per 1 day)
<i>gabapentin oral tablet 600 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>gabapentin oral tablet 800 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lacosamide intravenous solution</i>	2	
<i>lacosamide oral solution</i>	2	QL (40 mL per 1 day)
<i>lacosamide oral tablet</i>	2	QL (2 tablets per 1 day)
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	1 or 1b*	DO
<i>lamotrigine er oral tablet extended release 24 hour 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>lamotrigine er oral tablet extended release 24 hour 250 mg, 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral kit 21 x 25 mg & 7 x 50 mg</i>	1 or 1b*	QL (1 kit per 28 days)
<i>lamotrigine oral kit 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg</i>	1 or 1b*	QL (1 kit per 35 days)
<i>lamotrigine oral tablet</i>	1 or 1b*	DO
<i>lamotrigine oral tablet chewable 25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral tablet chewable 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 25 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>lamotrigine oral tablet dispersible 50 mg</i>	1 or 1b*	DO
<i>lamotrigine starter kit-blue oral kit</i>	1 or 1b*	QL (1 kit per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamotrigine starter kit-green oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>lamotrigine starter kit-orange oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>levetiracetam er oral tablet extended release 24 hour 500 mg</i>	2	QL (6 tablets per 1 day)
<i>levetiracetam er oral tablet extended release 24 hour 750 mg</i>	2	QL (4 tablets per 1 day)
<i>levetiracetam intravenous solution</i>	2	
<i>levetiracetam oral solution</i>	2	QL (30 mL per 1 day)
<i>levetiracetam oral tablet 1000 mg</i>	2	QL (3 tablets per 1 day)
<i>levetiracetam oral tablet 250 mg, 500 mg, 750 mg</i>	2	DO
<i>oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg</i>	2	DO
<i>oxcarbazepine er oral tablet extended release 24 hour 600 mg</i>	2	QL (4 tablets per 1 day)
<i>oxcarbazepine oral suspension</i>	1 or 1b*	QL (40 mL per 1 day)
<i>oxcarbazepine oral tablet 150 mg, 300 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxcarbazepine oral tablet 600 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (3 capsule per 1 day)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	2	QL (2 capsules per 1 day)
<i>pregabalin oral capsule 75 mg</i>	2	QL (3 capsules per 1 day)
<i>pregabalin oral solution</i>	2	QL (30 mL per 1 day)
<i>primidone oral tablet 125 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>primidone oral tablet 250 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>primidone oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>roovepra oral tablet</i>	2	DO
<i>rufinamide oral suspension</i>	2	QL (80 mL per 1 day)
<i>rufinamide oral tablet 200 mg</i>	2	DO
<i>rufinamide oral tablet 400 mg</i>	2	QL (8 tablets per 1 day)
<i>subvenite oral tablet</i>	1 or 1b*	DO
<i>subvenite starter kit-blue oral kit</i>	1 or 1b*	QL (1 kit per 28 days)
<i>subvenite starter kit-green oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>subvenite starter kit-orange oral kit</i>	1 or 1b*	QL (1 kit per 35 days)
<i>topiramate er oral capsule er 24 hour sprinkle 100 mg, 50 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>topiramate er oral capsule er 24 hour sprinkle 150 mg, 200 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>topiramate er oral capsule er 24 hour sprinkle 25 mg</i>	1 or 1b*	DO
<i>topiramate er oral capsule extended release 24 hour 100 mg, 50 mg</i>	2	QL (1 capsule per 1 day)
<i>topiramate er oral capsule extended release 24 hour 200 mg</i>	2	QL (2 capsules per 1 day)
<i>topiramate er oral capsule extended release 24 hour 25 mg</i>	2	DO
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>topiramate oral tablet 100 mg, 25 mg, 50 mg</i>	1 or 1b*	DO
<i>topiramate oral tablet 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>zonisamide oral capsule</i>	2	QL (6 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*CARBAMATES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>felbamate oral suspension</i>	2	QL (30 mL per 1 day)
<i>felbamate oral tablet</i>	2	QL (6 tablets per 1 day)
*GABA MODULATORS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>tiagabine hcl oral tablet</i>	2	QL (2 tablets per 1 day)
<i>vigabatrin oral packet</i>	4	QL (6 packets per 1 day); SP
<i>vigabatrin oral tablet</i>	4	LD; QL (6 tablets per 1 day)
<i>vigadrone oral packet</i>	4	LD; QL (6 packets per 1 day)
<i>vigabatrin</i> (Vigadrone Oral Tablet)	4	LD; QL (6 tablets per 1 day)
*HYDANTOINS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
DILANTIN ORAL CAPSULE 30 MG (<i>phenytoin sodium extended</i>)	2	
<i>fosphenytoin sodium injection solution</i>	2	
PHENYTEK ORAL CAPSULE (<i>phenytoin sodium extended</i>)	1 or 1b*	
<i>phenytoin infatabs oral tablet chewable</i>	1 or 1b*	
<i>phenytoin oral suspension</i>	1 or 1b*	
<i>phenytoin oral tablet chewable</i>	1 or 1b*	
<i>phenytoin sodium extended oral capsule</i>	1 or 1b*	
<i>phenytoin sodium injection solution</i>	1 or 1b*	
*SUCCINIMIDES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>ethosuximide oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>ethosuximide oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>methsuximide oral capsule</i>	2	QL (4 capsules per 1 day)
*VALPROIC ACID*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>divalproex sodium oral capsule delayed release sprinkle</i>	1 or 1b*	QL (8 capsules per 1 day)
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>divalproex sodium oral tablet delayed release 500 mg</i>	1 or 1b*	QL (7 tablets per 1 day)
<i>valproate sodium intravenous solution</i>	1 or 1b*	
<i>valproic acid oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>valproic acid oral solution</i>	1 or 1b*	
ANTIDEPRESSANTS - DRUGS FOR THE NERVOUS SYSTEM		
*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)*** - DRUGS FOR DEPRESSION		
<i>mirtazapine oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mirtazapine oral tablet dispersible</i>	1 or 1b*	
*ANTIDEPRESSANTS - MISC.*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg</i>	1 or 1b*	DO
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg, 450 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>bupropion hcl oral tablet 100 mg</i>	1 or 1b*	QL (4.5 tablet per 1 day)
<i>bupropion hcl oral tablet 75 mg</i>	1 or 1b*	DO
*MONOAMINE OXIDASE INHIBITORS (MAOIS)*** - DRUGS FOR DEPRESSION		
<i>phenelzine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>tranylcypromine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)*** - DRUGS FOR DEPRESSION		
<i>citalopram hydrobromide oral solution</i>	1 or 1b*	
<i>citalopram hydrobromide oral tablet</i>	1 or 1b*	
<i>escitalopram oxalate oral solution</i>	1 or 1b*	
<i>escitalopram oxalate oral tablet</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule delayed release</i>	1 or 1b*	
<i>fluoxetine hcl oral solution</i>	1 or 1b*	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	
<i>fluvoxamine maleate er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>fluvoxamine maleate oral tablet</i>	1 or 1b*	
<i>paroxetine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>paroxetine hcl oral suspension</i>	2	
<i>paroxetine hcl oral tablet</i>	1 or 1b*	
<i>sertraline hcl oral concentrate</i>	1 or 1b*	
<i>sertraline hcl oral tablet</i>	1 or 1b*	
*SEROTONIN MODULATORS*** - DRUGS FOR DEPRESSION		
<i>nefazodone hcl oral tablet 100 mg, 50 mg</i>	1 or 1b*	DO
<i>nefazodone hcl oral tablet 150 mg, 250 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>nefazodone hcl oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>trazodone hcl oral tablet 100 mg, 150 mg, 50 mg</i>	1 or 1a*	DO
<i>trazodone hcl oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
TRINTELLIX ORAL TABLET 10 MG, 5 MG (<i>vortioxetine hbr</i>)	3	DO
TRINTELLIX ORAL TABLET 20 MG (<i>vortioxetine hbr</i>)	3	QL (1 tablet per 1 day)
<i>vilazodone hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	DO
<i>vilazodone hcl oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)*** - DRUGS FOR DEPRESSION		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg</i>	1 or 1b*	DO
<i>duloxetine hcl oral capsule delayed release particles 20 mg</i>	2	QL (6 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	2	QL (4 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	2	QL (3 capsule per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 60 mg</i>	2	QL (2 capsules per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>venlafaxine hcl oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
*TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>amitriptyline hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1a*	DO
<i>amitriptyline hcl oral tablet 100 mg</i>	1 or 1a*	QL (3 tablets per 1 day)
<i>amitriptyline hcl oral tablet 150 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>amoxapine oral tablet 100 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>amoxapine oral tablet 150 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>amoxapine oral tablet 25 mg, 50 mg</i>	1 or 1b*	DO
<i>clomipramine hcl oral capsule 25 mg</i>	1 or 1b*	DO
<i>clomipramine hcl oral capsule 50 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>clomipramine hcl oral capsule 75 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>desipramine hcl oral tablet 10 mg, 25 mg, 50 mg, 75 mg</i>	2	DO
<i>desipramine hcl oral tablet 100 mg</i>	2	QL (3 tablets per 1 day)
<i>desipramine hcl oral tablet 150 mg</i>	2	QL (2 tablets per 1 day)
<i>doxepin hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1 or 1b*	DO
<i>doxepin hcl oral capsule 100 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>doxepin hcl oral capsule 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxepin hcl oral concentrate</i>	1 or 1b*	QL (30 mL per 1 day)
<i>imipramine hcl oral tablet 10 mg, 25 mg</i>	1 or 1b*	DO
<i>imipramine hcl oral tablet 50 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>imipramine pamoate oral capsule 100 mg, 75 mg</i>	1 or 1b*	DO
<i>imipramine pamoate oral capsule 125 mg, 150 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>nortriptyline hcl oral capsule 10 mg, 25 mg</i>	1 or 1b*	DO
<i>nortriptyline hcl oral capsule 50 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>nortriptyline hcl oral capsule 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>nortriptyline hcl oral solution</i>	1 or 1b*	QL (75 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>protriptyline hcl oral tablet 10 mg</i>	2	QL (6 tablets per 1 day)
<i>protriptyline hcl oral tablet 5 mg</i>	2	DO
<i>trimipramine maleate oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>trimipramine maleate oral capsule 25 mg, 50 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
ANTIDIABETICS - HORMONES		
*ALPHA-GLUCOSIDASE INHIBITORS*** - DRUGS FOR DIABETES		
<i>acarbose oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>miglitol oral tablet</i>	1 or 1b*	QL (3 tablets per 1 day)
*BIGUANIDES*** - DRUGS FOR DIABETES		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>metformin hcl er oral tablet extended release 24 hour 750 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metformin hcl oral solution</i>	3	PA; QL (2 bottles per 30 days)
<i>metformin hcl oral tablet 1000 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metformin hcl oral tablet 500 mg</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>metformin hcl oral tablet 850 mg</i>	1 or 1b*; \$0	QL (3 tablets per 1 day)
*DIABETIC OTHER*** - DRUGS FOR DIABETES		
BAQSIMI ONE PACK NASAL POWDER (<i>glucagon</i>)	3	QL (2 packs per 30 days)
BAQSIMI TWO PACK NASAL POWDER (<i>glucagon</i>)	3	QL (1 pack per 30 days)
<i>diazoxide oral suspension</i>	2	
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED 1 MG	1 or 1b*	QL (2 kits per 30 days)
GLUCAGON EMERGENCY INJECTION SOLUTION RECONSTITUTED 1 MG/ML	3	QL (2 kits per 30 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>glucagon</i>)	3	QL (2 packs per 30 days)
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>glucagon</i>)	3	QL (1 pack per 30 days)
GVOKE KIT SUBCUTANEOUS SOLUTION (<i>glucagon</i>)	3	QL (2 kits per 30 days)
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>glucagon</i>)	3	QL (2 packs per 30 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>dasiglucagon hcl</i>)	3	QL (1.2 mL per 30 days)
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dasiglucagon hcl</i>)	3	QL (1.2 mL per 30 days)
*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** - DRUGS FOR DIABETES		
<i>alogliptin benzoate oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
JANUVIA ORAL TABLET (<i>sitagliptin phosphate</i>)	2	ST; QL (1 tablet per 1 day)
*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>alogliptin-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1** or **1a***=Drugs with the lowest cost share **Tier 1** or **1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUMET ORAL TABLET (<i>sitagliptin phos-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG (<i>sitagliptin phos-metformin hcl</i>)	2	ST; QL (1 tablet per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG (<i>sitagliptin phos-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>alogliptin-pioglitazone oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*HUMAN INSULIN*** - DRUGS FOR DIABETES		
HUMALOG INJECTION SOLUTION (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (<i>insulin lispro prot & lispro</i>)	2	QL (30 mL per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (<i>insulin lispro</i>)	2	QL (30 mL per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin regular human</i>)	2	PA; QL (18 mL per 30 days)
INSULIN LISPRO (1 UNIT DIAL) SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	ST; QL (30 mL per 30 days)
INSULIN LISPRO INJECTION SOLUTION	2	QL (30 mL per 30 days)
INSULIN LISPRO JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	2	QL (30 mL per 30 days)
INSULIN LISPRO PROT & LISPRO SUBCUTANEOUS SUSPENSION PEN-INJECTOR	2	QL (30 mL per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LANTUS SUBCUTANEOUS SOLUTION (<i>insulin glargine</i>)	2	QL (30 mL per 30 days)
LYUMJEV INJECTION SOLUTION (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin lispro-aabc</i>)	2	QL (30 mL per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (12 mL per 30 days)
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine</i>)	2	QL (13.5 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (<i>insulin degludec</i>)	2	QL (18 mL per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1** or **1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRESIBA SUBCUTANEOUS SOLUTION (<i>insulin degludec</i>)	2	QL (30 mL per 30 days)
*INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>tirzepatide</i>)	2	PA; QL (4 pens per 28 days)
*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES		
<i>liraglutide subcutaneous solution pen-injector</i>	2	PA; QL (1 box per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 pen per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (1 unit per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>semaglutide</i>)	2	PA; QL (0.11 mL per 1 day)
RYBELSUS ORAL TABLET 14 MG, 7 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 30 days)
RYBELSUS ORAL TABLET 3 MG (<i>semaglutide</i>)	2	PA; QL (1 carton per 1 lifetime)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 pens per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	2	PA; QL (4 syringes per 28 days)
*INSULIN-INCRETIN MIMETIC COMBINATIONS*** - DRUGS FOR DIABETES		
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin glargine-lixisenatide</i>)	2	ST; QL (5 pen per 25 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>insulin degludec-liraglutide</i>)	2	ST; QL (5 pen per 30 days)
*MEGLITINIDE ANALOGUES*** - DRUGS FOR DIABETES		
<i>nateglinide oral tablet</i>	2	QL (3 tablets per 1 day)
<i>repaglinide oral tablet 0.5 mg, 1 mg</i>	2	QL (4 tablets per 1 day)
<i>repaglinide oral tablet 2 mg</i>	2	QL (8 tablets per 1 day)
*PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR DIABETES		
<i>mifepristone oral tablet 300 mg</i>	4	PA; LD; QL (4 tablets per 1 day)
*SGLT2 INHIBITOR - DPP-4 INHIBITOR - BIGUANIDE COMB*** - DRUGS FOR DIABETES		
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (1 tablet per 1 day)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG (<i>empagliflozin-linagliptin-metformin</i>)	2	ST; QL (2 tablets per 1 day)
*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS*** - DRUGS FOR DIABETES		
GLYXAMBI ORAL TABLET (<i>empagliflozin-linagliptin</i>)	2	ST; QL (1 tablet per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS*** - DRUGS FOR DIABETES		
<i>dapagliflozin propanediol oral tablet</i>	2	ST; QL (1 tablet per 1 day)
FARXIGA ORAL TABLET (<i>dapagliflozin propanediol</i>)	2	ST; QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET (<i>empagliflozin</i>)	2	ST; QL (1 tablet per 1 day)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - DRUGS FOR DIABETES		
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg</i>	2	ST; QL (1 tablet per 1 day)
<i>dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg</i>	2	ST; QL (2 tablets per 1 day)
SYNJARDY ORAL TABLET (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG (<i>empagliflozin-metformin hcl</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (1 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablet per 1 day)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG (<i>dapagliflozin prop-metformin</i>)	2	ST; QL (2 tablets per 1 day)
*SULFONYLUREA-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
*SULFONYLUREAS*** - DRUGS FOR DIABETES		
<i>glimepiride oral tablet 1 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>glimepiride oral tablet 2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>glimepiride oral tablet 4 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 10 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 2.5 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>glipizide er oral tablet extended release 24 hour 5 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>glipizide oral tablet 10 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>glipizide oral tablet 2.5 mg</i>	1 or 1a*	QL (16 tablets per 1 day)
<i>glipizide oral tablet 5 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>glyburide micronized oral tablet 1.5 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>glyburide micronized oral tablet 3 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>glyburide micronized oral tablet 6 mg</i>	1 or 1b*	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glyburide oral tablet 1.25 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>glyburide oral tablet 2.5 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>glyburide oral tablet 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl-glimepiride oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)
*THIAZOLIDINEDIONES*** - DRUGS FOR DIABETES		
<i>pioglitazone hcl oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS FOR THE STOMACH		
*ANTIPERISTALTIC AGENTS*** - DRUGS FOR DIARRHEA		
<i>diphenoxylate-atropine oral liquid</i>	1 or 1b*	
<i>diphenoxylate-atropine oral tablet</i>	1 or 1b*	
<i>loperamide hcl oral capsule</i>	1 or 1b*	QL (8 capsules per 1 day)
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
*ANTIDOTES - CHELATING AGENTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>deferasirox granules oral packet</i>	4	PA; SP
<i>deferasirox oral packet</i>	4	PA; SP
<i>deferasirox oral tablet</i>	4	PA; SP
<i>deferasirox oral tablet soluble</i>	4	PA; SP
<i>deferiprone oral tablet</i>	4	PA; LD
*ANTIDOTES AND SPECIFIC ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>acetylcysteine intravenous solution</i>	2	
<i>fomepizole intravenous solution</i>	1 or 1b*	
<i>methylene blue intravenous solution</i>	1 or 1b*	
SODIUM THIOSULFATE INTRAVENOUS SOLUTION	1 or 1b*	
*BENZODIAZEPINE ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
<i>flumazenil intravenous solution</i>	1 or 1b*	
*OPIOID ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING		
KLOXXADO NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
<i>naloxone hcl injection solution</i>	1 or 1a*	QL (6 vial per 90 days)
<i>naloxone hcl injection solution cartridge</i>	1 or 1a*	QL (6 syringe per 90 days)
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml</i>	1 or 1a*	QL (6 syringes per 3 months)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1 or 1a*	QL (6 syringe per 90 days)
<i>naloxone hcl nasal liquid</i>	1 or 1b*	QL (6 nasal sprays per 3 monthss)
<i>naltrexone hcl oral tablet</i>	1 or 1b*	
OPVEE NASAL SOLUTION (<i>nalmefene hcl</i>)	2	QL (3 cartons per 90 days)
REXTOVY NASAL LIQUID (<i>naloxone hcl</i>)	2	QL (6 nasal sprays per 3 monthss)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>naltrexone</i>)	4	QL (1 vial per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE (<i>naloxone hcl</i>)	2	QL (6 syringes per 3 monthss)
ANTIEMETICS - DRUGS FOR THE STOMACH		
*5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>granisetron hcl intravenous solution</i>	2	
<i>granisetron hcl oral tablet</i>	2	QL (10 tablets per 30 days)
<i>ondansetron hcl +rfid injection solution</i>	2	
<i>ondansetron hcl injection solution</i>	2	
<i>ondansetron hcl injection solution prefilled syringe</i>	2	
<i>ondansetron hcl oral solution</i>	2	QL (8 mL per 1 day)
<i>ondansetron hcl oral tablet 24 mg</i>	2	QL (8 tablet per 30 days)
<i>ondansetron hcl oral tablet 4 mg</i>	2	QL (48 tablets per 30 days)
<i>ondansetron hcl oral tablet 8 mg</i>	2	QL (24 tablets per 30 days)
<i>ondansetron oral tablet dispersible 16 mg</i>	2	QL (4 tablets per 30 days)
<i>ondansetron oral tablet dispersible 4 mg</i>	2	QL (48 tablets per 30 days)
<i>ondansetron oral tablet dispersible 8 mg</i>	2	QL (24 tablets per 30 days)
<i>palonosetron hcl intravenous solution 0.25 mg/5ml</i>	2	
<i>palonosetron hcl intravenous solution prefilled syringe</i>	2	
*ANTIEMETIC COMBINATIONS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>doxylamine-pyridoxine oral tablet delayed release</i>	1 or 1b*	PA; QL (4 tablet per 1 day)
*ANTIEMETICS - ANTICHOLINERGIC*** - DRUGS FOR VOMITING AND NAUSEA		
<i>meclizine hcl oral tablet 25 mg</i>	1 or 1a*	
<i>meclizine hcl oral tablet 50 mg</i>	1 or 1b*	
<i>scopolamine transdermal patch 72 hour</i>	1 or 1b*	
<i>trimethobenzamide hcl oral capsule</i>	1 or 1b*	
*ANTIEMETICS - MISCELLANEOUS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>dronabinol oral capsule</i>	2	QL (4 capsules per 1 day)
*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA		
<i>aprepitant oral capsule 125 mg</i>	2	QL (5 capsules per 25 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aprepitant oral capsule 40 mg</i>	2	QL (1 capsule per 1 fill)
<i>aprepitant oral capsule 80 & 125 mg</i>	2	QL (15 capsules per 25 days)
<i>aprepitant oral capsule 80 mg</i>	2	QL (10 capsules per 25 days)
<i>fosaprepitant dimeglumine intravenous solution reconstituted</i>	2	QL (5 vial per 30 days)
ANTIFUNGALS - DRUGS FOR INFECTIONS		
*ANTIFUNGALS*** - DRUGS FOR FUNGUS		
<i>amphotericin b intravenous solution reconstituted</i>	2	
<i>amphotericin b liposome intravenous suspension reconstituted</i>	2	
<i>flucytosine oral capsule</i>	2	PA
<i>griseofulvin microsize oral suspension</i>	1 or 1b*	
<i>griseofulvin microsize oral tablet</i>	1 or 1b*	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	1 or 1b*	
<i>nystatin oral tablet</i>	1 or 1b*	
<i>terbinafine hcl oral tablet</i>	1 or 1b*	
*IMIDAZOLES*** - DRUGS FOR FUNGUS		
<i>ketoconazole oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*TRIAZOLES*** - DRUGS FOR FUNGUS		
<i>fluconazole in sodium chloride intravenous solution</i>	1 or 1b*	
<i>fluconazole oral suspension reconstituted 10 mg/ml</i>	1 or 1b*	QL (40 mL per 1 day)
<i>fluconazole oral suspension reconstituted 40 mg/ml</i>	1 or 1b*	QL (10 mL per 1 day)
<i>fluconazole oral tablet 100 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>fluconazole oral tablet 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>fluconazole oral tablet 50 mg</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>itraconazole oral capsule</i>	2	PA; QL (4.2 capsules per 1 day)
<i>itraconazole oral solution</i>	2	PA; QL (20 mL per 1 day)
<i>posaconazole intravenous solution</i>	2	
<i>posaconazole oral suspension</i>	2	PA; QL (20 mL per 1 day)
<i>posaconazole oral tablet delayed release</i>	2	PA; QL (93 tablets per 30 days)
<i>voriconazole oral suspension reconstituted</i>	2	PA; QL (17.5 mL per 1 day)
<i>voriconazole oral tablet 200 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>voriconazole oral tablet 50 mg</i>	2	PA; QL (6 tablets per 1 day)
ANTI-HISTAMINES - DRUGS FOR THE LUNGS		
*ANTI-HISTAMINES - ETHANOLAMINES*** - DRUGS FOR ALLERGIES		
<i>carbinoxamine maleate er oral suspension extended release</i>	1 or 1b*	ST; QL (40 mL per 1 day)
<i>carbinoxamine maleate oral solution</i>	1 or 1b*	ST; QL (20 mL per 1 day)
<i>carbinoxamine maleate oral tablet 4 mg</i>	1 or 1b*	ST; QL (6 tablets per 1 day)
<i>carbzah oral solution</i>	1 or 1b*	ST; QL (20 mL per 1 day)
<i>clemastine fumarate oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl injection solution</i>	2	
*ANTIHISTAMINES - NON-SEDATING*** - DRUGS FOR ALLERGIES		
<i>cetirizine hcl oral solution</i>	1 or 1b*	BE; QL (10 mL per 1 day)
<i>desloratadine oral tablet</i>	3	QL (1 tablet per 1 day)
<i>desloratadine oral tablet dispersible</i>	3	QL (1 tablet per 1 day)
<i>levocetirizine dihydrochloride oral tablet</i>	1 or 1b*	BE; QL (1 tablet per 1 day)
*ANTIHISTAMINES - PHENOTHIAZINES*** - DRUGS FOR ALLERGIES		
<i>promethazine hcl injection solution</i>	1 or 1a*	
<i>promethazine hcl oral solution 12.5 mg/10ml</i>	1 or 1a*	QL (40 mL per 1 day)
<i>promethazine hcl oral tablet 12.5 mg, 25 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>promethazine hcl oral tablet 50 mg</i>	1 or 1a*	QL (1 tablet per 1 day)
<i>promethazine hcl rectal suppository</i>	2	QL (6 suppositories per 1 day)
<i>promethegan rectal suppository 12.5 mg, 25 mg</i>	2	QL (6 suppositories per 1 day)
<i>promethegan rectal suppository 50 mg</i>	2	QL (1 suppository per 1 day)
*ANTIHISTAMINES - PIPERIDINES*** - DRUGS FOR ALLERGIES		
<i>ciproheptadine hcl oral syrup</i>	1 or 1b*	
<i>ciproheptadine hcl oral tablet</i>	1 or 1b*	
ANTIHYPERTENSIVES - DRUGS FOR THE HEART		
*ANTIHYPERTENSIVES - MISC.*** - DRUGS FOR CHOLESTEROL		
<i>icosapent ethyl oral capsule 0.5 gm</i>	2	PA; QL (8 capsules per 1 day)
<i>icosapent ethyl oral capsule 1 gm</i>	2	PA; QL (4 capsule per 1 day)
<i>omega-3-acid ethyl esters oral capsule</i>	1 or 1b*	PA; QL (4 capsule per 1 day)
VASCEPA ORAL CAPSULE 0.5 GM (<i>icosapent ethyl</i>)	2	PA; QL (8 capsules per 1 day)
VASCEPA ORAL CAPSULE 1 GM (<i>icosapent ethyl</i>)	2	PA; QL (4 capsule per 1 day)
*BILE ACID SEQUESTRANTS*** - DRUGS FOR CHOLESTEROL		
<i>cholestyramine light oral packet</i>	2	QL (24 grams per 1 day)
<i>cholestyramine light oral powder</i>	2	QL (30 grams per 1 day)
<i>cholestyramine oral packet</i>	2	QL (6 packets per 1 day)
<i>cholestyramine oral powder</i>	2	QL (54 gm per 1 day)
<i>colesevelam hcl oral packet</i>	3	QL (1 packet per 1 day)
<i>colesevelam hcl oral tablet</i>	2	QL (6 tablets per 1 day)
<i>colestipol hcl oral granules</i>	1 or 1b*	QL (45 grams per 1 day)
<i>colestipol hcl oral packet</i>	1 or 1b*	QL (30 grams per 1 day)
<i>colestipol hcl oral tablet</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>prevalite oral packet</i>	2	QL (24 grams per 1 day)
<i>prevalite oral powder</i>	2	QL (30 grams per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*FIBRIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
<i>fenofibrate micronized oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibrate oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	3	ST; QL (1 tablet per 1 day)
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fenofibric acid oral capsule delayed release</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibric acid oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>gemfibrozil oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*HMG COA REDUCTASE INHIBITORS*** - DRUGS FOR CHOLESTEROL		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	DO
<i>atorvastatin calcium oral tablet 40 mg</i>	1 or 1b*	DO
<i>atorvastatin calcium oral tablet 80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fluvastatin sodium oral capsule</i>	1 or 1b*; \$0	DO
<i>lovastatin oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	DO
<i>lovastatin oral tablet 40 mg</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1 or 1b*; \$0	DO
<i>pravastatin sodium oral tablet 80 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>rosuvastatin calcium oral tablet 10 mg, 5 mg</i>	2; \$0	DO
<i>rosuvastatin calcium oral tablet 20 mg</i>	2	DO
<i>rosuvastatin calcium oral tablet 40 mg</i>	2	QL (1 tablet per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 5 mg</i>	1 or 1b*; \$0	DO
<i>simvastatin oral tablet 40 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>simvastatin oral tablet 80 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB*** - DRUGS FOR CHOLESTEROL		
<i>ezetimibe-simvastatin oral tablet</i>	2	ST; QL (1 tablet per 1 day)
*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS*** - DRUGS FOR CHOLESTEROL		
<i>ezetimibe oral tablet</i>	2	QL (1 tablet per 1 day)
*NICOTINIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL		
<i>niacin (antihyperlipidemic) oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 750 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 500 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>niacor oral tablet</i>	1 or 1b*	ST; QL (12 tablets per 1 day)
*PCSK9 INHIBITORS*** - DRUGS FOR CHOLESTEROL		
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>evolocumab</i>)	3	PA; QL (3 syringe per 28 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (evolocumab)	3	PA; QL (3 syringe per 28 days)
ANTIHYPERTENSIVES - DRUGS FOR THE HEART		
*ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>amlodipine besy-benazepril hcl oral capsule 2.5-10 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>amlodipine besy-benazepril hcl oral capsule 5-10 mg, 5-20 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>trandolapril-verapamil hcl er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
*ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>benazepril-hydrochlorothiazide oral tablet 5-6.25 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>captopril-hydrochlorothiazide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fosinopril sodium-hctz oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>lisinopril-hydrochlorothiazide oral tablet 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*ACE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>benazepril hcl oral tablet 10 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>benazepril hcl oral tablet 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>benazepril hcl oral tablet 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>benazepril hcl oral tablet 5 mg</i>	1 or 1a*	QL (16 tablets per 1 day)
<i>captopril oral tablet 100 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>captopril oral tablet 12.5 mg</i>	1 or 1b*	QL (24 tablets per 1 day)
<i>captopril oral tablet 25 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>captopril oral tablet 50 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>enalapril maleate oral solution</i>	2	QL (40 mg per 1 day)
<i>enalapril maleate oral tablet 10 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>enalapril maleate oral tablet 2.5 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>enalapril maleate oral tablet 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>enalapril maleate oral tablet 5 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>enalaprilat intravenous solution</i>	1 or 1b*	
<i>fosinopril sodium oral tablet 10 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>fosinopril sodium oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fosinopril sodium oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>lisinopril oral tablet 10 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>lisinopril oral tablet 2.5 mg</i>	1 or 1a*	QL (32 tablets per 1 day)
<i>lisinopril oral tablet 20 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lisinopril oral tablet 30 mg, 40 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>lisinopril oral tablet 5 mg</i>	1 or 1a*	QL (16 tablets per 1 day)
<i>moexipril hcl oral tablet 15 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>moexipril hcl oral tablet 7.5 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>perindopril erbumine oral tablet 2 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>perindopril erbumine oral tablet 4 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>perindopril erbumine oral tablet 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>quinapril hcl oral tablet 10 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>quinapril hcl oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>quinapril hcl oral tablet 40 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>quinapril hcl oral tablet 5 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>ramipril oral capsule 1.25 mg</i>	1 or 1b*	QL (16 capsules per 1 day)
<i>ramipril oral capsule 10 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>ramipril oral capsule 2.5 mg</i>	1 or 1b*	QL (8 capsules per 1 day)
<i>ramipril oral capsule 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>trandolapril oral tablet 1 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>trandolapril oral tablet 2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>trandolapril oral tablet 4 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*AGENTS FOR PHEOCHROMOCYTOMA*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>metyrosine oral capsule</i>	1 or 1b*	PA; QL (16 capsules per 1 day); SP
<i>phenoxybenzamine hcl oral capsule</i>	2	PA; QL (12 capsules per 1 day)
<i>phentolamine mesylate injection solution reconstituted</i>	1 or 1b*	
*ANGIOTENSIN II RECEPTOR ANTAG & CA CHANNEL BLOCKER COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate-valsartan oral tablet 5-160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-olmesartan oral tablet 5-20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-amlodipine oral tablet 40-10 mg, 80-10 mg, 80-5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-amlodipine oral tablet 40-5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium-hctz oral tablet 50-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-hctz oral tablet 80-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ANGIOTENSIN II RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>candesartan cilexetil oral tablet 16 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil oral tablet 32 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>candesartan cilexetil oral tablet 4 mg, 8 mg</i>	1 or 1b*	DO
<i>irbesartan oral tablet 150 mg, 75 mg</i>	1 or 1b*	DO
<i>irbesartan oral tablet 300 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 25 mg</i>	1 or 1b*	DO
<i>losartan potassium oral tablet 50 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil oral tablet 20 mg, 5 mg</i>	1 or 1b*	DO
<i>olmesartan medoxomil oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan oral tablet 20 mg, 40 mg</i>	1 or 1b*	DO
<i>telmisartan oral tablet 80 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
VALSARTAN ORAL SOLUTION	2	PA; QL (80 mL per 1 day)
<i>valsartan oral tablet 160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan oral tablet 320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan oral tablet 40 mg, 80 mg</i>	1 or 1b*	DO
*ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>clonidine hcl oral tablet 0.1 mg</i>	1 or 1a*	QL (12 tablets per 1 day)
<i>clonidine hcl oral tablet 0.2 mg</i>	1 or 1a*	QL (6 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clonidine hcl oral tablet 0.3 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr</i>	2	QL (12 patches per 28 days)
<i>clonidine transdermal patch weekly 0.3 mg/24hr</i>	2	QL (0.29 patches per 1 day)
<i>guanfacine hcl oral tablet</i>	1 or 1b*	
<i>methyldopa oral tablet 250 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>methyldopa oral tablet 500 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
*ANTIADRENERGICS - PERIPHERALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>doxazosin mesylate oral tablet 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>prazosin hcl oral capsule</i>	1 or 1b*	
<i>terazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>terazosin hcl oral capsule 10 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
*BETA BLOCKER & DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>atenolol-chlorthalidone oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 50-25 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>metoprolol-hydrochlorothiazide oral tablet 100-50 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*DIRECT RENIN INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>aliskiren fumarate oral tablet 150 mg</i>	2	DO
<i>aliskiren fumarate oral tablet 300 mg</i>	2	QL (1 tablet per 1 day)
*SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>eplerenone oral tablet</i>	2	
*VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>hydralazine hcl injection solution</i>	2	
<i>hydralazine hcl oral tablet</i>	1 or 1b*	
<i>minoxidil oral tablet</i>	1 or 1b*	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS FOR INFECTIONS		
*ANTI-INFECTIVE AGENTS - MISC.*** - DRUGS FOR INFECTIONS		
<i>metronidazole oral capsule</i>	1 or 1a*	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1 or 1a*	
<i>pentamidine isethionate inhalation solution reconstituted</i>	2	
<i>pentamidine isethionate injection solution reconstituted</i>	4	
<i>tinidazole oral tablet 250 mg</i>	1 or 1b*	QL (5 tablets per 28 days)
<i>tinidazole oral tablet 500 mg</i>	1 or 1b*	QL (20 tablets per 1 fill)
TRIMETHOPRIM ORAL TABLET	1 or 1a*	
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	3	PA; QL (9 tablets per 1 fill)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XIFAXAN ORAL TABLET 550 MG (<i>rifaximin</i>)	3	PA; QL (126 tablet per 252 days)
*ANTI-INFECTIVE MISC. - COMBINATIONS*** - ANTIBIOTICS		
<i>sulfamethoxazole-trimethoprim intravenous solution</i>	2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1 or 1a*	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1 or 1a*	
<i>sulfatrim pediatric oral suspension</i>	1 or 1a*	
*ANTIPROTOZOAL AGENTS*** - DRUGS FOR PARASITES		
<i>atovaquone oral suspension</i>	2	
<i>nitazoxanide oral tablet</i>	2	QL (6 tablets per 1 fill)
*CARBAPENEM COMBINATIONS*** - ANTIBIOTICS		
<i>imipenem-cilastatin intravenous solution reconstituted</i>	2	
*CARBAPENEMS*** - ANTIBIOTICS		
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	2	
*CHLORAMPHENICALS*** - ANTIBIOTICS		
<i>chloramphenicol sod succinate intravenous solution reconstituted</i>	2	
*GLYCOPEPTIDES*** - ANTIBIOTICS		
<i>vancomycin hcl intravenous solution reconstituted 100 gm</i>	2	QL (1 vial per 30 days)
<i>vancomycin hcl oral capsule</i>	2	QL (240 capsules per 30 days)
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml</i>	2	QL (1200 mL per 30 days)
VANCOMYCIN HCL ORAL SOLUTION RECONSTITUTED 250 MG/5ML	2	QL (1200 mL per 30 days)
*LEPROSTATICS*** - ANTIBIOTICS		
<i>dapsone oral tablet</i>	2	
*LINCOSAMIDES*** - ANTIBIOTICS		
<i>clindamycin hcl oral capsule</i>	1 or 1b*	
<i>clindamycin palmitate hcl oral solution reconstituted</i>	1 or 1b*	
<i>clindamycin phosphate in d5w intravenous solution</i>	1 or 1b*	
<i>clindamycin phosphate injection solution</i>	1 or 1b*	
*MONOBACTAMS*** - ANTIBIOTICS		
<i>aztreonam injection solution reconstituted</i>	2	
*OXAZOLIDINONES*** - ANTIBIOTICS		
<i>linezolid intravenous solution</i>	1 or 1b*	
<i>linezolid oral suspension reconstituted</i>	1 or 1b*	PA; QL (900 mL per 30 days)
<i>linezolid oral tablet</i>	1 or 1b*	PA; QL (28 tablet per 30 days)
*POLYMYXINS*** - ANTIBIOTICS		
<i>colistimethate sodium (cba) injection solution reconstituted</i>	2	
<i>polymyxin b sulfate injection solution reconstituted</i>	2	
*URINARY ANTI-INFECTIVES*** - ANTIBIOTICS		
<i>fosfomicin tromethamine oral packet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methenamine hippurate oral tablet</i>	2	
<i>nitrofurantoin macrocrystal oral capsule</i>	1 or 1b*	
<i>nitrofurantoin monohyd macro oral capsule</i>	1 or 1b*	
<i>nitrofurantoin oral suspension 25 mg/5ml, 50 mg/10ml</i>	1 or 1b*	
ANTIMALARIALS - DRUGS FOR INFECTIONS		
*ANTIMALARIAL COMBINATIONS*** - DRUGS FOR PARASITES		
<i>atovaquone-proguanil hcl oral tablet</i>	1 or 1b*	
*ANTIMALARIALS*** - DRUGS FOR PARASITES		
<i>chloroquine phosphate oral tablet</i>	1 or 1a*	
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 100 MG, 300 MG	1 or 1b*	QL (2 tablets per 1 day)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
HYDROXYCHLOROQUINE SULFATE ORAL TABLET 400 MG	1 or 1b*	QL (1 tablet per 1 day)
<i>mefloquine hcl oral tablet</i>	1 or 1b*	QL (5 tablets per 28 days)
<i>pyrimethamine oral tablet</i>	1 or 1b*	PA; QL (3 tablets per 1 day)
<i>quinine sulfate oral capsule</i>	1 or 1b*	PA; QL (60 capsule per 30 days)
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS FOR NERVES AND MUSCLES		
*ANTIMYASTHENIC/CHOLINERGIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES		
<i>pyridostigmine bromide er oral tablet extended release</i>	2	
<i>pyridostigmine bromide oral solution</i>	2	
<i>pyridostigmine bromide oral tablet</i>	2	
ANTIMYCOBACTERIAL AGENTS - DRUGS FOR INFECTIONS		
*ANTIMYCOBACTERIAL AGENTS*** - ANTIBIOTICS		
<i>cycloserine oral capsule</i>	1 or 1b*	
<i>ethambutol hcl oral tablet</i>	2	
<i>isoniazid injection solution</i>	1 or 1a*	
<i>isoniazid oral syrup</i>	1 or 1a*	
<i>isoniazid oral tablet</i>	1 or 1a*	
PRIFTIN ORAL TABLET (<i>rifapentine</i>)	2	
<i>pyrazinamide oral tablet</i>	2	
<i>rifabutin oral capsule</i>	2	
<i>rifampin intravenous solution reconstituted</i>	2	
<i>rifampin oral capsule</i>	2	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS FOR CANCER		
*ALKYLATING AGENTS*** - DRUGS FOR CANCER		
MYLERAN ORAL TABLET (<i>busulfan</i>)	4; OC	OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER		
<i>abiraterone acetate oral tablet 250 mg</i>	4; OC	PA; QL (4 tablet per 1 day); SP; OC
<i>abiraterone acetate oral tablet 500 mg</i>	4; OC	PA; QL (2 tablets per 1 day); SP; OC
<i>abiraterone acetate</i> (Abirtega Oral Tablet)	4; OC	PA; QL (2 tablets per 1 day); SP; OC
*ANTIADRENALS*** - DRUGS FOR CANCER		
LYSODREN ORAL TABLET (<i>mitotane</i>)	4; OC	LD; QL (38 tablet per 1 day); OC
*ANTIANDROGENS*** - DRUGS FOR CANCER		
<i>bicalutamide oral tablet</i>	2; OC	QL (1 tablet per 1 day); OC
ERLEADA ORAL TABLET 240 MG (<i>apalutamide</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
ERLEADA ORAL TABLET 60 MG (<i>apalutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
<i>nilutamide oral tablet</i>	4; OC	QL (1 tablet per 1 day); OC
NUBEQA ORAL TABLET (<i>darolutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL CAPSULE (<i>enzalutamide</i>)	4; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
XTANDI ORAL TABLET 40 MG (<i>enzalutamide</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
XTANDI ORAL TABLET 80 MG (<i>enzalutamide</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*ANTIESTROGENS*** - DRUGS FOR CANCER		
SOLTAMOX ORAL SOLUTION (<i>tamoxifen citrate</i>)	2; OC; \$0	OC
<i>tamoxifen citrate oral tablet</i>	2; OC; \$0	OC
<i>toremifene citrate oral tablet</i>	4; OC	OC
*ANTIMETABOLITES*** - DRUGS FOR CANCER		
<i>capecitabine oral tablet</i>	4; OC	PA; SP; OC
<i>mercaptopurine oral suspension</i>	2; OC	PA; OC
<i>mercaptopurine oral tablet</i>	2; OC	OC
<i>methotrexate sodium (pf) injection solution</i>	1 or 1b*	
<i>methotrexate sodium injection solution</i>	1 or 1b*	
<i>methotrexate sodium injection solution reconstituted</i>	1 or 1b*	
<i>methotrexate sodium oral tablet</i>	2; OC	OC
TABLOID ORAL TABLET (<i>thioguanine</i>)	2; OC	OC
TREXALL ORAL TABLET (<i>methotrexate sodium</i>)	2; OC	ST; OC
*ANTINEOPLASTIC - ALK INHIBITORS*** - DRUGS FOR CANCER		
ALECENSA ORAL CAPSULE (<i>alectinib hcl</i>)	2; OC	PA; LD; QL (8 capsule per 1 day); SP; OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALUNBRIG ORAL TABLET 180 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
ALUNBRIG ORAL TABLET 30 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); OC
ALUNBRIG ORAL TABLET 90 MG (<i>brigatinib</i>)	2; OC	PA; LD; QL (2 tablets per 1 day); OC
ALUNBRIG ORAL TABLET THERAPY PACK (<i>brigatinib</i>)	2; OC	PA; LD; QL (1 pack per 30 days); OC
XALKORI ORAL CAPSULE (<i>crizotinib</i>)	4; OC	PA; LD; QL (4 capsules per 1 day); SP; OC
*ANTINEOPLASTIC - ANTI-HER2 AGENTS*** - DRUGS FOR CANCER		
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab</i>)	4	LD; SP
KANJINTI INTRAVENOUS SOLUTION RECONSTITUTED (<i>trastuzumab-anns</i>)	4	LD; SP
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS*** - DRUGS FOR CANCER		
BOSULIF ORAL CAPSULE 100 MG (<i>bosutinib</i>)	2; OC	PA; QL (6 capsules per 1 day); SP; OC
BOSULIF ORAL CAPSULE 50 MG (<i>bosutinib</i>)	2; OC	PA; QL (1 capsule per 1 day); SP; OC
BOSULIF ORAL TABLET 100 MG (<i>bosutinib</i>)	2; OC	PA; QL (6 tablets per 1 day); SP; OC
BOSULIF ORAL TABLET 400 MG, 500 MG (<i>bosutinib</i>)	2; OC	PA; QL (1 tablet per 1 day); SP; OC
<i>dasatinib oral tablet</i>	1 or 1b*; OC	PA; QL (1 tablet per 1 day); SP; OC
<i>imatinib mesylate oral tablet</i>	1 or 1b*; OC	PA; QL (2 tablets per 1 day); SP; OC
<i>nilotinib hcl oral capsule</i>	4; OC	PA; QL (4 capsules per 1 day); SP; OC
*ANTINEOPLASTIC - BRAF KINASE INHIBITORS*** - DRUGS FOR CANCER		
TAFINLAR ORAL CAPSULE (<i>dabrafenib mesylate</i>)	4; OC	PA; LD; QL (4 capsule per 1 day); SP; OC
ZELBORAF ORAL TABLET (<i>vemurafenib</i>)	4; OC	PA; LD; QL (8 tablet per 1 day); SP; OC
*ANTINEOPLASTIC - BTK INHIBITORS*** - DRUGS FOR CANCER		
CALQUENCE ORAL TABLET (<i>acalabrutinib maleate</i>)	4; OC	PA; LD; QL (2 capsules per 1 day); OC
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (3 capsule per 1 day); OC
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
IMBRUVICA ORAL SUSPENSION (<i>ibrutinib</i>)	2; OC	PA; LD; QL (8 mL per 1 day); OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMBRUVICA ORAL TABLET (<i>ibrutinib</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - EGFR INHIBITORS*** - DRUGS FOR CANCER		
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	1 or 1b*; OC	PA; QL (1 tablet per 1 day); SP; OC
<i>erlotinib hcl oral tablet 25 mg</i>	1 or 1b*; OC	PA; QL (3 tablets per 1 day); SP; OC
<i>gefitinib oral tablet</i>	4; OC	PA; QL (1 tablet per 1 day); SP; OC
GILOTRIF ORAL TABLET (<i>afatinib dimaleate</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); OC
*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS*** - DRUGS FOR CANCER		
ERIVEDGE ORAL CAPSULE (<i>vismodegib</i>)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS*** - DRUGS FOR CANCER		
ZOLINZA ORAL CAPSULE (<i>vorinostat</i>)	4; OC	PA; QL (4 capsule per 1 day); SP; OC
*ANTINEOPLASTIC - IMMUNOMODULATORS*** - DRUGS FOR CANCER		
POMALYST ORAL CAPSULE (<i>pomalidomide</i>)	4; OC	PA; LD; QL (21 capsules per 28 days); SP; OC
*ANTINEOPLASTIC - MEK INHIBITORS*** - DRUGS FOR CANCER		
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	4; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER		
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	4; OC	PA; SP; OC
<i>everolimus oral tablet soluble</i>	4; OC	PA; SP; OC
<i>everolimus</i> (Torpenz Oral Tablet)	4; OC	PA; LD; SP; OC
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS*** - DRUGS FOR CANCER		
CABOMETYX ORAL TABLET (<i>cabozantinib s-malate</i>)	2; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	4; OC	PA; LD; QL (3 tablet per 1 day); OC
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); OC
COMETRIQ (100 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose-pack per 56 days); SP; OC
COMETRIQ (140 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMETRIQ (60 MG DAILY DOSE) ORAL KIT (<i>cabozantinib s-malate</i>)	4; OC	PA; LD; QL (1 dose pack per 28 days); SP; OC
<i>lapatinib ditosylate oral tablet</i>	4; OC	PA; QL (6 tablet per 1 day); SP; OC
<i>pazopanib hcl oral tablet</i>	4; OC	PA; QL (4 tablet per 1 day); SP; OC
<i>sorafenib tosylate oral tablet</i>	4; OC	PA; QL (4 tablet per 1 day); SP; OC
STIVARGA ORAL TABLET (<i>regorafenib</i>)	4; OC	PA; LD; QL (84 tablets per 28 days); SP; OC
<i>sunitinib malate oral capsule</i>	4; OC	PA; QL (1 capsule per 1 day); SP; OC
*ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS*** - DRUGS FOR CANCER		
VITRAKVI ORAL CAPSULE 100 MG (<i>larotrectinib sulfate</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
VITRAKVI ORAL CAPSULE 25 MG (<i>larotrectinib sulfate</i>)	4; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
VITRAKVI ORAL SOLUTION (<i>larotrectinib sulfate</i>)	4; OC	PA; LD; QL (10 mL per 1 day); SP; OC
*ANTINEOPLASTIC COMBINATIONS*** - DRUGS FOR CANCER		
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION (<i>trastuzumab-hyaluronidase-oysk</i>)	4	LD; SP
*ANTINEOPLASTICS MISC.*** - DRUGS FOR CANCER		
ACTIMMUNE SUBCUTANEOUS SOLUTION (<i>interferon gamma-1b</i>)	4	PA; LD; SP
<i>hydroxyurea oral capsule</i>	2; OC	OC
MATULANE ORAL CAPSULE (<i>procarbazine hcl</i>)	4; OC	LD; OC
*AROMATASE INHIBITORS*** - DRUGS FOR CANCER		
<i>anastrozole oral tablet</i>	2; OC; \$0	OC
<i>exemestane oral tablet</i>	2; OC; \$0	OC
<i>letrozole oral tablet</i>	2; OC; \$0	OC
*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER		
IBRANCE ORAL CAPSULE (<i>palbociclib</i>)	4; OC	PA; LD; QL (21 capsules per 28 days); SP; OC
IBRANCE ORAL TABLET 100 MG, 75 MG (<i>palbociclib</i>)	4; OC	PA; LD; QL (21 tablets per 28 days); SP; OC
IBRANCE ORAL TABLET 125 MG (<i>palbociclib</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); SP; OC
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; QL (0.75 tablet per 1 day); SP; OC
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; QL (1.5 tablets per 1 day); SP; OC
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK (<i>ribociclib succinate</i>)	4; OC	PA; QL (2.25 tablets per 1 day); SP; OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERZENIO ORAL TABLET (<i>abemaciclib</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*FOLIC ACID ANTAGONISTS RESCUE AGENTS*** - DRUGS FOR CANCER		
<i>leucovorin calcium injection solution</i>	1 or 1b*	
<i>leucovorin calcium injection solution reconstituted</i>	1 or 1b*	
<i>leucovorin calcium oral tablet</i>	2	QL (2 tablets per 1 day)
*GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS*** - DRUGS FOR CANCER		
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	4	PA; QL (2 units per 310 days); SP
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>degarelix acetate</i>)	4	PA; QL (1 kit per 28 days); SP
ORGOVYX ORAL TABLET (<i>relugolix</i>)	4; OC	PA; LD; QL (1 tablet per 1 day); OC
*IMIDAZOTETRAZINES*** - DRUGS FOR CANCER		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg</i>	4; OC	PA; QL (2 capsules per 1 day); SP; OC
<i>temozolomide oral capsule 20 mg</i>	4; OC	PA; QL (4 capsule per 1 day); SP; OC
<i>temozolomide oral capsule 5 mg</i>	4; OC	PA; QL (3 capsule per 1 day); SP; OC
*JANUS ASSOCIATED KINASE (JAK) INHIBITORS*** - DRUGS FOR CANCER		
JAKAFI ORAL TABLET (<i>ruxolitinib phosphate</i>)	4; OC	PA; LD; QL (2 tablets per 1 day); SP; OC
*LHRH ANALOGS*** - DRUGS FOR CANCER		
<i>leuprolide acetate injection kit</i>	4	PA; SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>triptorelin pamoate</i>)	4	PA; QL (1 vial per 84 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG (<i>triptorelin pamoate</i>)	4	PA; QL (1 syringe per 168 days); SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>triptorelin pamoate</i>)	4	PA; QL (1 kit per 28 days); SP
*MITOTIC INHIBITORS*** - DRUGS FOR CANCER		
<i>etoposide oral capsule</i>	4; OC	SP; OC
*NITROGEN MUSTARDS AND RELATED ANALOGUES*** - DRUGS FOR CANCER		
<i>cyclophosphamide oral capsule</i>	4; OC	SP; OC
LEUKERAN ORAL TABLET (<i>chlorambucil</i>)	2; OC	OC

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS*** - DRUGS FOR CANCER		
LYNPARZA ORAL TABLET (<i>olaparib</i>)	4; OC	PA; LD; QL (4 tablets per 1 day); SP; OC
ZEJULA ORAL TABLET (<i>niraparib tosylate</i>)	4; OC	PA; LD; QL (3 tablets per 1 day); SP; OC
*PROGESTINS-ANTINEOPLASTIC*** - DRUGS FOR CANCER		
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml</i>	1 or 1b*; OC	OC
<i>megestrol acetate oral tablet</i>	1 or 1b*; OC	OC
*RETINOIDS*** - DRUGS FOR CANCER		
<i>tretinoin oral capsule</i>	2; OC	OC
*SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR CANCER		
<i>bexarotene oral capsule</i>	4; OC	PA; QL (10 capsules per 1 day); SP; OC
*TOPOISOMERASE I INHIBITORS*** - DRUGS FOR CANCER		
HYCAMTIN ORAL CAPSULE (<i>topotecan hcl</i>)	4; OC	PA; SP; OC
*URINARY TRACT PROTECTIVE AGENTS*** - DRUGS FOR CANCER		
<i>mesna intravenous solution</i>	1 or 1b*	PA
<i>mesna oral tablet</i>	2	PA
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS*** - DRUGS FOR CANCER		
AVASTIN INTRAVENOUS SOLUTION (<i>bevacizumab</i>)	4	PA; LD; SP
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (6 tablets per 1 day); SP; OC
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	2; OC	PA; LD; QL (4 tablet per 1 day); SP; OC
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (60 capsules per 30 days); SP; OC
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (90 capsules per 30 days); SP; OC
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (30 capsules per 30 days); SP; OC

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK (<i>lenvatinib mesylate</i>)	2; OC	PA; LD; QL (1 pack per 30 days); SP; OC
MVASI INTRAVENOUS SOLUTION (<i>bevacizumab-awwb</i>)	4	PA; LD; SP
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIPARKINSON ANTICHOLINERGICS*** - DRUGS FOR PARKINSON		
<i>benztropine mesylate injection solution</i>	1 or 1a*	
<i>benztropine mesylate oral tablet</i>	1 or 1a*	
<i>trihexyphenidyl hcl oral solution</i>	1 or 1a*	
<i>trihexyphenidyl hcl oral tablet</i>	1 or 1a*	
*ANTIPARKINSON DOPAMINERGICS*** - DRUGS FOR PARKINSON		
<i>amantadine hcl oral capsule</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>amantadine hcl oral solution</i>	1 or 1b*	QL (40 mL per 1 day)
<i>amantadine hcl oral tablet</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>bromocriptine mesylate oral capsule</i>	1 or 1b*	
<i>bromocriptine mesylate oral tablet</i>	1 or 1b*	
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS*** - DRUGS FOR PARKINSON		
<i>rasagiline mesylate oral tablet 0.5 mg</i>	2	QL (2 tablets per 1 day)
<i>rasagiline mesylate oral tablet 1 mg</i>	2	QL (1 tablet per 1 day)
<i>selegiline hcl oral capsule</i>	2	
<i>selegiline hcl oral tablet</i>	2	
*CENTRAL/PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
<i>tolcapone oral tablet</i>	2	PA; QL (6 tablet per 1 day)
*DECARBOXYLASE INHIBITORS*** - DRUGS FOR PARKINSON		
<i>carbidopa oral tablet</i>	2	
*LEVODOPA COMBINATIONS*** - DRUGS FOR PARKINSON		
<i>carbidopa-levodopa er oral tablet extended release</i>	2	
<i>carbidopa-levodopa oral tablet</i>	1 or 1b*	
<i>carbidopa-levodopa oral tablet dispersible</i>	2	
<i>carbidopa-levodopa-entacapone oral tablet</i>	2	
*NONERGOLINE DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR PARKINSON		
<i>apomorphine hcl subcutaneous solution cartridge</i>	4	PA; QL (2 mL per 1 day); SP
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>pramipexole dihydrochloride oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>ropinirole hcl er oral tablet extended release 24 hour</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ropinirole hcl oral tablet</i>	1 or 1b*	
*PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON		
<i>entacapone oral tablet</i>	2	QL (8 tablet per 1 day)
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*ANTIMANIC AGENTS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>lithium carbonate er oral tablet extended release 300 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>lithium carbonate er oral tablet extended release 450 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>lithium carbonate oral capsule 150 mg</i>	1 or 1a*	QL (12 capsules per 1 day)
<i>lithium carbonate oral capsule 300 mg</i>	1 or 1a*	QL (6 capsules per 1 day)
<i>lithium carbonate oral capsule 600 mg</i>	1 or 1a*	QL (3 capsules per 1 day)
<i>lithium carbonate oral tablet</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>lithium oral solution</i>	1 or 1b*	
*ANTIPSYCHOTICS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG (<i>lumateperone tosylate</i>)	3	DO; AL
CAPLYTA ORAL CAPSULE 42 MG (<i>lumateperone tosylate</i>)	3	AL; QL (1 capsule per 1 day)
<i>lurasidone hcl oral tablet 120 mg</i>	2	AL
<i>lurasidone hcl oral tablet 20 mg, 40 mg</i>	2	DO; AL
<i>lurasidone hcl oral tablet 60 mg</i>	2	AL; QL (1 tablet per 1 day)
<i>lurasidone hcl oral tablet 80 mg</i>	2	AL; QL (2 tablets per 1 day)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG (<i>cariprazine hcl</i>)	2	DO; AL
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	2	AL; QL (1 capsule per 1 day)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg</i>	2	DO; AL
<i>ziprasidone hcl oral capsule 60 mg, 80 mg</i>	2	AL; QL (2 capsules per 1 day)
<i>ziprasidone mesylate intramuscular solution reconstituted</i>	2	AL; QL (6 vials per 28 days)
*BENZISOXAZOLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg</i>	2	DO; AL
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	2	AL; QL (2 tablets per 1 day)
<i>paliperidone er oral tablet extended release 24 hour 9 mg</i>	2	AL; QL (1 tablet per 1 day)
<i>risperidone microspheres er intramuscular suspension reconstituted er</i>	2	AL; QL (2 injections per 28 days)
<i>risperidone oral solution</i>	1 or 1b*	AL; QL (8 mL per 1 day)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>risperidone oral tablet 3 mg, 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	2	DO; AL
<i>risperidone oral tablet dispersible 3 mg, 4 mg</i>	2	AL; QL (4 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*BUTYROPHENONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>haloperidol decanoate intramuscular solution</i>	1 or 1b*	AL; QL (5 mL per 30 days)
<i>haloperidol lactate injection solution</i>	1 or 1b*	AL
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	1 or 1b*	AL; QL (30 mL per 1 day)
<i>haloperidol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>haloperidol oral tablet 10 mg, 20 mg, 5 mg</i>	1 or 1b*	AL; QL (3 tablets per 1 day)
*DIBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>clozapine oral tablet 100 mg</i>	2	AL; QL (9 tablets per 1 day)
<i>clozapine oral tablet 200 mg</i>	2	AL; QL (4 tablets per 1 day)
<i>clozapine oral tablet 25 mg, 50 mg</i>	2	DO; AL
<i>clozapine oral tablet dispersible 100 mg</i>	2	AL; QL (9 tablets per 1 day)
<i>clozapine oral tablet dispersible 12.5 mg, 25 mg</i>	2	DO; AL
<i>clozapine oral tablet dispersible 150 mg</i>	2	AL; QL (6 tablets per 1 day)
<i>clozapine oral tablet dispersible 200 mg</i>	2	AL; QL (4 tablets per 1 day)
*DIBENZO-OXEPINO PYRROLES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>asenapine maleate sublingual tablet sublingual 10 mg</i>	2	AL; QL (2 tablets per 1 day)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg, 5 mg</i>	2	DO; AL
*DIBENZOTHIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	2	DO; AL
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	2	AL; QL (2 tablets per 1 day)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>quetiapine fumarate oral tablet 150 mg</i>	1 or 1b*	AL; QL (5 tablets per 1 day)
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>	1 or 1b*	AL; QL (2 tablets per 1 day)
*DIBENZOXAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>loxapine succinate oral capsule 50 mg</i>	1 or 1b*	AL; QL (4 capsules per 1 day)
*DIHYDROINDOLONES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>molindone hcl oral tablet 10 mg, 5 mg</i>	2	DO; AL
<i>molindone hcl oral tablet 25 mg</i>	2	AL; QL (4 tablets per 1 day)
*PHENOTHIAZINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>chlorpromazine hcl injection solution</i>	1 or 1b*	AL; Effective 01/01/2026: Tier 2
CHLORPROMAZINE HCL ORAL CONCENTRATE 100 MG/ML	1 or 1b*	AL; Effective 01/01/2026: Tier 2; QL (8 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHLORPROMAZINE HCL ORAL CONCENTRATE 30 MG/ML	1 or 1b*	AL; Effective 01/01/2026: Tier 2; QL (26 mL per 1 day)
<i>chlorpromazine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL; Effective 01/01/2026: Tier 2
<i>chlorpromazine hcl oral tablet 100 mg, 200 mg</i>	1 or 1b*	AL; Effective 01/01/2026: Tier 2; QL (4 tablets per 1 day)
<i>compro rectal suppository</i>	1 or 1b*	AL
<i>fluphenazine decanoate injection solution</i>	1 or 1b*	AL
<i>fluphenazine hcl injection solution</i>	1 or 1b*	AL
<i>fluphenazine hcl oral concentrate</i>	1 or 1b*	AL; QL (8 mL per 1 day)
<i>fluphenazine hcl oral elixir</i>	1 or 1b*	AL; QL (80 mL per 1 day)
<i>fluphenazine hcl oral tablet 1 mg, 2.5 mg, 5 mg</i>	1 or 1b*	DO; AL
<i>fluphenazine hcl oral tablet 10 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>perphenazine oral tablet 16 mg</i>	1 or 1b*	AL; QL (1 tablet per 1 day)
<i>perphenazine oral tablet 2 mg</i>	1 or 1b*	DO; AL
<i>perphenazine oral tablet 4 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
<i>perphenazine oral tablet 8 mg</i>	1 or 1b*	AL; QL (3 tablets per 1 day)
<i>prochlorperazine edisylate injection solution</i>	1 or 1b*	AL
<i>prochlorperazine maleate oral tablet</i>	1 or 1a*	AL
<i>prochlorperazine rectal suppository</i>	1 or 1b*	AL
<i>thioridazine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1 or 1b*	DO; AL
<i>thioridazine hcl oral tablet 100 mg</i>	1 or 1b*	AL; QL (8 tablets per 1 day)
<i>trifluoperazine hcl oral tablet 1 mg, 2 mg</i>	1 or 1b*	DO; AL
<i>trifluoperazine hcl oral tablet 10 mg, 5 mg</i>	1 or 1b*	AL; QL (4 tablets per 1 day)
*QUINOLINONE DERIVATIVES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>aripiprazole oral solution</i>	2	AL; QL (30 mL per 1 day)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg</i>	2	DO; AL
<i>aripiprazole oral tablet 20 mg, 30 mg</i>	2	AL; QL (1 tablet per 1 day)
<i>aripiprazole oral tablet dispersible 10 mg</i>	2	AL; QL (3 tablets per 1 day)
<i>aripiprazole oral tablet dispersible 15 mg</i>	2	AL; QL (2 tablets per 1 day)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG (<i>brexpiprazole</i>)	3	DO; AL
REXULTI ORAL TABLET 4 MG (<i>brexpiprazole</i>)	3	AL; QL (1 tablet per 1 day)
*THIENBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>olanzapine intramuscular solution reconstituted</i>	2	AL; QL (3 injections per 1 fill)
<i>olanzapine oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	1 or 1b*	DO; AL
<i>olanzapine oral tablet 15 mg, 20 mg</i>	1 or 1b*	AL; QL (1 tablets per 1 day)
<i>olanzapine oral tablet dispersible 10 mg, 5 mg</i>	2	DO; AL

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olanzapine oral tablet dispersible 15 mg</i>	2	AL; QL (1 tablets per 1 day)
<i>olanzapine oral tablet dispersible 20 mg</i>	2	AL; QL (1 tablet per 1 day)
*THIOXANTHENES*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>thiothixene oral capsule 1 mg, 2 mg, 5 mg</i>	1 or 1b*	PA; DO
<i>thiothixene oral capsule 10 mg</i>	1 or 1b*	PA; QL (6 capsules per 1 day)
ANTIVIRALS - DRUGS FOR INFECTIONS		
*ANTIRETROVIRAL COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
<i>abacavir sulfate-lamivudine oral tablet</i>	2	QL (1 tablet per 1 day)
BIKTARVY ORAL TABLET (<i>bictegravir-emtricitab-tenofovir</i>)	4	QL (1 tablet per 1 day)
CIMDUO ORAL TABLET (<i>lamivudine-tenofovir</i>)	4	QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	2	QL (1 tablet per 1 day)
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	2; \$0	QL (1 tablet per 1 day)
DOVATO ORAL TABLET (<i>dolutegravir-lamivudine</i>)	4	QL (1 tablet per 1 day)
<i>efavirenz-emtricitab-tenofovir df oral tablet</i>	4	QL (1 tablet per 1 day)
<i>efavirenz-lamivudine-tenofovir oral tablet</i>	4	QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>emtricitab- rilpivir-tenofovir df oral tablet</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
GENVOYA ORAL TABLET (<i>elviteg-cobic-emtricit-tenofaf</i>)	4	QL (1 tablet per 1 day)
<i>lamivudine-zidovudine oral tablet</i>	2	QL (2 tablets per 1 day)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	4	QL (10 tablets per 1 day)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	4	QL (4 tablets per 1 day)
STRIBILD ORAL TABLET (<i>elviteg-cobic-emtricit-tenofdf</i>)	4	QL (1 tablet per 1 day)
TRIUMEQ ORAL TABLET (<i>abacavir-dolutegravir-lamivud</i>)	4	QL (1 tablet per 1 day)
TRIUMEQ PD ORAL TABLET SOLUBLE	4	QL (6 tablets per 1 day)
*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)*** - DRUGS FOR VIRAL INFECTIONS		
<i>maraviroc oral tablet</i>	4	QL (4 tablets per 1 day)
*ANTIRETROVIRALS - FUSION INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>enfuvirtide</i>)	4	PA; LD; QL (2 vials per 1 day)
*ANTIRETROVIRALS - INTEGRASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
ISENTRESS ORAL TABLET (<i>raltegravir potassium</i>)	4	QL (4 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 100 MG (<i>raltegravir potassium</i>)	4	QL (6 tablets per 1 day)
ISENTRESS ORAL TABLET CHEWABLE 25 MG (<i>raltegravir potassium</i>)	4	QL (24 tablets per 1 day)
TIVICAY ORAL TABLET (<i>dolutegravir sodium</i>)	4	QL (2 tablets per 1 day)
TIVICAY PD ORAL TABLET SOLUBLE (<i>dolutegravir sodium</i>)	4	QL (12 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTIRETROVIRALS - PROTEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
APTIVUS ORAL CAPSULE (<i>tipranavir</i>)	4	PA; QL (4 capsules per 1 day)
<i>atazanavir sulfate oral capsule 150 mg, 200 mg</i>	4	QL (2 capsules per 1 day)
<i>atazanavir sulfate oral capsule 300 mg</i>	4	QL (1 capsule per 1 day)
<i>darunavir oral tablet 600 mg</i>	4	QL (2 tablets per 1 day)
<i>darunavir oral tablet 800 mg</i>	4	QL (1 tablet per 1 day)
<i>fosamprenavir calcium oral tablet</i>	4	QL (4 tablets per 1 day)
PREZISTA ORAL SUSPENSION (<i>darunavir</i>)	4	QL (14 mL per 1 day)
PREZISTA ORAL TABLET 150 MG (<i>darunavir</i>)	4	QL (6 tablets per 1 day)
PREZISTA ORAL TABLET 75 MG (<i>darunavir</i>)	4	QL (10 tablets per 1 day)
REYATAZ ORAL PACKET (<i>atazanavir sulfate</i>)	4	QL (5 packets per 1 day)
<i>ritonavir oral tablet</i>	4	QL (12 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
EDURANT ORAL TABLET (<i>rilpivirine hcl</i>)	4	PA; QL (1 tablet per 1 day)
EDURANT PED ORAL TABLET SOLUBLE (<i>rilpivirine hcl</i>)	4	PA; QL (6 tablets per 1 day)
<i>efavirenz oral tablet</i>	4	QL (1 tablet per 1 day)
<i>etravirine oral tablet 100 mg</i>	4	PA; QL (4 tablets per 1 day)
<i>etravirine oral tablet 200 mg</i>	4	PA; QL (2 tablets per 1 day)
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	4	PA; QL (16 tablets per 1 day)
<i>nevirapine er oral tablet extended release 24 hour</i>	4	QL (1 tablet per 1 day)
<i>nevirapine oral suspension</i>	4	QL (40 mL per 1 day)
<i>nevirapine oral tablet</i>	4	QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES*** - DRUGS FOR VIRAL INFECTIONS		
<i>abacavir sulfate oral solution</i>	4	QL (32 mL per 1 day)
<i>abacavir sulfate oral tablet</i>	4	QL (2 tablets per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
<i>emtricitabine oral capsule</i>	4; \$0	QL (1 capsule per 1 day)
EMTRIVA ORAL SOLUTION (<i>emtricitabine</i>)	4	QL (29 mL per 1 day)
<i>lamivudine oral solution</i>	4	QL (32 mL per 1 day)
<i>lamivudine oral tablet 150 mg</i>	4	PA; QL (2 tablets per 1 day)
<i>lamivudine oral tablet 300 mg</i>	4	PA; QL (1 tablet per 1 day)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES*** - DRUGS FOR VIRAL INFECTIONS		
<i>zidovudine oral capsule</i>	4	QL (6 capsules per 1 day)
<i>zidovudine oral syrup</i>	4	QL (64 mL per 1 day)
<i>zidovudine oral tablet</i>	4	QL (2 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>tenofovir disoproxil fumarate oral tablet</i>	4; \$0	QL (1 tablet per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	4	QL (1 tablet per 1 day)
*ANTIVIRAL COMBINATIONS*** - DRUGS FOR INFECTIONS		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	1 or 1b*	QL (1 pack per 90 days)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	1 or 1b*	QL (1 pack per 90 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK (<i>nirmatrelvir-ritonavir</i>)	1 or 1b*	QL (1 pack per 90 days)
*CMV AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>valganciclovir hcl oral solution reconstituted</i>	4	
<i>valganciclovir hcl oral tablet</i>	4	
*HEPATITIS B AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>adefovir dipivoxil oral tablet</i>	4	PA; QL (1 tablet per 1 day); SP
BARACLUDE ORAL SOLUTION (<i>entecavir</i>)	4	PA; QL (20 mL per 1 day)
<i>entecavir oral tablet</i>	4	PA; QL (1 tablet per 1 day)
<i>lamivudine oral tablet 100 mg</i>	4	PA; QL (1 tablet per 1 day)
VEMLIDY ORAL TABLET (<i>tenofovir alafenamide fumarate</i>)	4	PA; QL (1 tablet per 1 day); SP
*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; QL (1 packet per 1 day); SP
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; QL (2 packets per 1 day); SP
EPCLUSA ORAL TABLET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; QL (2 tablets per 1 day); SP
EPCLUSA ORAL TABLET 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	4	PA; QL (1 tablet per 1 day); SP
HARVONI ORAL PACKET 33.75-150 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; QL (1 packet per 1 day); SP
HARVONI ORAL PACKET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; QL (2 packets per 1 day); SP
HARVONI ORAL TABLET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; QL (2 tablets per 1 day); SP
HARVONI ORAL TABLET 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	4	PA; QL (1 tablet per 1 day); SP
VOSEVI ORAL TABLET (<i>sofosbuv-velpatasv-voxilaprev</i>)	4	PA; QL (1 tablet per 1 day); SP
*HEPATITIS C AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>ribavirin oral capsule</i>	4	QL (6 capsules per 1 day); SP
<i>ribavirin oral tablet</i>	4	QL (6 tablets per 1 day); SP
*HERPES AGENTS - PURINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>acyclovir oral capsule</i>	1 or 1b*	
<i>acyclovir oral suspension</i>	1 or 1b*	
<i>acyclovir oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acyclovir sodium intravenous solution</i>	1 or 1b*	
<i>valacyclovir hcl oral tablet 1 gm</i>	1 or 1b*	QL (30 tablets per 1 fill)
<i>valacyclovir hcl oral tablet 500 mg</i>	1 or 1b*	QL (60 tablets per 30 days)
*HERPES AGENTS - THYMIDINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>famciclovir oral tablet 125 mg, 250 mg</i>	1 or 1b*	QL (60 tablets per 1 fill)
<i>famciclovir oral tablet 500 mg</i>	1 or 1b*	QL (21 tablets per 1 fill)
*INFLUENZA AGENTS*** - DRUGS FOR VIRAL INFECTIONS		
<i>rimantadine hcl oral tablet</i>	1 or 1b*	
*MISC. ANTIVIRALS*** - DRUGS FOR VIRAL INFECTIONS		
LAGEVRIO ORAL CAPSULE (<i>molnupiravir</i>)	3	QL (40 capsules per 90 days)
*NEURAMINIDASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
<i>oseltamivir phosphate oral capsule 30 mg</i>	1 or 1b*	QL (20 capsule per 90 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	1 or 1b*	QL (10 capsule per 90 days)
<i>oseltamivir phosphate oral suspension reconstituted</i>	1 or 1b*	QL (20 ML per 90 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED (<i>zanamivir</i>)	2	QL (1 unit per 90 days)
*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS		
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK (<i>baloxavir marboxil</i>)	3	QL (1 dose pack per 90 days)
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK (<i>baloxavir marboxil</i>)	3	QL (1 dose pack per 90 days)
*RSV AGENTS - NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS		
<i>ribavirin inhalation solution reconstituted</i>	2	
BETA BLOCKERS - DRUGS FOR THE HEART		
*ALPHA-BETA BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>carvedilol oral tablet 12.5 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>carvedilol oral tablet 25 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carvedilol oral tablet 3.125 mg</i>	1 or 1b*	QL (32 tablets per 1 day)
<i>carvedilol oral tablet 6.25 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg</i>	2	QL (8 capsules per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 20 mg</i>	2	QL (4 capsules per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 40 mg</i>	2	QL (2 capsules per 1 day)
<i>carvedilol phosphate er oral capsule extended release 24 hour 80 mg</i>	2	QL (1 capsule per 1 day)
<i>labetalol hcl oral tablet 100 mg</i>	1 or 1b*	QL (24 tablets per 1 day)
<i>labetalol hcl oral tablet 200 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>labetalol hcl oral tablet 300 mg</i>	1 or 1b*	QL (8 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>labetalol hcl oral tablet 400 mg</i>	2	QL (6 tablets per 1 day)
*BETA BLOCKERS CARDIO-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>acebutolol hcl oral capsule</i>	1 or 1b*	
<i>atenolol oral tablet</i>	1 or 1a*	
<i>betaxolol hcl oral tablet</i>	1 or 1b*	
<i>bisoprolol fumarate oral tablet</i>	1 or 1b*	
<i>esmolol hcl intravenous solution 100 mg/10ml</i>	1 or 1b*	
<i>metoprolol succinate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>metoprolol tartrate intravenous solution</i>	1 or 1a*	
<i>metoprolol tartrate oral tablet</i>	1 or 1a*	
<i>nebivolol hcl oral tablet</i>	2	
*BETA BLOCKERS NON-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>nadolol oral tablet 20 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>nadolol oral tablet 40 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>nadolol oral tablet 80 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>pindolol oral tablet 10 mg</i>	2	QL (6 tablets per 1 day)
<i>pindolol oral tablet 5 mg</i>	2	QL (12 tablets per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	QL (5 capsules per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 160 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 60 mg</i>	1 or 1b*	QL (10 capsules per 1 day)
<i>propranolol hcl er oral capsule extended release 24 hour 80 mg</i>	1 or 1b*	QL (8 capsules per 1 day)
<i>propranolol hcl intravenous solution</i>	1 or 1b*	
<i>propranolol hcl oral solution</i>	1 or 1b*	QL (80 mL per 1 day)
<i>propranolol hcl oral tablet 10 mg</i>	1 or 1b*	QL (64 tablets per 1 day)
<i>propranolol hcl oral tablet 20 mg</i>	1 or 1b*	QL (32 tablets per 1 day)
<i>propranolol hcl oral tablet 40 mg</i>	1 or 1b*	QL (16 tablets per 1 day)
<i>propranolol hcl oral tablet 60 mg</i>	1 or 1b*	QL (10 tablets per 1 day)
<i>propranolol hcl oral tablet 80 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>sotalol hcl (af) oral tablet 120 mg, 80 mg</i>	2	QL (3 tablet per 1 day)
<i>sotalol hcl (af) oral tablet 160 mg</i>	2	QL (4 tablets per 1 day)
<i>sotalol hcl oral tablet 120 mg, 80 mg</i>	2	QL (3 tablets per 1 day)
<i>sotalol hcl oral tablet 160 mg</i>	2	QL (4 tablets per 1 day)
<i>sotalol hcl oral tablet 240 mg</i>	2	QL (2 tablets per 1 day)
<i>timolol maleate oral tablet 10 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>timolol maleate oral tablet 20 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>timolol maleate oral tablet 5 mg</i>	1 or 1b*	QL (12 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM CHANNEL BLOCKERS - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amlodipine besylate oral tablet 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate oral tablet 2.5 mg</i>	1 or 1b*	DO
<i>amlodipine besylate oral tablet 5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>cartia xt oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>cartia xt oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>cartia xt oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>cartia xt oral capsule extended release 24 hour 300 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er beads oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 12 hour 60 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral capsule extended release 12 hour 90 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>diltiazem hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>diltiazem hcl er oral tablet extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>diltiazem hcl er oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>diltiazem hcl intravenous solution</i>	1 or 1b*	
<i>diltiazem hcl oral tablet 120 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>diltiazem hcl oral tablet 30 mg, 60 mg</i>	1 or 1b*	DO
<i>diltiazem hcl oral tablet 90 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>dilt-xr oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>dilt-xr oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>dilt-xr oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>felodipine er oral tablet extended release 24 hour 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	1 or 1b*	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isradipine oral capsule 2.5 mg</i>	1 or 1b*	DO
<i>isradipine oral capsule 5 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>levamlodipine maleate oral tablet 2.5 mg</i>	1 or 1b*	ST; DO
<i>levamlodipine maleate oral tablet 5 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>matzim la oral tablet extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>matzim la oral tablet extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>matzim la oral tablet extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nicardipine hcl oral capsule 20 mg</i>	1 or 1b*	QL (6 capsule per 1 day)
<i>nicardipine hcl oral capsule 30 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 60 mg</i>	2	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg</i>	2	DO
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg</i>	2	QL (2 tablets per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine oral capsule 10 mg</i>	2	DO
<i>nifedipine oral capsule 20 mg</i>	2	QL (4 capsule per 1 day)
<i>nimodipine oral capsule</i>	2	QL (12 capsule per 1 day)
<i>nimodipine oral solution</i>	2	QL (120 mL per 1 day)
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 8.5 mg</i>	1 or 1b*	DO
<i>nisoldipine er oral tablet extended release 24 hour 25.5 mg, 30 mg, 34 mg, 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 120 mg</i>	1 or 1b*	DO
<i>tiadylt er oral capsule extended release 24 hour 180 mg</i>	1 or 1b*	QL (3 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>tiadylt er oral capsule extended release 24 hour 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>verapamil hcl er oral tablet extended release 120 mg</i>	1 or 1b*	DO
<i>verapamil hcl er oral tablet extended release 180 mg, 240 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>verapamil hcl intravenous solution</i>	1 or 1b*	
<i>verapamil hcl oral tablet 120 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>verapamil hcl oral tablet 40 mg, 80 mg</i>	1 or 1b*	DO
CARDIOTONICS - DRUGS FOR THE HEART		
*CARDIAC GLYCOSIDES*** - DRUGS FOR THE HEART		
<i>digoxin injection solution</i>	1 or 1b*	
<i>digoxin oral solution</i>	1 or 1b*	QL (10 mL per 1 day)
<i>digoxin oral tablet 125 mcg, 62.5 mcg</i>	1 or 1b*	DO

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>digoxin oral tablet 250 mcg</i>	1 or 1b*	QL (2 tablets per 1 day)
LANOXIN PEDIATRIC INJECTION SOLUTION (<i>digoxin</i>)	2	
*INOTROPES*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>dobutamine hcl intravenous solution</i>	1 or 1b*	
<i>milrinone lactate in dextrose intravenous solution</i>	1 or 1b*	
<i>milrinone lactate intravenous solution</i>	1 or 1b*	
CARDIOVASCULAR AGENTS - MISC. - DRUGS FOR THE HEART		
*CALCIUM CHANNEL BLOCKER & HMG COA REDUCTASE INHIBIT COMB*** - DRUGS FOR CHOLESTEROL		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1 or 1b*	DO
*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR HIGH BLOOD PRESSURE		
ENTRESTO ORAL CAPSULE SPRINKLE (<i>sacubitril-valsartan</i>)	3	QL (8 capsules per 1 day)
<i>sacubitril-valsartan oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
*NITRATE & VASODILATOR COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>isosorb dinitrate-hydralazine oral tablet</i>	2	QL (6 tablets per 1 day)
*PROSTAGLANDIN VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>alprostadil injection solution</i>	1 or 1b*	
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>treprostinil diolamine</i>)	4	PA; LD; QL (1 pack per 28 days); SP
ORENITRAM ORAL TABLET EXTENDED RELEASE (<i>treprostinil diolamine</i>)	4	PA; LD; SP
<i>treprostinil injection solution</i>	4	PA; LD; SP
*PULM HYPERTEN-SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)*** - DRUGS FOR HIGH BLOOD PRESSURE		
ADEMPAS ORAL TABLET (<i>riociguat</i>)	4	PA; LD; QL (3 tablets per 1 day); SP
*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>ambrisentan oral tablet</i>	4	PA; QL (1 tablet per 1 day); SP
<i>bosentan oral tablet</i>	4	PA; LD; QL (2 tablets per 1 day); SP
<i>bosentan oral tablet soluble</i>	4	PA; QL (2 tablets per 1 day); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPSUMIT ORAL TABLET (<i>macitentan</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
TRACLEER ORAL TABLET SOLUBLE (<i>bosentan</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>alyq oral tablet</i>	4	PA; QL (2 tablets per 1 day); SP
<i>sildenafil citrate oral suspension reconstituted</i>	4	PA; QL (24 mL per 1 day); SP
<i>sildenafil citrate oral tablet 20 mg</i>	4	PA; QL (12 tablets per 1 day); SP
<i>tadalafil (pah) oral tablet</i>	4	PA; QL (2 tablets per 1 day); SP
*PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST*** - DRUGS FOR HIGH BLOOD PRESSURE		
UPTRAVI INTRAVENOUS SOLUTION RECONSTITUTED (<i>selexipag</i>)	4	PA; LD; QL (2 vials per 1 day)
UPTRAVI ORAL TABLET (<i>selexipag</i>)	4	PA; LD; QL (2 tablets per 1 day); SP
UPTRAVI TITRATION ORAL TABLET THERAPY PACK (<i>selexipag</i>)	4	PA; LD; QL (1 kit per 1 one-time fill); SP
*SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1 or 1b*	PA
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1 or 1b*	PA
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; QL (30 tablets per 30 days)
<i>ildenafil citrate oral tablet dispersible</i>	1 or 1b*	PA
*SEPTAL AGENTS - ABLATION** - DRUGS FOR THE HEART		
<i>dehydrated alcohol intra-arterial solution</i>	2	
*SINUS NODE INHIBITORS** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>ivabradine hcl oral tablet</i>	2	PA
CEPHALOSPORINS - DRUGS FOR INFECTIONS		
*CEPHALOSPORINS - 1ST GENERATION*** - ANTIBIOTICS		
<i>cefadroxil oral capsule</i>	1 or 1b*	
<i>cefadroxil oral suspension reconstituted</i>	1 or 1b*	
<i>cefadroxil oral tablet</i>	1 or 1b*	
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 3 gm, 500 mg</i>	2	
<i>cefazolin sodium intravenous solution reconstituted 1 gm</i>	2	
<i>cephalexin oral capsule</i>	1 or 1a*	
<i>cephalexin oral suspension reconstituted</i>	1 or 1a*	
<i>cephalexin oral tablet</i>	1 or 1a*	
*CEPHALOSPORINS - 2ND GENERATION*** - ANTIBIOTICS		
CEFACLOR ER ORAL TABLET EXTENDED RELEASE 12 HOUR	2	
<i>cefactor oral capsule</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefaclor oral suspension reconstituted</i>	1 or 1b*	
<i>cefotetan disodium injection solution reconstituted</i>	2	
<i>cefoxitin sodium intravenous solution reconstituted</i>	2	
<i>cefprozil oral suspension reconstituted</i>	1 or 1b*	
<i>cefprozil oral tablet</i>	1 or 1b*	
<i>cefuroxime axetil oral tablet</i>	1 or 1b*	
<i>cefuroxime sodium injection solution reconstituted</i>	2	
<i>cefuroxime sodium intravenous solution reconstituted</i>	2	
*CEPHALOSPORINS - 3RD GENERATION*** - ANTIBIOTICS		
<i>cefdinir oral capsule</i>	1 or 1b*	
<i>cefdinir oral suspension reconstituted</i>	1 or 1b*	
<i>cefixime oral capsule</i>	2	
<i>cefixime oral suspension reconstituted</i>	2	
<i>cefpodoxime proxetil oral suspension reconstituted</i>	2	
<i>cefpodoxime proxetil oral tablet</i>	2	
<i>ceftazidime injection solution reconstituted</i>	2	
<i>ceftazidime intravenous solution reconstituted</i>	2	
<i>ceftriaxone sodium in dextrose intravenous solution</i>	2	
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	2	
<i>ceftriaxone sodium intravenous solution reconstituted</i>	2	
<i>tazicef injection solution reconstituted</i>	2	
<i>tazicef intravenous solution reconstituted</i>	2	
*CEPHALOSPORINS - 4TH GENERATION*** - ANTIBIOTICS		
<i>cefepime hcl injection solution reconstituted</i>	2	
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	2	
CONTRACEPTIVES - DRUGS FOR WOMEN		
*BIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>azurette oral tablet</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>kariva oral tablet</i>	1 or 1b*; \$0	
LO LOESTRIN FE ORAL TABLET (<i>norethin-eth estrad-fe biphas</i>)	2	
<i>pimtrea oral tablet</i>	1 or 1b*; \$0	
<i>simliya oral tablet</i>	1 or 1b*; \$0	
<i>viorele oral tablet</i>	1 or 1b*; \$0	
<i>volnea oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*COMBINATION CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>afirmelle oral tablet</i>	1 or 1a*; \$0	
<i>altavera oral tablet</i>	1 or 1a*; \$0	
<i>alyacen 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>apri oral tablet</i>	1 or 1a*; \$0	
<i>aubra eq oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>aurovela fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>aurovela fe 1/20 oral tablet</i>	1 or 1a*; \$0	
AVERI ORAL TABLET (<i>desogestrel-eth estrad-fe</i>)	3	
<i>aviane oral tablet</i>	1 or 1a*; \$0	
<i>ayuna oral tablet</i>	1 or 1a*; \$0	
<i>balziva oral tablet</i>	1 or 1a*; \$0	
<i>blisovi 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>blisovi fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>briellyn oral tablet</i>	1 or 1a*; \$0	
<i>charlotte 24 fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>chateal eq oral tablet</i>	1 or 1a*; \$0	
<i>cryselle-28 oral tablet</i>	1 or 1a*; \$0	
<i>cyred eq oral tablet</i>	1 or 1a*; \$0	
<i>dasetta 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>delyla oral tablet</i>	1 or 1a*; \$0	
<i>drospiren-eth estrad-levomefol oral tablet</i>	1 or 1b*; \$0	
<i>drospirenone-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>elinest oral tablet</i>	1 or 1a*; \$0	
<i>enskyce oral tablet</i>	1 or 1a*; \$0	
<i>estarylla oral tablet</i>	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol oral tablet</i>	1 or 1a*; \$0	
<i>falmina oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Feirza 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Feirza 1/20 Oral Tablet)	1 or 1a*; \$0	
FEMLYV ORAL TABLET DISPERSIBLE (<i>norethindrone acet-ethinyl est</i>)	3	
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable)	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe</i> (Galbriela Oral Tablet Chewable)	1 or 1b*; \$0	
<i>gemmily oral capsule</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hailey 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>hailey fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>isibloom oral tablet</i>	1 or 1a*; \$0	
<i>jasmiel oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad-fe bisg</i> (Joyeaux Oral Tablet)	1 or 1b*; \$0	
<i>juleber oral tablet</i>	1 or 1a*; \$0	
<i>junel 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>junel 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>junel fe 24 oral tablet</i>	1 or 1a*; \$0	
<i>kaitlib fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>kalliga oral tablet</i>	1 or 1a*; \$0	
<i>kelnor 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>kurvelo oral tablet</i>	1 or 1a*; \$0	
<i>larin 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>larin 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>larin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>lessina oral tablet</i>	1 or 1a*; \$0	
<i>levonorgest-eth estradiol-iron oral tablet</i>	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	1 or 1a*; \$0	
<i>levora 0.15/30 (28) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1.5/30 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin 1/20 (21) oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>loestrin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>loryna oral tablet</i>	1 or 1b*; \$0	
<i>low-ogestrel oral tablet</i>	1 or 1a*; \$0	
<i>lo-zumandimine oral tablet</i>	1 or 1b*; \$0	
<i>lutera oral tablet</i>	1 or 1a*; \$0	
<i>marlissa oral tablet</i>	1 or 1a*; \$0	
<i>merzee oral capsule</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable)	1 or 1a*; \$0	
<i>microgestin 1.5/30 oral tablet</i>	1 or 1a*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>microgestin 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1.5/30 oral tablet</i>	1 or 1a*; \$0	
<i>microgestin fe 1/20 oral tablet</i>	1 or 1a*; \$0	
<i>mili oral tablet</i>	1 or 1a*; \$0	
<i>levonorgest-eth estradiol-iron</i> (Minzoya Oral Tablet)	1 or 1b*; \$0	
<i>mono-lynyah oral tablet</i>	1 or 1a*; \$0	
<i>necon 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
NEXTSTELLIS ORAL TABLET (<i>drospirenone-estetrol</i>)	3	
<i>nikki oral tablet</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral capsule</i>	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est oral tablet</i>	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1 or 1a*; \$0	
<i>nortrel 0.5/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (21) oral tablet</i>	1 or 1a*; \$0	
<i>nortrel 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>nylia 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>philith oral tablet</i>	1 or 1a*; \$0	
<i>portia-28 oral tablet</i>	1 or 1a*; \$0	
<i>reclipsen oral tablet</i>	1 or 1a*; \$0	
<i>sprintec 28 oral tablet</i>	1 or 1a*; \$0	
<i>sronyx oral tablet</i>	1 or 1a*; \$0	
<i>syeda oral tablet</i>	1 or 1b*; \$0	
<i>tarina 24 fe oral tablet</i>	1 or 1a*; \$0	
<i>tarina fe 1/20 eq oral tablet</i>	1 or 1a*; \$0	
<i>taysofy oral capsule</i>	1 or 1b*; \$0	
<i>norgestrel-ethinyl estradiol</i> (Turqoz Oral Tablet)	1 or 1a*; \$0	
TYBLUME ORAL TABLET CHEWABLE (<i>levonorgestrel-ethinyl estrad</i>)	3	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet)	1 or 1b*; \$0	
<i>ethynodiol diac-eth estradiol</i> (Valtya 1/50 Oral Tablet)	1 or 1a*; \$0	
<i>vestura oral tablet</i>	1 or 1b*; \$0	
<i>vienva oral tablet</i>	1 or 1a*; \$0	
<i>vyfemla oral tablet</i>	1 or 1a*; \$0	
<i>vylibra oral tablet</i>	1 or 1a*; \$0	
<i>wera oral tablet</i>	1 or 1a*; \$0	
<i>wymzya fe oral tablet chewable</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estradiol-fe</i> (Xelria Fe Oral Tablet Chewable)	1 or 1b*; \$0	
<i>zovia 1/35 (28) oral tablet</i>	1 or 1a*; \$0	
<i>zumandimine oral tablet</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - TRANSDERMAL*** - BIRTH CONTROL PILLS		
<i>norelgestromin-eth estradiol transdermal patch weekly</i>	1 or 1b*; \$0	
TWIRLA TRANSDERMAL PATCH WEEKLY (<i>levonorgestrel-eth estradiol</i>)	3	
<i>xulane transdermal patch weekly</i>	1 or 1b*; \$0	
<i>zafemy transdermal patch weekly</i>	1 or 1b*; \$0	
*COMBINATION CONTRACEPTIVES - VAGINAL*** - BIRTH CONTROL PILLS		
ANNOVERA VAGINAL RING (<i>segesterone-ethinyl estradiol</i>)	3	
<i>eluryng vaginal ring</i>	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Vaginal Ring)	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring)	1 or 1b*; \$0	
*CONTINUOUS CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>amethyst oral tablet</i>	1 or 1b*; \$0	
<i>dolishale oral tablet</i>	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet 90-20 mcg</i>	1 or 1b*; \$0	
*EMERGENCY CONTRACEPTIVES*** - BIRTH CONTROL PILLS		
ELLA ORAL TABLET (<i>ulipristal acetate</i>)	2; \$0	
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>ashlyna oral tablet</i>	1 or 1b*; \$0	
<i>camrese lo oral tablet</i>	1 or 1b*; \$0	
<i>camrese oral tablet</i>	1 or 1b*; \$0	
<i>daysee oral tablet</i>	1 or 1b*; \$0	
<i>iclevia oral tablet</i>	1 or 1b*; \$0	
<i>introvale oral tablet</i>	1 or 1b*; \$0	
<i>jaimiess oral tablet</i>	1 or 1b*; \$0	
<i>jolessa oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth est & eth est oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day oral tablet</i>	1 or 1b*; \$0	
<i>lojaimiess oral tablet</i>	1 or 1b*; \$0	
<i>rivelsa oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Rosyrah Oral Tablet)	1 or 1b*; \$0	
<i>setlakin oral tablet</i>	1 or 1b*; \$0	
<i>simpesse oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*FOUR PHASE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
NATAZIA ORAL TABLET (<i>estradiol valerate-dienogest</i>)	3	
*PROGESTIN CONTRACEPTIVES - INJECTABLE*** - BIRTH CONTROL PILLS		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (<i>medroxyprogesterone acetate</i>)	2; \$0	
<i>medroxyprogesterone acetate intramuscular suspension</i>	1 or 1b*; \$0	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe</i>	1 or 1b*; \$0	
*PROGESTIN CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>camila oral tablet</i>	1 or 1b*; \$0	
<i>deblitane oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Emzahh Oral Tablet)	1 or 1b*; \$0	
<i>errin oral tablet</i>	1 or 1b*; \$0	
<i>heather oral tablet</i>	1 or 1b*; \$0	
<i>incassia oral tablet</i>	1 or 1b*; \$0	
<i>jencycla oral tablet</i>	1 or 1b*; \$0	
<i>lyleq oral tablet</i>	1 or 1b*; \$0	
<i>lyza oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Meleya Oral Tablet)	1 or 1b*; \$0	
<i>nora-be oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone oral tablet</i>	1 or 1b*; \$0	
<i>norlyroc oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Orquidea Oral Tablet)	1 or 1b*; \$0	
<i>sharobel oral tablet</i>	1 or 1b*; \$0	
SLYND ORAL TABLET (<i>drospirenone</i>)	3	
*TRIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS		
<i>alyacen 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>aranelle oral tablet</i>	1 or 1a*; \$0	
<i>dasetta 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>enpresse-28 oral tablet</i>	1 or 1a*; \$0	
<i>leena oral tablet</i>	1 or 1a*; \$0	
<i>levonest oral tablet</i>	1 or 1a*; \$0	
<i>levonorg-eth estrad triphasic oral tablet</i>	1 or 1a*; \$0	
<i>norgestim-eth estrad triphasic oral tablet</i>	1 or 1b*; \$0	
<i>nortrel 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>nylia 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>tilia fe oral tablet</i>	1 or 1b*; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tri-estarylla oral tablet</i>	1 or 1b*; \$0	
<i>tri-legest fe oral tablet</i>	1 or 1b*; \$0	
<i>tri-linyah oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-estarylla oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-marzia oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-mili oral tablet</i>	1 or 1b*; \$0	
<i>tri-lo-sprintec oral tablet</i>	1 or 1b*; \$0	
<i>tri-mili oral tablet</i>	1 or 1b*; \$0	
<i>tri-sprintec oral tablet</i>	1 or 1b*; \$0	
<i>tri-vylibra lo oral tablet</i>	1 or 1b*; \$0	
<i>tri-vylibra oral tablet</i>	1 or 1b*; \$0	
<i>velivet oral tablet</i>	1 or 1a*; \$0	
<i>norethindron-ethinyl estrad-fe</i> (Xarah Fe Oral Tablet)	1 or 1b*; \$0	
CORTICOSTEROIDS - HORMONES		
*GLUCOCORTICOSTEROIDS*** - DRUGS FOR INFLAMMATION		
<i>budesonide er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>budesonide oral capsule delayed release particles</i>	2	QL (3 capsule per 1 day)
<i>dexameth sod phos (pf) +rfid injection solution prefilled syringe</i>	1 or 1b*	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE (<i>dexamethasone</i>)	2	
<i>dexamethasone oral elixir</i>	1 or 1a*	
<i>dexamethasone oral solution</i>	1 or 1a*	
<i>dexamethasone oral tablet</i>	1 or 1a*	
<i>dexamethasone oral tablet therapy pack</i>	1 or 1b*	
DEXAMETHASONE SOD PHOS (PF) INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
<i>dexamethasone sod phos +rfid injection solution prefilled syringe</i>	1 or 1b*	
<i>dexamethasone sodium phosphate injection solution 100 mg/10ml, 120 mg/30ml, 20 mg/5ml</i>	1 or 1b*	
DEXAMETHASONE SODIUM PHOSPHATE INJECTION SOLUTION PREFILLED SYRINGE	1 or 1b*	
<i>hidex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>hydrocortisone oral tablet</i>	1 or 1b*	
<i>hydrocortisone sod suc (pf) injection solution reconstituted</i>	1 or 1b*	
<i>methylprednisolone oral tablet</i>	1 or 1a*	
<i>methylprednisolone oral tablet therapy pack</i>	1 or 1a*	
<i>methylprednisolone sodium succ injection solution reconstituted</i>	1 or 1b*	
<i>prednisolone oral solution</i>	1 or 1a*	
<i>prednisolone oral tablet</i>	2	
<i>prednisolone sodium phosphate oral solution</i>	1 or 1a*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>prednisolone sodium phosphate oral tablet dispersible 15 mg</i>	1 or 1a*	QL (4 tablets per 1 day)
<i>prednisolone sodium phosphate oral tablet dispersible 30 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>prednisone oral solution</i>	1 or 1a*	
<i>prednisone oral tablet</i>	1 or 1a*	
<i>prednisone oral tablet therapy pack</i>	1 or 1a*	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED 1000 MG, 250 MG, 500 MG (<i>hydrocortisone sod succinate</i>)	3	
<i>taperdex 12-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 6-day oral tablet therapy pack</i>	1 or 1b*	
<i>taperdex 7-day oral tablet therapy pack</i>	1 or 1b*	
<i>triamcinolone acetonide injection suspension 10 mg/ml</i>	1 or 1b*	
*MINERALOCORTICOIDS*** - DRUGS FOR INFLAMMATION		
<i>fludrocortisone acetate oral tablet</i>	1 or 1b*	
COUGH/COLD/ALLERGY - DRUGS FOR THE LUNGS		
*ANTITUSSIVE - NONNARCOTIC*** - DRUGS FOR ALLERGIES		
<i>benzonatate oral capsule</i>	1 or 1b*	
*ANTITUSSIVE - OPIOID*** - DRUGS FOR COUGH AND COLD		
<i>hydrocodone bit-homatrop mbr oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
<i>hydrocodone bit-homatrop mbr oral tablet</i>	1 or 1a*	PA; QL (30 tablets per 5 days)
<i>hydromet oral solution</i>	1 or 1a*	AL; QL (150 mL per 5 days)
*DECONGESTANT & ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>promethazine-phenylephrine oral syrup</i>	1 or 1b*	QL (2 fills per 30 days)
*MISC. RESPIRATORY INHALANTS*** - DRUGS FOR ALLERGIES		
<i>sodium chloride</i> (Nebusal Inhalation Nebulization Solution 3 %)	2	
<i>sodium chloride</i> (Pulmosal Inhalation Nebulization Solution)	1 or 1b*	
<i>sodium chloride inhalation nebulization solution</i>	2	
*MUCOLYTICS*** - DRUGS FOR THE LUNGS		
<i>acetylcysteine inhalation solution</i>	2	
*NON-NARC ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	1 or 1a*	QL (2 fills per 30 days)
*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>pseudoeph-bromphen-dm oral syrup</i>	1 or 1b*	
*OPIOID ANTITUSSIVE-ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD		
<i>hydrocod poli-chlorphe poli er oral suspension extended release</i>	1 or 1b*	AL; QL (120 mL per 1 fill)
<i>promethazine-codeine oral solution</i>	1 or 1a*	AL; QL (100 mL per 5 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMATOLOGICALS - DRUGS FOR THE SKIN		
*ACNE ANTIBIOTICS*** - DRUGS FOR THE SKIN		
<i>clindacin etz external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>clindamycin phosphate</i> (Clindacin External Foam)	1 or 1b*	QL (100 grams per 30 days)
<i>clindacin-p external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>clindamycin phos (once-daily) external gel</i>	1 or 1b*	QL (75 ml/gm per 30 days)
<i>clindamycin phos (twice-daily) external gel</i>	1 or 1b*	QL (75 ml/gm per 30 days)
<i>clindamycin phosphate external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clindamycin phosphate external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external solution</i>	1 or 1b*	QL (4 mL per 1 day)
<i>clindamycin phosphate external swab</i>	1 or 1b*	QL (2 pads per 1 day)
<i>dapsone external gel</i>	3	ST; QL (90 grams per 30 days)
<i>ery external pad</i>	1 or 1b*	QL (2 pads per 1 day)
<i>erythromycin external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>erythromycin external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>sulfacetamide sodium (acne) external lotion</i>	1 or 1b*	
*ACNE COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene-benzoyl peroxide external gel 0.3-2.5 %</i>	1 or 1b*	PA; QL (60 grams per 30 days)
<i>benzoyl peroxide-erythromycin external gel</i>	1 or 1b*	QL (46.6 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-3.75 %</i>	2	QL (50 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %</i>	1 or 1b*	QL (50 grams per 30 days)
<i>clindamycin-tretinoin external gel</i>	3	PA; QL (60 grams per 30 days)
<i>neuac external gel</i>	1 or 1b*	QL (45 grams per 30 days)
*ACNE PRODUCTS*** - DRUGS FOR THE SKIN		
<i>accutane oral capsule</i>	2	PA
<i>adapalene external cream</i>	1 or 1b*	PA; QL (1.5 grams per 1 day)
<i>adapalene external gel 0.3 %</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>adapalene external pad</i>	1 or 1b*	PA; QL (1 swab per 1 day)
<i>amnestem oral capsule 10 mg, 20 mg, 40 mg</i>	2	PA
<i>isotretinoin</i> (Amnestem Oral Capsule 30 Mg)	2	PA
<i>claravis oral capsule</i>	2	PA
<i>isotretinoin oral capsule</i>	2	PA
<i>tretinoin external cream</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin external gel</i>	1 or 1b*	PA; QL (45 grams per 30 days)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	1 or 1b*	PA; QL (50 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zenatane oral capsule</i>	2	PA
*ANTIBIOTICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>gentamicin sulfate external cream</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>gentamicin sulfate external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
<i>mupirocin external ointment</i>	1 or 1b*	QL (30 grams per 1 fill)
*ANTIFUNGALS - TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>clotrimazole-betamethasone external cream</i>	1 or 1b*	QL (180 grams per 30 days)
<i>clotrimazole-betamethasone external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
<i>nystatin-triamcinolone external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin-triamcinolone external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
*ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ciclodan external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox external gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>ciclopirox external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ciclopirox external solution</i>	1 or 1b*	QL (7 mL per 30 days)
<i>ciclopirox olamine external cream</i>	1 or 1b*	QL (90 grams per 30 days)
<i>ciclopirox olamine external suspension</i>	1 or 1b*	QL (60 mL per 30 days)
<i>nystatin</i> (Klayesta External Powder)	1 or 1b*	QL (60 grams per 30 days)
<i>naftifine hcl external cream 1 %</i>	2	ST; QL (90 grams per 30 days)
<i>naftifine hcl external cream 2 %</i>	2	ST; QL (60 grams per 30 days)
<i>naftifine hcl external gel</i>	2	ST; QL (60 grams per 30 days)
<i>nyamyc external powder</i>	1 or 1b*	QL (60 grams per 30 days)
<i>nystatin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>nystatin external powder</i>	1 or 1b*	QL (60 grams per 30 days)
<i>nystop external powder</i>	1 or 1b*	QL (60 grams per 30 days)
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL*** - DRUGS FOR THE SKIN		
<i>fluorouracil external cream 0.5 %</i>	1 or 1b*	ST; QL (30 gm per 365 days)
<i>fluorouracil external cream 5 %</i>	1 or 1b*	AL; QL (40 gm per 365 days)
<i>fluorouracil external solution</i>	1 or 1b*	AL; QL (10 mL per 365 days)
*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S*** - DRUGS FOR THE SKIN		
<i>diclofenac sodium external gel 3 %</i>	2	PA; QL (300 grams per 1 year)
*ANTIPRURITICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>doxepin hcl external cream</i>	2	PA; QL (1 tube per 1 fill)
*ANTIPSORIATICS - SYSTEMIC*** - DRUGS FOR THE SKIN		
<i>acitretin oral capsule 10 mg, 17.5 mg</i>	2	QL (1 capsule per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acitretin oral capsule 25 mg</i>	2	QL (2 capsules per 1 day)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (2 pens per 28 days); SP
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (1 pen per 28 days); SP
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>secukinumab</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>secukinumab</i>)	4	PA; LD; QL (1 pen per 28 days); SP
<i>methoxsalen rapid oral capsule</i>	4	SP
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>ustekinumab-aekn</i>)	4	PA; QL (1 syringe per 84 days); SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>risankizumab-rzaa</i>)	4	PA; QL (1 unit per 12 weeks); SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>risankizumab-rzaa</i>)	4	PA; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION (<i>ustekinumab</i>)	4	PA; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (<i>ustekinumab</i>)	4	PA; QL (1 unit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (<i>ustekinumab</i>)	4	PA; QL (1 syringe per 12 weeks); SP
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>ixekizumab</i>)	4	PA; LD; QL (1 auto-injector per 28 days); SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>ixekizumab</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>guselkumab</i>)	4	PA; QL (1 mL per 56 days); SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>guselkumab</i>)	4	PA; QL (1 mL per 56 days); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>guselkumab</i>)	4	PA; QL (1 mL per 56 days); SP
<i>ustekinumab subcutaneous solution</i>	4	PA; QL (1 syringe per 12 weeks); SP
<i>ustekinumab subcutaneous solution prefilled syringe</i>	4	PA; QL (1 syringe per 12 weeks); SP
*ANTIPSORIATICS*** - DRUGS FOR THE SKIN		
<i>calcipotriene external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external foam</i>	3	ST; QL (120 grams per 30 days)
<i>calcipotriene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>calcipotriene external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>calcitrene external ointment</i>	1 or 1b*	QL (120 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcitriol external ointment</i>	1 or 1b*	QL (800 grams per 28 days)
<i>tazarotene external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>tazarotene external gel</i>	2	QL (100 grams per 30 days)
*ANTISEBORRHEIC PRODUCTS*** - DRUGS FOR THE SKIN		
<i>selenium sulfide external lotion</i>	1 or 1a*	QL (120 mL per 30 days)
*ANTIVIRALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>acyclovir external cream</i>	1 or 1b*	PA; QL (5 gm per 30 days)
<i>acyclovir external ointment</i>	1 or 1b*	QL (30 gm per 30 days)
<i>peniclovir external cream</i>	2	PA; QL (5 gm per 30 days)
*ATOPIC DERMATITIS - JANUS KINASE (JAK) INHIBITORS*** - DRUGS FOR THE SKIN		
OPZELURA EXTERNAL CREAM (<i>ruxolitinib phosphate</i>)	3	PA; QL (1 tube per 30 days)
*ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE SKIN		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>dupilumab</i>)	4	PA; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>dupilumab</i>)	4	PA; SP
*BURN PRODUCTS*** - DRUGS FOR THE SKIN		
<i>silver sulfadiazine external cream</i>	1 or 1a*	
<i>ssd external cream</i>	1 or 1a*	
*CORTICOSTEROIDS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>ala-cort external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>alclometasone dipropionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>alclometasone dipropionate external ointment</i>	1 or 1b*	QL (2 grams per 1 day)
<i>betamethasone dipropionate aug external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate aug external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate aug external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>betamethasone dipropionate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone dipropionate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone dipropionate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>betamethasone valerate external lotion</i>	1 or 1b*	QL (60 mL per 30 days)
<i>betamethasone valerate external ointment</i>	1 or 1b*	QL (45 grams per 30 days)
<i>clobetasol propionate e external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate emulsion external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>clobetasol propionate external cream 0.05 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external foam</i>	1 or 1b*	QL (100 mL per 30 days)
<i>clobetasol propionate external gel</i>	1 or 1b*	QL (60 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobetasol propionate external liquid</i>	1 or 1b*	QL (125 mL per 30 days)
<i>clobetasol propionate external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>clobetasol propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>clobetasol propionate external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)
<i>clobetasol propionate external solution</i>	1 or 1b*	QL (50 mL per 30 days)
<i>clodan external shampoo</i>	1 or 1b*	QL (3.94 mL per 1 day)
<i>desonide external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>desonide external gel</i>	1 or 1b*	QL (2 grams per 1 day)
<i>desonide external lotion</i>	1 or 1b*	QL (118 mL per 30 days)
<i>desonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinolone acetonide body external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinolone acetonide external cream 0.01 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinolone acetonide external cream 0.025 %</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external ointment</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinolone acetonide external solution</i>	1 or 1b*	QL (90 mL per 30 days)
<i>fluocinolone acetonide scalp external oil</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluocinonide emulsified base external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>fluocinonide external gel</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluocinonide external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>fluticasone propionate external cream</i>	1 or 1b*	QL (60 grams per 30 days)
<i>fluticasone propionate external lotion</i>	1 or 1b*	QL (120 mL per 30 days)
<i>fluticasone propionate external ointment</i>	1 or 1b*	QL (60 grams per 30 days)
<i>halobetasol propionate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>halobetasol propionate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>hydrocortisone external cream 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>hydrocortisone external lotion 2.5 %</i>	1 or 1a*	QL (118 mL per 30 days)
<i>hydrocortisone external ointment 2.5 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>mometasone furoate external cream</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external ointment</i>	1 or 1b*	QL (50 grams per 30 days)
<i>mometasone furoate external solution</i>	1 or 1b*	QL (60 mL per 30 days)
<i>tovet external foam</i>	1 or 1b*	QL (100 grams per 30 days)
<i>triamcinolone acetonide external cream</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external lotion</i>	1 or 1a*	QL (60 mL per 30 days)
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %</i>	1 or 1a*	QL (454 grams per 30 days)
<i>triamcinolone acetonide external ointment 0.5 %</i>	1 or 1a*	QL (30 grams per 30 days)
<i>triderm external cream</i>	1 or 1a*	QL (454 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>econazole nitrate external cream</i>	1 or 1b*	QL (85 grams per 30 days)
<i>ketoconazole external cream</i>	1 or 1b*	QL (120 grams per 30 days)
<i>ketoconazole external foam</i>	3	QL (100 grams per 30 days)
<i>ketoconazole external shampoo</i>	1 or 1b*	QL (120 mL per 30 days)
<i>ketodan external foam</i>	3	QL (100 grams per 30 days)
<i>luliconazole external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>oxiconazole nitrate external cream</i>	3	ST; QL (90 grams per 30 days)
<i>sulconazole nitrate external cream</i>	1 or 1b*	ST; QL (60 grams per 30 days)
<i>sulconazole nitrate external solution</i>	1 or 1b*	ST; QL (60 mL per 30 days)
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL*** - DRUGS FOR THE SKIN		
<i>imiquimod external cream 3.75 %</i>	1 or 1b*	QL (28 units per 28 days)
<i>imiquimod external cream 5 %</i>	1 or 1b*	QL (48 packet per 365 days)
<i>imiquimod pump external cream</i>	1 or 1b*	ST; QL (1 pump bottle per 28 days)
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS*** - DRUGS FOR THE SKIN		
<i>podofilox external gel</i>	2	QL (7 grams per 28 days)
<i>podofilox external solution</i>	1 or 1b*	QL (7 mL per 28 days)
*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>glydo external prefilled syringe</i>	2	
<i>lidocaine external ointment 5 %</i>	2	QL (5 grams per 1 day)
<i>lidocaine external patch 5 %</i>	2	PA; QL (3 patches per 1 day)
<i>lidocaine hcl external solution</i>	2	QL (10 mL per 1 day)
<i>lidocaine hcl urethral/mucosal external gel</i>	2	
<i>lidocaine hcl urethral/mucosal external prefilled syringe</i>	2	
<i>lidocaine</i> (Tridacaine Ii External Patch)	2	PA; QL (3 patches per 1 day)
<i>lidocaine</i> (Tridacaine Iii External Patch)	2	PA; QL (3 patches per 1 day)
*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>pimecrolimus external cream</i>	1 or 1b*	ST; QL (100 grams per 30 days)
<i>tacrolimus external ointment</i>	1 or 1b*	ST; QL (100 grams per 30 days)
*OXABOROLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN		
<i>tavaborole external solution</i>	2	ST; QL (1 bottle per 30 days)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL*** - DRUGS FOR THE SKIN		
EUCRISA EXTERNAL OINTMENT (<i>crisaborole</i>)	3	ST; QL (100 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*ROSACEA AGENTS*** - DRUGS FOR THE SKIN		
<i>azelaic acid external gel</i>	1 or 1b*	QL (50 grams per 30 days)
<i>brimonidine tartrate external gel</i>	2	QL (30 grams per 30 days)
<i>ivermectin external cream</i>	2	QL (45 grams per 30 days)
<i>metronidazole external cream</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 0.75 %</i>	1 or 1b*	QL (45 grams per 30 days)
<i>metronidazole external gel 1 %</i>	1 or 1b*	QL (60 grams per 30 days)
<i>metronidazole external lotion</i>	1 or 1b*	QL (59 mL per 30 days)
ZILXI EXTERNAL FOAM (<i>minocycline hcl micronized</i>)	2	QL (1 gram per 1 day)
*SCABICIDES & PEDICULICIDES*** - DRUGS FOR THE SKIN		
<i>crotan external lotion</i>	2	QL (60 grams per 30 days)
<i>malathion external lotion</i>	1 or 1b*	QL (4 mL per 1 day)
<i>permethrin external cream</i>	1 or 1b*	QL (120 grams per 30 days)
PRURADIK EXTERNAL LOTION (<i>crotamiton</i>)	2	QL (60 grams per 30 days)
<i>spinosad external suspension</i>	1 or 1b*	QL (120 mL per 7 days)
*STEROID-LOCAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
PRAMOSONE EXTERNAL CREAM (<i>pramoxine-hc</i>)	2	
PRAMOSONE EXTERNAL LOTION (<i>pramoxine-hc</i>)	2	
*TAR PRODUCTS*** - DRUGS FOR THE SKIN		
<i>coal tar external solution</i>	1 or 1b*	
*TOPICAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>lidocaine-prilocaine external cream</i>	2	QL (30 grams per 30 days)
<i>lidocaine-prilocaine external kit</i>	2	QL (1 kit per 30 days)
*TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR THE SKIN		
<i>bexarotene external gel</i>	4	PA; QL (60 grams per 30 days); SP
*TOPICAL STEROID COMBINATIONS*** - DRUGS FOR THE SKIN		
<i>calcipotriene-betameth diprop external ointment</i>	3	ST; QL (400 grams per 28 days)
<i>calcipotriene-betameth diprop external suspension</i>	3	ST; QL (420 grams per 28 days)
*TYPE II 5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE SKIN		
<i>finasteride oral tablet 1 mg</i>	1 or 1b*	
DIGESTIVE AIDS - DRUGS FOR THE STOMACH		
*DIGESTIVE ENZYMES*** - DRUGS FOR THE STOMACH		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	2	QL (25 capsules per 1 day)
VIOKACE ORAL TABLET (<i>pancrelipase (lip-prot-amyl)</i>)	3	QL (25 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES (<i>pancrelipase (lip-prot-amyl)</i>)	2	QL (25 capsules per 1 day)
DIURETICS - DRUGS FOR THE HEART		
*CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>acetazolamide er oral capsule extended release 12 hour</i>	1 or 1b*	
<i>acetazolamide oral tablet</i>	1 or 1b*	
<i>acetazolamide sodium injection solution reconstituted</i>	1 or 1b*	
<i>dichlorphenamide oral tablet</i>	4	PA; QL (4 tablet per 1 day)
<i>methazolamide oral tablet</i>	2	
<i>dichlorphenamide</i> (Ormalvi Oral Tablet)	4	PA; LD; QL (4 tablet per 1 day)
*DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amiloride-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>spironolactone-hctz oral tablet</i>	1 or 1b*	
<i>triamterene-hctz oral capsule</i>	1 or 1a*	
<i>triamterene-hctz oral tablet</i>	1 or 1a*	
*LOOP DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>bumetanide injection solution</i>	1 or 1b*	
<i>bumetanide oral tablet</i>	1 or 1b*	
<i>ethacrynic acid oral tablet</i>	2	
<i>furosemide oral solution</i>	1 or 1a*	
<i>furosemide oral tablet</i>	1 or 1a*	
<i>toremide oral tablet</i>	1 or 1b*	
*OSMOTIC DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>mannitol intravenous solution</i>	1 or 1b*	
<i>osmitrol intravenous solution</i>	1 or 1b*	
*POTASSIUM SPARING DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>amiloride hcl oral tablet</i>	2	
<i>spironolactone oral suspension</i>	1 or 1b*	
<i>spironolactone oral tablet</i>	1 or 1a*	
<i>triamterene oral capsule</i>	2	
*THIAZIDES AND THIAZIDE-LIKE DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE		
<i>chlorothiazide sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>chlorthalidone oral tablet</i>	1 or 1a*	
<i>hydrochlorothiazide oral capsule</i>	1 or 1a*	
<i>hydrochlorothiazide oral tablet</i>	1 or 1a*	
<i>indapamide oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metolazone oral tablet</i>	1 or 1b*	
ENDOCRINE AND METABOLIC AGENTS - MISC. - HORMONES		
*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR WOMEN		
<i>mifepristone oral tablet 200 mg</i>	1 or 1b*	\$0 for Fully insured members in California
*BISPHOSPHONATES*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>alendronate sodium oral solution</i>	1 or 1b*	QL (10.72 mg per 1 day)
<i>alendronate sodium oral tablet 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
FOSAMAX PLUS D ORAL TABLET (<i>alendronate-cholecalciferol</i>)	2	QL (0.15 tablets per 1 day)
<i>ibandronate sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 28 days)
<i>risedronate sodium oral tablet 150 mg</i>	1 or 1b*	QL (0.04 tablets per 1 day)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>risedronate sodium oral tablet 35 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
<i>risedronate sodium oral tablet delayed release</i>	1 or 1b*	QL (4 tablets per 28 days)
*CALCIMIMETIC AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	4	PA; QL (2 tablets per 1 day)
<i>cinacalcet hcl oral tablet 90 mg</i>	4	PA; QL (4 tablets per 1 day)
*CALCITONINS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitonin (salmon) injection solution</i>	4	
<i>calcitonin (salmon) nasal solution</i>	2	QL (0.13 mL per 1 day)
*CARNITINE REPLENISHER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>levocarnitine intravenous solution</i>	2	
<i>levocarnitine oral solution</i>	2	
<i>levocarnitine oral tablet</i>	2	
<i>levocarnitine sf oral solution</i>	2	
*DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR WOMEN		
<i>cabergoline oral tablet</i>	1 or 1b*	QL (0.58 tablets per 1 day)
*GNRH/LHRH ANTAGONISTS*** - DRUGS FOR WOMEN		
ORILISSA ORAL TABLET 150 MG (<i>elagolix sodium</i>)	2	PA; QL (1 tablet per 1 day)
ORILISSA ORAL TABLET 200 MG (<i>elagolix sodium</i>)	2	PA; QL (2 tablets per 1 day)
*GROWTH HORMONE RECEPTOR ANTAGONISTS*** - DRUGS FOR GROWTH		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED (<i>pegvisomant</i>)	4	PA; LD; QL (1 vial per 1 day); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*GROWTH HORMONES*** - DRUGS FOR GROWTH		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (<i>somatropin</i>)	4	PA; QL (1 syringe per 1 day); SP
GENOTROPIN SUBCUTANEOUS CARTRIDGE (<i>somatropin</i>)	4	PA; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 12 MG, 6 MG (<i>somatropin</i>)	4	PA; QL (1 vial per 1 day); SP
HUMATROPE INJECTION CARTRIDGE 24 MG (<i>somatropin</i>)	4	PA; QL (1 injection per 1 day); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 7.6 MG, 9.1 MG (<i>lonapegsomatropin-tcgd</i>)	4	PA; LD; QL (8 cartridges per 28 days); SP
SKYTROFA SUBCUTANEOUS CARTRIDGE 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG (<i>lonapegsomatropin-tcgd</i>)	4	PA; LD; QL (4 cartridges per 28 days); SP
*HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	4	PA; SP
<i>nitisinone oral capsule 20 mg</i>	4	PA
*HOMOCYSTINURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>betaine oral powder</i>	4	LD
*HYPERAMMONEMIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>carglumic acid oral tablet soluble</i>	4	PA; LD
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>calcitriol intravenous solution</i>	1 or 1b*	PA
<i>calcitriol oral capsule</i>	1 or 1b*	PA
<i>calcitriol oral solution</i>	2	PA
<i>doxercalciferol intravenous solution</i>	2	PA
<i>doxercalciferol oral capsule</i>	2	PA
<i>paricalcitol oral capsule</i>	2	PA
*HYPOPHOSPHATASIA (HPP) AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
STRENSIQ SUBCUTANEOUS SOLUTION (<i>asfotase alfa</i>)	4	PA; LD
*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS*** - DRUGS FOR WOMEN		
SYNAREL NASAL SOLUTION (<i>nafarelin acetate</i>)	4	PA; QL (5 bottle per 30 days); SP
*OVULATION STIMULANTS-GONADOTROPINS*** - DRUGS FOR WOMEN		
GONAL-F INJECTION SOLUTION RECONSTITUTED (<i>follitropin alfa</i>)	4	PA; SP
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR (<i>follitropin alfa</i>)	4	PA; SP
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chorionic gonadotropin</i>)	4	PA; SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*OVULATION STIMULANTS-SYNTHETIC*** - DRUGS FOR WOMEN		
<i>clomiphene citrate</i> (Clomid Oral Tablet)	1 or 1b*	PA
<i>clomiphene citrate oral tablet</i>	1 or 1b*	PA
*PHENYLKETONURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>sapropterin dihydrochloride</i> (Javygtor Oral Packet)	4	PA; LD
<i>sapropterin dihydrochloride</i> (Javygtor Oral Tablet)	4	PA; LD
<i>sapropterin dihydrochloride oral packet</i>	4	PA; SP
<i>sapropterin dihydrochloride oral tablet</i>	4	PA; SP
*RANK LIGAND (RANKL) INHIBITORS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>denosumab</i>)	4	PA; QL (1 syringe per 180 days); SP
XGEVA SUBCUTANEOUS SOLUTION (<i>denosumab</i>)	4	PA; QL (1 vial per 28 days); SP
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
<i>raloxifene hcl oral tablet</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
*SELECTIVE VASOPRESSIN V2-RECEPTOR ANTAGONISTS*** - HORMONES		
<i>tolvaptan oral tablet</i>	4	PA; LD; QL (4 tablets per 1 day); SP
<i>tolvaptan oral tablet therapy pack</i>	4	PA; LD; QL (1 carton per 28 days)
*SOMATOSTATIC AGENTS*** - DRUGS FOR GROWTH		
LANREOTIDE ACETATE SUBCUTANEOUS SOLUTION	4	PA; LD; QL (1 syringe/vial per 28 days); SP
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION (<i>lanreotide acetate</i>)	4	PA; LD; QL (1 syringe/vial per 28 days); SP
*UREA CYCLE DISORDER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS		
PHEBURANE ORAL PELLETT (<i>sodium phenylbutyrate</i>)	4	PA; LD; QL (8 bottles per 30 days); SP
<i>sodium phenylbutyrate oral powder</i>	4	PA; QL (25 GM per 1 day); SP
<i>sodium phenylbutyrate oral tablet</i>	4	PA; QL (40 tablets per 1 day); SP
*VASOPRESSIN*** - HORMONES		
<i>desmopressin ace spray refrig nasal solution</i>	1 or 1b*	
<i>desmopressin acetate injection solution</i>	1 or 1b*	
<i>desmopressin acetate oral tablet 0.1 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>desmopressin acetate oral tablet 0.2 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>desmopressin acetate pf injection solution</i>	1 or 1b*	
<i>desmopressin acetate spray nasal solution</i>	1 or 1b*	
<i>vasopressin +rfid intravenous solution</i>	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>vasopressin intravenous solution</i>	2	
ESTROGENS - HORMONES		
*ESTROGEN & PROGESTIN*** - DRUGS FOR WOMEN		
<i>estradiol-norethindrone acet</i> (Abigale Lo Oral Tablet)	1 or 1b*	
<i>estradiol-norethindrone acet</i> (Abigale Oral Tablet)	1 or 1b*	
BIJUVA ORAL CAPSULE (<i>estradiol-progesterone</i>)	2	QL (1 capsule per 1 day)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY (<i>estradiol-levonorgestrel</i>)	2	QL (4 patch per 28 days)
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY (<i>estradiol-norethindrone acet</i>)	2	QL (8 patch per 28 days)
<i>estradiol-norethindrone acet oral tablet</i>	1 or 1b*	
<i>fyavolv oral tablet</i>	1 or 1b*	
<i>jinteli oral tablet</i>	1 or 1b*	
<i>mimvey oral tablet</i>	1 or 1b*	
<i>norethindrone-eth estradiol oral tablet</i>	1 or 1b*	
PREMPHASE ORAL TABLET (<i>conj estrog-medroxyprogest ace</i>)	2	
PREMPRO ORAL TABLET (<i>conj estrog-medroxyprogest ace</i>)	2	
*ESTROGENS*** - DRUGS FOR WOMEN		
<i>dotti transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol oral tablet</i>	1 or 1b*	
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm</i>	2	QL (1 packet per 1 day)
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	2	QL (37.5 grams per 30 days)
<i>estradiol transdermal gel 1.25 mg/1.25gm</i>	2	QL (30 packets per 30 days)
<i>estradiol transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol transdermal patch weekly</i>	1 or 1b*	QL (4 patches per 28 days)
<i>estradiol valerate intramuscular oil</i>	1 or 1b*	
EVAMIST TRANSDERMAL SOLUTION (<i>estradiol</i>)	2	QL (16.2 mL per 30 days)
<i>lyllana transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED (<i>estrogens conjugated</i>)	2	
PREMARIN ORAL TABLET (<i>estrogens conjugated</i>)	2	QL (1 tablet per 1 day)
FLUOROQUINOLONES - DRUGS FOR INFECTIONS		
*FLUOROQUINOLONES*** - ANTIBIOTICS		
<i>ciprofloxacin hcl oral tablet</i>	1 or 1b*	
<i>ciprofloxacin in d5w intravenous solution</i>	2	
<i>levofloxacin in d5w intravenous solution</i>	2	
<i>levofloxacin intravenous solution</i>	2	QL (1 fill per 30 days)
<i>levofloxacin oral solution</i>	2	
<i>levofloxacin oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**=Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>moxifloxacin hcl oral tablet</i>	2	
<i>ofloxacin oral tablet</i>	1 or 1b*	
GASTROINTESTINAL AGENTS - MISC. - DRUGS FOR THE STOMACH		
*5-HT4 RECEPTOR AGONISTS*** - DRUGS FOR THE STOMACH		
<i>prucalopride succinate oral tablet</i>	2	QL (1 tablet per 1 day)
*GALLSTONE SOLUBILIZING AGENTS*** - DRUGS FOR THE STOMACH		
<i>ursodiol oral capsule 300 mg</i>	2	
<i>ursodiol oral tablet</i>	2	
*GASTROINTESTINAL ANTIALLERGY AGENTS*** - DRUGS FOR THE STOMACH		
<i>cromolyn sodium oral concentrate</i>	1 or 1b*	
*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
<i>lubiprostone oral capsule</i>	2	QL (2 capsules per 1 day)
*GASTROINTESTINAL STIMULANTS**** - DRUGS FOR THE STOMACH		
<i>metoclopramide hcl injection solution</i>	1 or 1a*	
<i>metoclopramide hcl oral solution</i>	1 or 1a*	QL (60 mL per 1 day)
<i>metoclopramide hcl oral tablet 10 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>metoclopramide hcl oral tablet 5 mg</i>	1 or 1a*	QL (12 tablets per 1 day)
<i>metoclopramide hcl oral tablet dispersible</i>	1 or 1a*	QL (12 tablets per 1 day)
*IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS**** - DRUGS FOR CONSTIPATION		
LINZESS ORAL CAPSULE (<i>linaclotide</i>)	2	QL (1 capsule per 1 day)
*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS**** - DRUGS FOR IRRITABLE BOWEL SYNDROME		
<i>alosetron hcl oral tablet</i>	2	PA; QL (2 tablets per 1 day)
*INFLAMMATORY BOWEL AGENTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium oral capsule</i>	1 or 1b*	QL (9 capsule per 1 day)
<i>mesalamine er oral capsule extended release 24 hour</i>	2	QL (4 capsules per 1 day)
<i>mesalamine oral capsule delayed release</i>	2	QL (6 tablets per 1 day)
<i>mesalamine oral tablet delayed release 1.2 gm</i>	2	QL (4 tablets per 1 day)
<i>mesalamine oral tablet delayed release 800 mg</i>	2	QL (6 tablet per 1 day)
<i>mesalamine rectal enema</i>	2	QL (60 mL per 1 day)
<i>mesalamine rectal suppository</i>	2	QL (1 suppository per 1 day)
<i>mesalamine-cleanser rectal kit</i>	2	QL (4 kits per 28 days)
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG (<i>mesalamine</i>)	2	QL (16 capsule per 1 day)
PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG (<i>mesalamine</i>)	2	QL (8 capsule per 1 day)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfasalazine oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>sulfasalazine oral tablet delayed release</i>	1 or 1b*	QL (8 tablet per 1 day)
*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED (<i>vedolizumab</i>)	4	PA; LD; QL (1 vial per 56 days); SP
*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
SELARSDI INTRAVENOUS SOLUTION (<i>ustekinumab-aekn (iv)</i>)	4	PA; QL (4 vials per 1 one time fill); SP
SKYRIZI INTRAVENOUS SOLUTION (<i>risankizumab-rzaa</i>)	4	PA; QL (6 vials per 1 one-time fill); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE (<i>risankizumab-rzaa</i>)	4	PA; QL (1 kit per 56 days); SP
STELARA INTRAVENOUS SOLUTION (<i>ustekinumab</i>)	4	PA; QL (4 vials per 6 months); SP
TREMFYA INTRAVENOUS SOLUTION (<i>guselkumab</i>)	4	PA; QL (3 vials per 6 months); SP
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML (<i>guselkumab</i>)	4	PA; QL (1 pen/syringe per 28 days); SP
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/2ML (<i>guselkumab</i>)	4	PA; QL (1 pen/syringe per 28 days); SP
*INTESTINAL ACIDIFIERS*** - DRUGS FOR THE STOMACH		
<i>enulose oral solution</i>	1 or 1b*	
<i>generlac oral solution</i>	1 or 1b*	
<i>lactulose encephalopathy oral solution</i>	1 or 1b*	
*PERIPHERAL OPIOID RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH		
<i>alvimopan oral capsule</i>	1 or 1b*	
*PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR AGONISTS*** - DRUGS FOR THE STOMACH		
IQIRVO ORAL TABLET (<i>elafibranor</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH		
<i>calcium acetate (phos binder) oral capsule</i>	2	QL (12 capsules per 1 day)
<i>calcium acetate oral tablet 667 mg</i>	2	QL (12 tablets per 1 day)
<i>ferric citrate oral tablet</i>	2	QL (9 tablets per 1 day)
<i>lanthanum carbonate oral tablet chewable</i>	2	QL (3 tablets per 1 day)
<i>sevelamer carbonate oral packet 0.8 gm</i>	2	QL (6 packets per 1 day)
<i>sevelamer carbonate oral packet 2.4 gm</i>	2	QL (3 packets per 1 day)
<i>sevelamer carbonate oral tablet</i>	2	QL (9 tablets per 1 day)
<i>sevelamer hcl oral tablet 400 mg</i>	2	QL (15 tablets per 1 day)
<i>sevelamer hcl oral tablet 800 mg</i>	2	QL (9 tablets per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*TUMOR NECROSIS FACTOR ALPHA BLOCKERS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab-axxq</i>)	4	PA; LD; SP
INFLIXIMAB INTRAVENOUS SOLUTION RECONSTITUTED	4	PA; LD; SP
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED (<i>infliximab</i>)	4	PA; SP
GENERAL ANESTHETICS - DRUGS FOR PAIN AND FEVER		
*ANESTHETICS - MISC.*** - DRUGS FOR SEDATION		
<i>etomidate intravenous solution</i>	1 or 1b*	
<i>fresenius propoven intravenous emulsion</i>	1 or 1b*	
<i>ketamine hcl injection solution 50 mg/ml</i>	1 or 1b*	
<i>propofol intravenous emulsion</i>	1 or 1b*	
*BARBITURATE ANESTHETICS*** - DRUGS FOR SEDATION		
<i>methohexital sodium injection solution reconstituted</i>	1 or 1b*	
*VOLATILE ANESTHETICS*** - DRUGS FOR SEDATION		
<i>desflurane inhalation solution</i>	1 or 1b*	
<i>isoflurane inhalation solution</i>	1 or 1b*	
<i>sevoflurane inhalation solution</i>	1 or 1b*	
<i>terrell inhalation solution</i>	1 or 1b*	
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS FOR THE URINARY SYSTEM		
*5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>finasteride oral tablet 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE PROSTATE		
<i>alfuzosin hcl er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>silodosin oral capsule</i>	2	QL (1 capsule per 1 day)
<i>tamsulosin hcl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)
*ANTI-INFECTIVE GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>neomycin-polymyxin b gu irrigation solution</i>	2	
*CITRATES*** - DRUGS FOR INFECTIONS		
<i>potassium citrate er oral tablet extended release</i>	1 or 1b*	
*GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>acetic acid irrigation solution</i>	1 or 1b*	
<i>argyle sterile saline irrigation solution</i>	2	
<i>curity sterile saline irrigation solution</i>	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glycine irrigation solution</i>	1 or 1b*	
<i>glycine urologic irrigation solution</i>	1 or 1b*	
<i>sodium chloride irrigation solution</i>	2	
*PROSTATIC HYPERTROPHY AGENT COMBINATIONS*** - DRUGS FOR THE PROSTATE		
<i>dutasteride-tamsulosin hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
*URINARY STONE AGENTS*** - DRUGS FOR THE URINARY SYSTEM		
<i>tiopronin oral tablet</i>	2	PA; QL (10 tablet per 1 day)
<i>tiopronin oral tablet delayed release</i>	2	PA; LD; QL (10 tablet per 1 day)
<i>tiopronin</i> (Venxxiva Oral Tablet Delayed Release 100 Mg)	2	PA; LD; QL (3 tablet per 1 day)
<i>tiopronin</i> (Venxxiva Oral Tablet Delayed Release 300 Mg)	2	PA; LD; QL (10 tablet per 1 day)
GOUT AGENTS - DRUGS FOR PAIN AND FEVER		
*GOUT AGENT COMBINATIONS*** - GOUT DRUGS		
<i>colchicine-probenecid oral tablet</i>	1 or 1b*	
*GOUT AGENTS*** - GOUT DRUGS		
<i>allopurinol oral tablet 100 mg</i>	1 or 1a*	QL (8 tablets per 1 day)
<i>allopurinol oral tablet 300 mg</i>	1 or 1a*	QL (2 tablets per 1 day)
<i>allopurinol sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>colchicine oral tablet</i>	2	QL (2.3 tablet per 1 day)
<i>febuxostat oral tablet</i>	2	ST; QL (1 tablet per 1 day)
*URICOSURICS*** - GOUT DRUGS		
<i>probenecid oral tablet</i>	1 or 1b*	
HEMATOLOGICAL AGENTS - MISC. - DRUGS FOR THE BLOOD		
*BRADYKININ B2 RECEPTOR ANTAGONISTS*** - DRUGS FOR THE BLOOD		
<i>icatibant acetate subcutaneous solution prefilled syringe</i>	4	PA; QL (18 syringes per 30 days); SP
<i>sajazir subcutaneous solution prefilled syringe</i>	4	PA; LD; QL (18 syringes per 30 days)
*C1 ESTERASE INHIBITORS*** - DRUGS FOR THE BLOOD		
BERINERT INTRAVENOUS KIT (<i>c1 esterase inhibitor (human)</i>)	4	PA; LD; QL (24 kits per 30 days); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT (<i>c1 esterase inhibitor (human)</i>)	4	PA; LD; QL (24 vials per 28 days); SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	4	PA; LD; QL (16 vials per 28 days); SP
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED (<i>c1 esterase inhibitor (recomb)</i>)	4	PA; LD; QL (16 vials per 30 days); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD		
BRILINTA ORAL TABLET (<i>ticagrelor</i>)	2	Effective 01/01/2026: NF; QL (2 tablets per 1 day)
<i>ticagrelor oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>eptifibatide intravenous solution</i>	2	
<i>tirofiban hcl in nacl intravenous solution</i>	2	
*HEMATORHEOLOGIC AGENTS*** - DRUGS FOR THE BLOOD		
<i>pentoxifylline er oral tablet extended release</i>	1 or 1b*	
*PHOSPHODIESTERASE III INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>cilostazol oral tablet</i>	2	
*PLASMA EXPANDERS*** - DRUGS FOR THE BLOOD		
<i>hetastarch-nacl intravenous solution</i>	1 or 1b*	
<i>lmd in d5w intravenous solution</i>	1 or 1b*	
<i>lmd in nacl intravenous solution</i>	1 or 1b*	
*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE BLOOD		
TAKHZYRO SUBCUTANEOUS SOLUTION (<i>lanadelumab-flyo</i>)	4	PA; LD; QL (1 vial per 28 days); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>lanadelumab-flyo</i>)	4	PA; LD; QL (1 syringe per 28 days); SP
*PLASMA KALLIKREIN INHIBITORS*** - DRUGS FOR THE BLOOD		
KALBITOR SUBCUTANEOUS SOLUTION (<i>ecallantide</i>)	4	PA; LD; QL (36 vials per 30 days); SP
*PLATELET AGGREGATION INHIBITOR COMBINATIONS*** - DRUGS FOR THE BLOOD		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
*PLATELET AGGREGATION INHIBITORS*** - DRUGS FOR THE BLOOD		
<i>dipyridamole oral tablet</i>	2	
*PROTAMINE*** - DRUGS FOR THE BLOOD		
<i>protamine sulfate intravenous solution</i>	1 or 1b*	
*QUINAZOLINE AGENTS*** - DRUGS FOR THE BLOOD		
<i>anagrelide hcl oral capsule 0.5 mg</i>	1 or 1b*	QL (20 capsules per 1 day)
<i>anagrelide hcl oral capsule 1 mg</i>	1 or 1b*	QL (10 capsules per 1 day)
*THIENOPYRIDINE DERIVATIVES*** - DRUGS FOR THE BLOOD		
<i>clopidogrel bisulfate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>prasugrel hcl oral tablet</i>	2	QL (1 tablet per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMATOPOIETIC AGENTS - DRUGS FOR NUTRITION		
*AGENTS FOR GAUCHER DISEASE*** - DRUGS FOR NUTRITION		
CERDELGA ORAL CAPSULE (<i>eliglustat tartrate</i>)	2	PA; LD; QL (2 capsules per 1 day); SP
<i>miglustat oral capsule</i>	2	PA; QL (3 capsules per 1 day); SP
<i>miglustat</i> (Yargesa Oral Capsule)	2	PA; LD; QL (3 capsules per 1 day); SP
*AMINO ACIDS*** - DRUGS FOR NUTRITION		
<i>l-glutamine oral packet</i>	4	PA; SP
*COBALAMINS*** - DRUGS FOR NUTRITION		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1 or 1a*	
<i>hydroxocobalamin acetate intramuscular solution</i>	1 or 1b*	
*CYTOTOXIC AGENTS*** - DRUGS FOR NUTRITION		
DROXIA ORAL CAPSULE (<i>hydroxyurea</i>)	2	
*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)*** - DRUGS FOR NUTRITION		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION (<i>darbepoetin alfa</i>)	4	PA; QL (4 vials per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 60 MCG/0.3ML (<i>darbepoetin alfa</i>)	4	PA; QL (4 syringes per 28 days); SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 500 MCG/ML (<i>darbepoetin alfa</i>)	4	PA; QL (4 syringes per 30 days); SP
PROCRIT INJECTION SOLUTION (<i>epoetin alfa</i>)	4	PA; QL (12 mL per 28 days); SP
RETACRIT INJECTION SOLUTION (<i>epoetin alfa-epbx</i>)	4	PA; QL (12 mL per 28 days); SP
*FOLIC ACID/FOLATES*** - DRUGS FOR NUTRITION		
<i>folic acid injection solution</i>	1 or 1a*	
*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)*** - DRUGS FOR NUTRITION		
NEULASTA ONPRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim</i>)	4	PA; QL (2 injectors/kits per 28 days); SP
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim</i>)	4	PA; QL (2 syringes per 28 days); SP
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	4	PA; QL (2 syringes per 28 days); SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>pegfilgrastim-cbqv</i>)	4	PA; QL (2 syringes per 28 days); SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>pegfilgrastim-cbqv</i>)	4	PA; QL (2 syringes per 28 days); SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE (<i>filgrastim-sndz</i>)	4	PA; SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*IRON*** - DRUGS FOR NUTRITION		
FERAHEME INTRAVENOUS SOLUTION (<i>ferumoxytol</i>)	4	PA; Effective 01/01/2026: NF; QL (2 vials per 6 days); SP
FERRLECIT INTRAVENOUS SOLUTION (<i>na ferric gluc cplx in sucrose</i>)	4	PA; Effective 01/01/2026: NF; QL (16 vials per 8 weekss); SP
<i>ferumoxytol intravenous solution</i>	4	PA; QL (2 vials per 6 days); SP
INFED INJECTION SOLUTION (<i>iron dextran</i>)	4	PA; SP
<i>iron sucrose intravenous solution</i>	4	PA; QL (1000 mg per 14 days); SP
<i>na ferric gluc cplx in sucrose intravenous solution</i>	4	PA; QL (16 vials per 8 weekss); SP
VENOFER INTRAVENOUS SOLUTION (<i>iron sucrose</i>)	4	PA; Effective 01/01/2026: NF; QL (1000 mg per 14 days); SP
*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS*** - DRUGS FOR NUTRITION		
<i>eltrombopag olamine oral packet 12.5 mg</i>	4	PA; DO; SP
<i>eltrombopag olamine oral packet 25 mg</i>	4	PA; QL (3 dose-packs per 1 day); SP
<i>eltrombopag olamine oral tablet 12.5 mg, 25 mg</i>	4	PA; DO; SP
<i>eltrombopag olamine oral tablet 50 mg</i>	4	PA; QL (3 tablets per 1 day); SP
<i>eltrombopag olamine oral tablet 75 mg</i>	4	PA; QL (1 tablet per 1 day); SP
HEMOSTATICS - DRUGS FOR THE BLOOD		
*HEMOSTATICS - SYSTEMIC*** - DRUGS TO PREVENT BLEEDING		
<i>aminocaproic acid intravenous solution</i>	1 or 1b*	
<i>aminocaproic acid oral solution</i>	2	QL (120 mL per 1 day)
<i>aminocaproic acid oral tablet 1000 mg</i>	2	
<i>aminocaproic acid oral tablet 500 mg</i>	2	QL (60 tablets per 1 day)
<i>tranexamic acid intravenous solution</i>	2	
<i>tranexamic acid oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS FOR THE NERVOUS SYSTEM		
*BARBITURATE HYPNOTICS*** - DRUGS FOR INSOMNIA		
<i>pentobarbital sodium injection solution</i>	1 or 1b*	
<i>phenobarbital oral elixir</i>	1 or 1b*	QL (100 mL per 1 day)
<i>phenobarbital oral tablet 100 mg, 60 mg, 64.8 mg, 97.2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>phenobarbital oral tablet 15 mg, 16.2 mg, 30 mg, 32.4 mg</i>	1 or 1b*	DO
<i>phenobarbital sodium injection solution</i>	1 or 1b*	
*BENZODIAZEPINE HYPNOTICS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>estazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>flurazepam hcl oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>midazolam hcl (pf) +rfid injection solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>midazolam hcl (pf) injection solution</i>	1 or 1b*	
<i>midazolam hcl injection solution 10 mg/10ml, 10 mg/2ml, 25 mg/5ml, 5 mg/ml, 50 mg/10ml</i>	1 or 1b*	
<i>midazolam hcl oral syrup</i>	1 or 1b*	QL (10 mL per 1 fill)
<i>midazolam-sodium chloride (pf) intravenous solution</i>	1 or 1b*	
<i>quazepam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>temazepam oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>triazolam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
*HYPNOTICS - TRICYCLIC AGENTS*** - DRUGS FOR INSOMNIA		
<i>doxepin hcl oral tablet</i>	2	ST; QL (1 tablet per 1 day)
*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR INSOMNIA		
<i>eszopiclone oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zaleplon oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>zolpidem tartrate er oral tablet extended release</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate sublingual tablet sublingual</i>	2	ST; QL (1 tablet per 1 day)
*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES*** - DRUGS FOR INSOMNIA		
<i>dexmedetomidine hcl in nacl intravenous solution</i>	1 or 1b*	
<i>dexmedetomidine hcl intravenous solution 200 mcg/2ml</i>	1 or 1b*	
*SELECTIVE MELATONIN RECEPTOR AGONISTS*** - DRUGS FOR INSOMNIA		
<i>ramelteon oral tablet</i>	2	QL (1 tablet per 1 day)
<i>tasimelteon oral capsule</i>	4	PA; QL (1 capsule per 1 day)
LAXATIVES - DRUGS FOR THE STOMACH		
*BOWEL EVACUANT COMBINATIONS*** - DRUGS TO PREVENT CONSTIPATION		
<i>GAVILYTE-C ORAL SOLUTION RECONSTITUTED (peg 3350-kcl-nabcb-nacl-nasulf)</i>	1 or 1a*; \$0	QL (1 bottle per 30 days)
<i>gavilyte-g oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg 3350-kcl-na bicarb-nacl (Gavilyte-N With Flavor Pack Oral Solution Reconstituted)</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>na sulfate-k sulfate-mg sulf oral solution</i>	1 or 1b*; \$0	QL (1 kit per 30 days)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes oral solution reconstituted</i>	1 or 1a*; \$0	QL (4000 grams per 30 days)
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted</i>	1 or 1b*; \$0	QL (1 gram per 30 days)
<i>SUTAB ORAL TABLET (sodium sulfate-mag sulfate-kcl)</i>	2	QL (24 tablets per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*LAXATIVES - MISCELLANEOUS*** - DRUGS TO PREVENT CONSTIPATION		
<i>constulose oral solution</i>	1 or 1b*	QL (60 mL per 1 day)
KRISTALOSE ORAL PACKET (<i>lactulose</i>)	2	ST; QL (2 packets per 1 day)
LACTULOSE ORAL PACKET 10 GM	2	ST; QL (2 packets per 1 day)
<i>lactulose oral packet 20 gm</i>	2	ST; QL (2 packets per 1 day)
<i>lactulose oral solution</i>	1 or 1b*	QL (60 mL per 1 day)
LOCAL ANESTHETICS-PARENTERAL - DRUGS FOR PAIN AND FEVER		
*LOCAL ANESTHETIC & SYMPATHOMIMETIC*** - DRUGS FOR SEDATION		
<i>bupivacaine-epinephrine (pf) injection solution</i>	1 or 1b*	
<i>lidocaine-epinephrine (pf) injection solution</i>	1 or 1b*	
<i>lidocaine-epinephrine injection solution 0.5 %-1:200000, 2 %-1:100000</i>	1 or 1b*	
<i>sensorcaine/epinephrine injection solution</i>	1 or 1b*	
<i>sensorcaine-mpf/epinephrine injection solution 0.25% -1:200000</i>	1 or 1b*	
*LOCAL ANESTHETICS - AMIDES*** - DRUGS FOR SEDATION		
<i>bupivacaine hcl (pf) injection solution</i>	1 or 1b*	
<i>lidocaine hcl (pf) injection solution</i>	1 or 1b*	
<i>lidocaine hcl injection solution 0.5 %</i>	1 or 1b*	
<i>polocaine injection solution</i>	1 or 1b*	
<i>polocaine-mpf injection solution</i>	1 or 1b*	
<i>ropivacaine hcl injection solution 10 mg/ml, 5 mg/ml, 7.5 mg/ml</i>	1 or 1b*	
ROPIVACAINE HCL INJECTION SOLUTION 2 MG/ML	1 or 1b*	
<i>sensorcaine injection solution</i>	1 or 1b*	
<i>sensorcaine-mpf injection solution</i>	1 or 1b*	
*LOCAL ANESTHETICS - ESTERS*** - DRUGS FOR SEDATION		
<i>chloroprocaine hcl (pf) injection solution</i>	1 or 1b*	
MACROLIDES - DRUGS FOR INFECTIONS		
*AZITHROMYCIN*** - ANTIBIOTICS		
<i>azithromycin intravenous solution reconstituted</i>	2	
<i>azithromycin oral suspension reconstituted</i>	1 or 1b*	
<i>azithromycin oral tablet</i>	1 or 1b*	
*CLARITHROMYCIN*** - ANTIBIOTICS		
<i>clarithromycin er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>clarithromycin oral suspension reconstituted</i>	1 or 1b*	
<i>clarithromycin oral tablet</i>	1 or 1b*	
*ERYTHROMYCINS*** - ANTIBIOTICS		
<i>e.e.s. 400 oral tablet</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>erythromycin base oral capsule delayed release particles</i>	1 or 1b*	
<i>erythromycin base oral tablet</i>	1 or 1b*	
<i>erythromycin base oral tablet delayed release</i>	1 or 1b*	
<i>erythromycin ethylsuccinate oral suspension reconstituted</i>	2	
<i>erythromycin lactobionate intravenous solution reconstituted</i>	2	
<i>erythromycin oral tablet delayed release</i>	1 or 1b*	
*FIDAXOMICIN*** - ANTIBIOTICS		
<i>fidaxomicin oral tablet</i>	2	QL (20 tablets per 1 fill)
MEDICAL DEVICES AND SUPPLIES - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
*CERVICAL CAPS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
FEMCAP VAGINAL DEVICE (<i>cervical caps</i>)	2; \$0	
*DIAPHRAGMS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM (<i>diaphragm wide seal</i>)	2; \$0	
*GLUCOSE MONITORING TEST SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 units per 30 days)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	2	PA; QL (1 unit per 90 days)
DEXCOM G7 15 DAY SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 Sensors per 30 days)
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 receiver per 1 year)
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (3 sensors per 30 days)
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 kits per 30 days)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 reader per 1 year)
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 units per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 30 days)
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 1 year)
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	2	PA; QL (2 sensors per 28 days)
FREESTYLE LIBRE READER DEVICE (<i>continuous glucose receiver</i>)	2	PA; QL (1 unit per 365 days)
*INSULIN ADMINISTRATION SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 Personal Diabetes Manager per 4 years)
OMNIPOD 5 LIBRE2 PLUS G6 PODS (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 4 yearss)
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	2	PA; QL (15 pods per 30 days)
TWIST REFILL KIT KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 30 days)
TWIST REFILL KIT/INFUSION SET KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 30 days)
TWIST STARTER KIT KIT (<i>insulin disposable pump</i>)	2	PA; QL (1 kit per 6 months)
*NEEDLES & SYRINGES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT		
<i>aq insulin syringe</i>	3	ST; QL (200 syringes per 30 days)
<i>aqinject pen needle</i>	3	ST; QL (200 needles per 30 days)
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
BD INSULIN SYRINGE U-500 (<i>insulin syringe/needle u-500</i>)	2	QL (200 syringes per 30 days)
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
DROPSAFE SAFETY SYRINGE/NEEDLE (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 needles per 30 days)
EMBECTA INSULIN SYRINGE (<i>insulin syringe-needle u-100</i>)	2	QL (200 syringes per 30 days)
EMBECTA INSULIN SYRINGE U-500 (<i>insulin syringe/needle u-500</i>)	2	QL (200 syringes per 30 days)
<i>insulin syringe-needle u-100 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 28g x 1/2" 1 ml, 30g x 1/2" 1 ml</i>	3	ST; QL (200 syringes per 30 days)
INSULIN SYRINGE-NEEDLE U-100 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.5 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	3	ST; QL (200 syringes per 30 days)
MAGELLAN INSULIN SAFETY SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MARATHON MEDICAL PENTIPS (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
MONOJECT INSULIN SYRINGE U-100 1 ML (<i>insulin syringes (disposable)</i>)	3	ST; QL (200 syringes per 30 days)
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
PEN NEEDLES 30G X 5 MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM	3	ST; QL (200 needles per 30 days)
PENTIPS 29G X 12MM , 31G X 5 MM , 31G X 8 MM , 32G X 4 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
PRO COMFORT PEN NEEDLES 32G X 4 MM , 32G X 5 MM	3	ST; QL (200 needles per 30 days)
<i>sure comfort pen needles 31g x 6 mm</i>	3	ST; QL (200 needles per 30 days)
SURE COMFORT PEN NEEDLES 32G X 4 MM	3	ST; QL (200 needles per 30 days)
ULTICARE INSULIN SAFETY SYR (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML (<i>insulin syringe-needle u-100</i>)	3	ST; QL (200 syringes per 30 days)
ULTICARE PEN NEEDLES 29G X 12.7MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	3	ST; QL (200 needles per 30 days)
MIGRAINE PRODUCTS - DRUGS FOR THE NERVOUS SYSTEM		
*CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAG (CGRP)*** - DRUGS FOR MIGRAINE HEADACHES		
NURTEC ORAL TABLET DISPERSIBLE (<i>rimegepant sulfate</i>)	2	PA; QL (8 tablets per 30 days)
QULIPTA ORAL TABLET (<i>atogepant</i>)	2	PA; QL (1 tablet per 1 day)
UBRELVY ORAL TABLET (<i>ubrogepant</i>)	2	ST; QL (16 tablets per 30 days)
*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES*** - DRUGS FOR MIGRAINE HEADACHES		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>erenumab-aooe</i>)	3	PA; QL (1 autoinjector per 28 days)
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>fremanezumab-vfrm</i>)	3	PA; QL (3 syringes per 90 days)
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>fremanezumab-vfrm</i>)	3	PA; QL (3 syringes per 90 days)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>galcanezumab-gnlm</i>)	3	PA; QL (3 syringes per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>galcanezumab-gnlm</i>)	3	PA; QL (1 pen per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>galcanezumab-gnlm</i>)	3	PA; QL (1 syringe per 28 days)
*ERGOT COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES		
<i>ergotamine-caffeine oral tablet</i>	1 or 1b*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>migergot rectal suppository</i>	1 or 1b*	
*MIGRAINE PRODUCTS*** - DRUGS FOR MIGRAINE HEADACHES		
<i>dihydroergotamine mesylate injection solution</i>	1 or 1b*	PA; QL (24 mL per 28 days)
*SELECTIVE SEROTONIN AGONISTS 5-HT(1)*** - DRUGS FOR MIGRAINE HEADACHES		
<i>almotriptan malate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>eletriptan hydrobromide oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>frovatriptan succinate oral tablet</i>	1 or 1b*	ST; QL (9 tablets per 30 days)
<i>naratriptan hcl oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan nasal solution</i>	1 or 1b*	QL (6 nasal inhalers per 30 days)
<i>sumatriptan succinate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge</i>	2	QL (6 cartridges per 30 days)
<i>sumatriptan succinate subcutaneous solution</i>	2	QL (5 vials per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	2	QL (6 syringes (2 ML) per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	2	QL (6 cartridges per 30 days)
<i>zolmitriptan nasal solution</i>	1 or 1b*	ST; QL (6 nasal inhalers per 30 days)
<i>zolmitriptan oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>zolmitriptan oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION		
*BICARBONATES*** - DRUGS FOR NUTRITION		
<i>sodium acetate intravenous solution 4 meq/ml</i>	1 or 1b*	
<i>sodium bicarbonate intravenous solution 4.2 %, 7.5 %</i>	2	
*ELECTROLYTES & DEXTROSE*** - DRUGS FOR NUTRITION		
<i>dextrose in lactated ringers intravenous solution</i>	1 or 1b*	
<i>dextrose-sodium chloride intravenous solution 10-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.45 %, 5-0.9 %</i>	1 or 1b*	
<i>kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%, 20-5-0.2 meq/l-%, 20-5-0.45 meq/l-%, 20-5-0.9 meq/l-%, 30-5-0.45 meq/l-%, 40-5-0.45 meq/l-%</i>	1 or 1b*	
<i>potassium cl in dextrose 5% intravenous solution</i>	1 or 1b*	
*ELECTROLYTES PARENTERAL*** - DRUGS FOR NUTRITION		
<i>KCL (0.149%) IN NACL INTRAVENOUS SOLUTION 20-0.45 MEQ/L-%</i>	1 or 1b*	
<i>kcl (0.149%) in nacl intravenous solution 20-0.9 meq/l-%</i>	1 or 1b*	
<i>KCL (0.298%) IN NACL INTRAVENOUS SOLUTION</i>	1 or 1b*	
<i>lactated ringers intravenous solution</i>	1 or 1b*	
<i>multiple electro type 1 ph 5.5 intravenous solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>multiple electro type 1 ph 7.4 intravenous solution</i>	1 or 1b*	
<i>ringers intravenous solution</i>	1 or 1b*	
*FLUORIDE*** - DRUGS FOR NUTRITION		
<i>sodium fluoride oral solution</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet chewable</i>	1 or 1a*; \$0	
*MAGNESIUM*** - DRUGS FOR NUTRITION		
MAGNESIUM SULFATE INJECTION SOLUTION	2	
*MANGANESE*** - DRUGS FOR NUTRITION		
<i>manganese chloride intravenous solution</i>	1 or 1b*	
*PHOSPHATE*** - DRUGS FOR NUTRITION		
K-PHOS ORAL TABLET (<i>potassium phosphate monobasic</i>)	2	Effective 01/01/2026: NF
<i>phospha 250 neutral oral tablet</i>	1 or 1b*	
<i>phosphorous oral tablet</i>	1 or 1b*	
<i>phospho-trin k500 oral tablet</i>	1 or 1b*	
<i>potassium phosphates intravenous solution 45 mmole/15ml</i>	1 or 1b*	
<i>sodium phosphates intravenous solution</i>	1 or 1b*	
*POTASSIUM*** - DRUGS FOR NUTRITION		
<i>klor-con 10 oral tablet extended release</i>	1 or 1b*	
<i>klor-con m10 oral tablet extended release</i>	1 or 1a*	
<i>klor-con m15 oral tablet extended release</i>	1 or 1a*	
<i>klor-con m20 oral tablet extended release</i>	1 or 1a*	
<i>klor-con oral packet</i>	1 or 1b*	
<i>klor-con oral tablet extended release</i>	1 or 1b*	
<i>potassium chloride crys er oral tablet extended release</i>	1 or 1a*	
<i>potassium chloride er oral capsule extended release</i>	1 or 1b*	
<i>potassium chloride er oral tablet extended release 10 meq</i>	1 or 1a*	
<i>potassium chloride er oral tablet extended release 15 meq, 20 meq, 8 meq</i>	1 or 1b*	
<i>potassium chloride intravenous solution 2 meq/ml</i>	1 or 1b*	
<i>potassium chloride oral packet</i>	1 or 1b*	
<i>potassium chloride oral solution</i>	1 or 1b*	
*SODIUM*** - DRUGS FOR NUTRITION		
<i>aquastat intravenous solution</i>	2	
<i>sodium chloride flush</i> (Aquastat Sfr Intravenous Solution)	2	
<i>bd posiflush intravenous solution</i>	2	
<i>sodium chloride flush</i> (Bd Posiflush Safescrub Intravenous Solution)	2	
<i>monoject flush syringe intravenous solution</i>	2	
<i>monoject sodium chloride flush intravenous solution</i>	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>normal saline flush intravenous solution</i>	2	
<i>saline flush intravenous solution</i>	2	
<i>sodium chloride (pf) injection solution</i>	2	
<i>sodium chloride injection solution 2.5 meq/ml</i>	2	
<i>sodium chloride intravenous solution 0.45 %, 3 %, 5 %</i>	2	
*TRACE MINERALS*** - DRUGS FOR NUTRITION		
SELENIOS ACID INTRAVENOUS SOLUTION 40 MCG/ML	1 or 1b*	
*ZINC*** - DRUGS FOR NUTRITION		
<i>zinc sulfate intravenous solution</i>	1 or 1b*	Effective 01/01/2026: NF
MISCELLANEOUS THERAPEUTIC CLASSES - VITAMINS AND MINERALS		
*ANTILEPTOTICS*** - VITAMINS AND MINERALS		
THALOMID ORAL CAPSULE (<i>thalidomide</i>)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*CHELATING AGENTS*** - VITAMINS AND MINERALS		
<i>penicillamine oral tablet</i>	2	PA; QL (8 tablets per 1 day); SP
<i>trientine hcl oral capsule 250 mg</i>	4	PA; QL (8 capsules per 1 day); SP
*CYCLOSPORINE ANALOGS*** - VITAMINS AND MINERALS		
<i>cyclosporine modified oral capsule</i>	4	
<i>cyclosporine modified oral solution</i>	4	
<i>cyclosporine oral capsule</i>	4	
<i>gengraf oral capsule</i>	4	
<i>gengraf oral solution</i>	4	
*IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS		
<i>lenalidomide oral capsule</i>	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
REVLIMID ORAL CAPSULE (<i>lenalidomide</i>)	4; OC	PA; LD; QL (1 capsule per 1 day); SP; OC
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS*** - VITAMINS AND MINERALS		
<i>mycophenolate mofetil oral capsule</i>	4	
<i>mycophenolate mofetil oral suspension reconstituted</i>	4	
<i>mycophenolate mofetil oral tablet</i>	4	
<i>mycophenolate sodium oral tablet delayed release</i>	4	
<i>mycophenolic acid oral tablet delayed release</i>	4	
*IRRIGATION SOLUTIONS*** - VITAMINS AND MINERALS		
<i>argyle sterile water irrigation solution</i>	1 or 1b*	
<i>lactated ringers irrigation solution</i>	1 or 1b*	
<i>physiolyte irrigation solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>physiosol irrigation irrigation solution</i>	1 or 1b*	
<i>sterile water for irrigation irrigation solution</i>	1 or 1b*	
<i>water for irrigation, sterile irrigation solution</i>	1 or 1b*	
*MACROLIDE IMMUNOSUPPRESSANTS*** - VITAMINS AND MINERALS		
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	4	
<i>sirolimus oral solution</i>	4	
<i>sirolimus oral tablet</i>	4	
<i>tacrolimus oral capsule</i>	4	
*POTASSIUM REMOVING AGENTS*** - VITAMINS AND MINERALS		
LOKELMA ORAL PACKET 10 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (34 packets per 30 days)
LOKELMA ORAL PACKET 5 GM (<i>sodium zirconium cyclosilicate</i>)	3	QL (3 packets per 1 day)
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sps (sodium polystyrene sulf) rectal suspension</i>	2	
*PURINE ANALOGS*** - VITAMINS AND MINERALS		
<i>azasan oral tablet</i>	1 or 1b*	
<i>azathioprine oral tablet</i>	1 or 1b*	
*SCLEROSING AGENTS*** - VITAMINS AND MINERALS		
<i>sodium tetradecyl sulfate intravenous solution</i>	1 or 1b*	
SOTRADECOL INTRAVENOUS SOLUTION 1 % (<i>sodium tetradecyl sulfate</i>)	1 or 1b*	
<i>sotradecol intravenous solution 3 %</i>	1 or 1b*	
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
*ANESTHETICS TOPICAL ORAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>lidocaine hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
<i>lidocaine viscous hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
*ANTI-INFECTIVES - THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clotrimazole mouth/throat troche</i>	1 or 1b*	QL (5 tablet per 1 day)
*ANTISEPTICS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT		
<i>chlorhexidine gluconate mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
<i>perio gard mouth/throat solution</i>	1 or 1a*	QL (480 mL per 30 days)
*DENTAL PRODUCTS - COMBINATIONS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>sodium fluoride 5000 enamel dental gel</i>	1 or 1b*	
<i>sodium fluoride 5000 sensitive dental gel</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*FLUORIDE DENTAL PRODUCTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>clinpro 5000 dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>denta 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>dentagel dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>easygel dental gel</i>	1 or 1b*	
<i>fluoridex daily renewal mouth/throat concentrate</i>	1 or 1b*	
<i>fluoridex dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fluoridex enhanced whitening dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>fluorimax 5000 dental paste</i>	1 or 1b*	
<i>fraiche 5000 dental dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>just right 5000 dental paste</i>	1 or 1b*	
<i>sf 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sf dental gel</i>	1 or 1a*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 plus dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride 5000 ppm dental gel</i>	1 or 1b*	QL (100 grams per 30 days)
<i>sodium fluoride 5000 ppm dental paste</i>	1 or 1b*	QL (3.77 grams per 1 day)
<i>sodium fluoride dental cream</i>	1 or 1b*	QL (3.4 grams per 1 day)
<i>sodium fluoride mouth/throat solution</i>	1 or 1a*	
*SALIVA STIMULANTS*** - DRUGS FOR THE MOUTH AND THROAT		
<i>cevimeline hcl oral capsule</i>	2	
<i>pilocarpine hcl oral tablet</i>	2	QL (4 tablets per 1 day)
*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT		
<i>triamcinolone acetonide (Kourzeq Mouth/Throat Paste)</i>	1 or 1b*	
<i>oralone mouth/throat paste</i>	1 or 1b*	
<i>triamcinolone acetonide mouth/throat paste</i>	1 or 1b*	
MULTIVITAMINS - DRUGS FOR NUTRITION		
*B-COMPLEX W/ C & FOLIC ACID*** - DRUGS FOR NUTRITION		
<i>b-plex oral tablet</i>	1 or 1b*; \$0	
*PED MULTI VITAMINS W/FL & FE*** - DRUGS FOR NUTRITION		
<i>multi-vitamin/fluoride/iron oral solution</i>	1 or 1b*	
*PED MV W/ FLUORIDE*** - DRUGS FOR NUTRITION		
<i>multivitamin w/fluoride oral tablet chewable</i>	1 or 1b*; \$0	
<i>multi-vitamin/fluoride oral solution</i>	1 or 1b*; \$0	
*PED VITAMINS ACD W/ FLUORIDE*** - DRUGS FOR NUTRITION		
<i>tri-vite/fluoride oral solution</i>	1 or 1b*; \$0	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*PRENATAL MV & MIN W/FE-FA*** - DRUGS FOR NUTRITION		
ATABEX EC ORAL TABLET DELAYED RELEASE (<i>prenatal vit-dss-fe cbn-fa</i>)	2	QL (1 tablet per 1 day)
ATABEX OB ORAL TABLET (<i>prenatal vit w/ fe bisg-fa</i>)	2	QL (1 tablet per 1 day)
C-NATE DHA ORAL CAPSULE	2	QL (1 capsule per 1 day)
COMPLETENATE ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
CO-NATAL FA ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
CONCEPT DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
CONCEPT OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
<i>elite-ob oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
FOLIVANE-OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
<i>inatal gt oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
M-NATAL PLUS ORAL TABLET	1 or 1b*	QL (1 tablet per 1 day)
NIVA-PLUS ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	2	QL (1 tablet per 1 day)
ONE VITE WOMENS PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
<i>pnv 27-ca/fe/fa oral tablet</i>	2	ST; QL (1 tablet per 1 day)
<i>pnv prenatal plus multivit+dha oral</i>	2	QL (2 units per 1 day)
<i>pnv-select oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET 29-1 MG	2	QL (1 tablet per 1 day)
<i>prenatal 19 oral tablet chewable</i>	1 or 1a*	QL (1 tablet per 1 day)
PRENATAL 19 ORAL TABLET CHEWABLE 29-1 MG	2	QL (1 tablet per 1 day)
PRENATAL ORAL TABLET 27-1 MG	2	QL (1 tablet per 1 day)
PRENATAL PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL PLUS VITAMIN/MINERAL ORAL TABLET	2	QL (1 tablet per 1 day)
PRENATAL-U ORAL CAPSULE (<i>prenatal w/o a vit-fe fum-fa</i>)	2	QL (1 capsule per 1 day)
PROVIDA OB ORAL CAPSULE (<i>prenat w/o a vit-fefum-fepo-fa</i>)	2	QL (1 capsule per 1 day)
SELECT-OB ORAL TABLET CHEWABLE 29-1 MG (<i>prenatal vit-fe psac cmplx-fa</i>)	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET	2	QL (1 tablet per 1 day)
SE-NATAL 19 ORAL TABLET CHEWABLE	2	QL (1 tablet per 1 day)
TARON-C DHA ORAL CAPSULE (<i>prenat-fefum-fepo-fa-omega 3</i>)	2	QL (1 capsule per 1 day)
THRIVITE RX ORAL TABLET	2	QL (1 tablet per 1 day)
TRINATAL RX 1 ORAL TABLET	2	QL (1 tablet per 1 day)
<i>trinate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)
VITAFOL GUMMIES ORAL TABLET CHEWABLE (<i>prenatal vit-fe phos-fa-omega</i>)	2	QL (3 gummies per 1 day)
WESTAB PLUS ORAL TABLET	2	QL (1 tablet per 1 day)
*PRENATAL MV & MIN W/FE-FA-CA-OMEGA 3 FISH OIL*** - DRUGS FOR NUTRITION		
COMPLETE NATAL DHA ORAL	2	QL (2 units per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>wesnatal dha complete oral</i>	2	QL (2 units per 1 day)
*PRENATAL MV & MIN W/FE-FA-DHA**** - DRUGS FOR NUTRITION		
<i>pnv-dha oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>prena 1 true oral</i>	2	QL (2 tablets per 1 day)
MUSCULOSKELETAL THERAPY AGENTS - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
*CENTRAL MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>baclofen oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>baclofen oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>carisoprodol oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 375 mg, 750 mg</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 10 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>cyclobenzaprine hcl oral tablet 5 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>methocarbamol injection solution</i>	1 or 1b*	
<i>methocarbamol oral tablet 500 mg</i>	1 or 1b*	QL (8 tablets per 1 day)
<i>methocarbamol oral tablet 750 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>orphenadrine citrate er oral tablet extended release 12 hour</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>orphenadrine citrate injection solution</i>	1 or 1b*	
<i>tizanidine hcl oral capsule 6 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>tizanidine hcl oral tablet 2 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>tizanidine hcl oral tablet 4 mg</i>	1 or 1b*	QL (9 tablets per 1 day)
*DIRECT MUSCLE RELAXANTS**** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
<i>dantrolene sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>dantrolene sodium oral capsule</i>	2	
<i>revonto intravenous solution reconstituted</i>	1 or 1b*	
*MUSCLE RELAXANT COMBINATIONS**** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES		
NORGESIC FORTE ORAL TABLET	1 or 1b*	ST; QL (4 tablets per 1 day)
<i>norgesic oral tablet</i>	1 or 1b*	ST; QL (8 tablets per 1 day)
ORPHENADRINE-ASPIRIN-CAFFEINE ORAL TABLET	1 or 1b*	ST; QL (8 tablets per 1 day)
<i>orphengesic forte oral tablet</i>	1 or 1b*	ST; QL (4 tablets per 1 day)
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
*ANTI-HISTAMINE-STEROID*** - ALLERGY		
<i>azelastine-fluticasone nasal suspension</i>	3	QL (1 bottle per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*NASAL ANTICHOLINERGICS*** - ALLERGY		
<i>ipratropium bromide nasal solution 0.03 %</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>ipratropium bromide nasal solution 0.06 %</i>	1 or 1b*	QL (1 mL per 1 day)
*NASAL ANTIHISTAMINES*** - ALLERGY		
<i>azelastine hcl nasal solution</i>	1 or 1b*	QL (1 package per 25 days)
<i>olopatadine hcl nasal solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*NASAL STEROIDS*** - ALLERGY		
<i>fluticasone propionate nasal suspension</i>	1 or 1a*	BE; QL (1 bottle per 30 days)
<i>mometasone furoate nasal suspension</i>	3	ST; BE; QL (1 bottle per 30 days)
NEUROMUSCULAR AGENTS - DRUGS FOR NERVES AND MUSCLES		
*BENZATHIAZOLES*** - DRUGS FOR NERVES AND MUSCLES		
<i>riluzole oral tablet</i>	4	PA; QL (4 tablets per 1 day); SP
*NONDEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES		
<i>atracurium besylate intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate (pf) intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate intravenous solution</i>	1 or 1b*	
<i>rocuronium bromide intravenous solution</i>	1 or 1b*	
<i>vecuronium bromide intravenous solution reconstituted</i>	1 or 1b*	
NUTRIENTS - DRUGS FOR NUTRITION		
*AMINO ACID MIXTURES*** - DRUGS FOR NUTRITION		
<i>aminosyn ii intravenous solution 15 %</i>	1 or 1b*	
<i>clinisol sf intravenous solution</i>	1 or 1b*	
<i>plenamine intravenous solution</i>	1 or 1b*	
*CARBOHYDRATES*** - DRUGS FOR NUTRITION		
<i>dextrose intravenous solution 10 %</i>	1 or 1b*	
OPHTHALMIC AGENTS - DRUGS FOR THE EYE		
*ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB*** - DRUGS FOR GLAUCOMA		
SIMBRINZA OPHTHALMIC SUSPENSION (<i>brinzolamide-brimonidine</i>)	2	QL (8 mL per 30 days)
*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS*** - DRUGS FOR GLAUCOMA		
<i>brimonidine tartrate-timolol ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
<i>dorzolamide hcl-timolol mal ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
<i>dorzolamide hcl-timolol mal pf ophthalmic solution</i>	1 or 1b*	QL (60 units per 30 days)
*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA		
<i>betaxolol hcl ophthalmic solution</i>	1 or 1b*	QL (0.5 mL per 1 day)
BETOPTIC-S OPHTHALMIC SUSPENSION (<i>betaxolol hcl</i>)	2	QL (15 mL per 30 days)
<i>carteolol hcl ophthalmic solution</i>	1 or 1a*	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levobunolol hcl ophthalmic solution</i>	1 or 1b*	
<i>timolol hemihydrate ophthalmic solution</i>	2	QL (15 mL per 30 days)
<i>timolol maleate (once-daily) ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>timolol maleate ocudose ophthalmic solution</i>	1 or 1b*	QL (20 mL per 30 days)
<i>timolol maleate ophthalmic gel forming solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>timolol maleate ophthalmic solution</i>	1 or 1b*	QL (20 mL per 30 days)
<i>timolol maleate pf ophthalmic solution 0.25 %</i>	1 or 1b*	QL (18 mL per 30 days)
<i>timolol maleate pf ophthalmic solution 0.5 %</i>	1 or 1b*	QL (20 mL per 30 days)
*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE		
<i>cyclopentolate hcl ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
<i>phenylephrine hcl ophthalmic solution 10 %</i>	1 or 1b*	
<i>tropicamide ophthalmic solution</i>	1 or 1b*	
*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
XIIDRA OPTHALMIC SOLUTION (<i>lifitegrast</i>)	2	PA; QL (2 vial per 1 day)
*MIOTICS - DIRECT ACTING*** - DRUGS FOR GLAUCOMA		
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1 or 1b*	
*OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS*** - DRUGS FOR THE EYE		
VABYSMO INTRAVITREAL SOLUTION (<i>faricimab-svoa</i>)	4	PA; LD; SP
VABYSMO INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>faricimab-svoa</i>)	4	PA; LD; SP
*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR ITCHY EYE		
<i>azelastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 24 days)
<i>cromolyn sodium ophthalmic solution</i>	1 or 1a*	QL (2 bottles per 30 days)
<i>epinastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 30 days)
*OPHTHALMIC ANTIBIOTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitracin ophthalmic ointment</i>	1 or 1b*	QL (7 grams per 30 days)
<i>ciprofloxacin hcl ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>gatifloxacin ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
<i>gentamicin sulfate ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>levofloxacin ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>moxifloxacin hcl (2x day) ophthalmic solution</i>	1 or 1b*	QL (3 mL per 30 days)
<i>moxifloxacin hcl ophthalmic solution</i>	2	QL (3 mL per 30 days)
<i>ofloxacin ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
<i>tobramycin ophthalmic solution</i>	1 or 1a*	QL (20 mL per 30 days)
*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitracin-polymyxin b ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>neomycin-polymyxin-gramicidin ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
<i>neo-polycin ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>polycin ophthalmic ointment</i>	1 or 1a*	QL (3.5 grams per 30 days)
<i>polymyxin b-trimethoprim ophthalmic solution</i>	1 or 1a*	QL (10 mL per 30 days)
*OPHTHALMIC ANTIVIRALS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>trifluridine ophthalmic solution</i>	1 or 1b*	QL (7.5 mL per 30 days)
*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR GLAUCOMA		
<i>brinzolamide ophthalmic suspension</i>	1 or 1b*	QL (15 mL per 30 days)
<i>dorzolamide hcl ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
*OPHTHALMIC DIAGNOSTIC PRODUCTS*** - DRUGS FOR THE EYE		
<i>ak-fluor intravenous solution</i>	1 or 1b*	
<i>altafluor benox ophthalmic solution</i>	1 or 1b*	
<i>fluorescein intravenous solution</i>	1 or 1b*	
<i>fluorescein sodium intravenous solution</i>	1 or 1b*	
<i>fluorescein-benoxinate ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC IMMUNOMODULATORS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>cyclosporine ophthalmic emulsion</i>	1 or 1b*	PA; QL (2 vials per 1 day)
RESTASIS MULTIDOSE OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (1 bottle per 28 days)
RESTASIS OPHTHALMIC EMULSION (<i>cyclosporine</i>)	2	PA; QL (2 vials per 1 day)
*OPHTHALMIC LOCAL ANESTHETICS*** - DRUGS FOR THE EYE		
<i>proparacaine hcl ophthalmic solution</i>	1 or 1b*	
<i>tetracaine hcl ophthalmic solution</i>	1 or 1b*	
*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bromfenac sodium (once-daily) ophthalmic solution</i>	2	QL (1.7 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.07 %</i>	2	QL (3 mL per 30 days)
<i>bromfenac sodium ophthalmic solution 0.075 %</i>	2	QL (5 mL per 30 days)
<i>diclofenac sodium ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
<i>flurbiprofen sodium ophthalmic solution</i>	1 or 1b*	QL (2.5 mL per 30 days)
ILEVRO OPHTHALMIC SUSPENSION (<i>nepafenac</i>)	2	QL (3 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.4 %</i>	1 or 1b*	QL (5 mL per 30 days)
<i>ketorolac tromethamine ophthalmic solution 0.5 %</i>	1 or 1b*	QL (10 mL per 30 days)
*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR GLAUCOMA		
<i>apraclonidine hcl ophthalmic solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>brimonidine tartrate ophthalmic solution 0.1 %</i>	2	QL (30 mL per 30 days)
<i>brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %</i>	1 or 1b*	QL (30 mL per 30 days)
*OPHTHALMIC STEROID COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	1 or 1a*	QL (7 mL per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic suspension</i>	1 or 1a*	QL (20 mL per 30 days)
<i>neomycin-polymyxin-hc ophthalmic suspension</i>	1 or 1b*	
<i>neo-polycin hc ophthalmic ointment</i>	1 or 1b*	QL (7 mL per 30 days)
<i>sulfacetamide-prednisolone ophthalmic solution</i>	1 or 1a*	QL (15 mL per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (<i>tobramycin-dexamethasone</i>)	2	
<i>tobramycin-dexamethasone ophthalmic suspension</i>	1 or 1b*	QL (10 mL per 30 days)
ZYLET OPHTHALMIC SUSPENSION (<i>loteprednol-tobramycin</i>)	2	QL (20 mL per 30 days)
*OPHTHALMIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>dexamethasone sodium phosphate ophthalmic solution</i>	1 or 1b*	
<i>difluprednate ophthalmic emulsion</i>	1 or 1b*	QL (10 mL per 30 days)
<i>fluorometholone ophthalmic suspension</i>	1 or 1b*	
LOTEMAX OPHTHALMIC OINTMENT (<i>loteprednol etabonate</i>)	3	QL (7 grams per 30 days)
<i>loteprednol etabonate ophthalmic gel</i>	1 or 1b*	QL (10 grams per 30 days)
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	1 or 1b*	QL (30 mL per 30 days)
<i>prednisolone acetate ophthalmic suspension</i>	1 or 1b*	QL (20 mL per 30 days)
*OPHTHALMIC SULFONAMIDES*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>sulfacetamide sodium ophthalmic ointment</i>	1 or 1b*	QL (3.5 grams per 30 days)
<i>sulfacetamide sodium ophthalmic solution</i>	1 or 1b*	QL (15 mL per 30 days)
*OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE		
CYSTARAN OPHTHALMIC SOLUTION (<i>cysteamine hcl</i>)	4	PA; LD; QL (60 mL per 28 days)
*PROSTAGLANDINS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA		
<i>bimatoprost ophthalmic solution</i>	2	
<i>latanoprost ophthalmic solution</i>	1 or 1b*	QL (5 mL per 30 days)
LUMIGAN OPHTHALMIC SOLUTION (<i>bimatoprost</i>)	2	QL (7.5 mL per 30 days)
<i>tafluprost (pf) ophthalmic solution</i>	2	QL (9 mL per 30 days)
<i>travoprost (bak free) ophthalmic solution</i>	1 or 1b*	QL (10 mL per 30 days)
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS*** - DRUGS FOR THE EYE		
BYOOVIZ INTRAVITREAL SOLUTION (<i>ranibizumab-nuna</i>)	4	PA; LD; SP
CIMERLI INTRAVITREAL SOLUTION (<i>ranibizumab-eqrn</i>)	4	PA; LD; SP
EYLEA HD INTRAVITREAL SOLUTION (<i>aflibercept</i>)	4	PA; LD; SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYLEA INTRAVITREAL SOLUTION (<i>aflibercept</i>)	4	PA; LD; SP
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>aflibercept</i>)	4	PA; LD; SP
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE (<i>ranibizumab</i>)	4	PA; LD; SP
OTIC AGENTS - DRUGS FOR THE EAR		
*OTIC AGENTS - MISCELLANEOUS**** - WAX REMOVAL		
<i>acetic acid otic solution</i>	1 or 1b*	
*OTIC ANTI-INFECTIVES**** - ANTIBIOTICS		
<i>ciprofloxacin hcl otic solution</i>	1 or 1b*	QL (28 containers per 1 fill)
<i>ofloxacin otic solution</i>	1 or 1b*	QL (10 mL per 1 fill)
*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS**** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>ciprofloxacin-dexamethasone otic suspension</i>	1 or 1b*	QL (7.5 mL per 1 fill)
<i>ciprofloxacin-fluocinolone pf otic solution</i>	1 or 1b*	QL (28 vials per 1 fill)
<i>neomycin-polymyxin-hc otic solution</i>	1 or 1b*	
<i>neomycin-polymyxin-hc otic suspension</i>	1 or 1b*	QL (15 mL per 30 days)
*OTIC STEROIDS**** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES		
<i>fluocinolone acetonide otic oil</i>	1 or 1b*	
<i>hydrocortisone-acetic acid otic solution</i>	1 or 1b*	QL (10 mL per 1 fill)
OXYTOCICS - HORMONES		
*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS**** - DRUGS FOR WOMEN		
<i>carboprost tromethamine intramuscular solution</i>	1 or 1b*	
*OXYTOCICS**** - DRUGS FOR WOMEN		
<i>methergine oral tablet</i>	1 or 1b*	
<i>methylergonovine maleate injection solution</i>	1 or 1b*	
<i>methylergonovine maleate oral tablet</i>	1 or 1b*	
<i>oxytocin injection solution</i>	1 or 1b*	
PASSIVE IMMUNIZING AND TREATMENT AGENTS - BIOLOGICAL AGENTS		
*ANTITOXINS-ANTIVENINS**** - BIOLOGICAL AGENTS		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED (<i>centruroides (scorpion) im fab</i>)	2	
ANTIVENIN LATRODECTUS MACTANS INJECTION KIT	2	
ANTIVENIN MICRURUS FULVIUS INTRAVENOUS SOLUTION RECONSTITUTED	2	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED (<i>crotalidae polyval immune fab</i>)	2	
*IMMUNE SERUMS**** - BIOLOGICAL AGENTS		
CUTAQUIG SUBCUTANEOUS SOLUTION (<i>immune globulin (human)-hipp</i>)	4	PA; LD; SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GAMUNEX-C INJECTION SOLUTION (<i>immune globulin (human)</i>)	4	PA; LD; SP
HIZENTRA SUBCUTANEOUS SOLUTION (<i>immune globulin (human)</i>)	4	PA; LD; SP
HIZENTRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>immune globulin (human)</i>)	4	PA; LD; SP
OCTAGAM INTRAVENOUS SOLUTION (<i>immune globulin (human)</i>)	4	PA; LD; SP
XEMBIFY SUBCUTANEOUS SOLUTION (<i>immune globulin (human)-klhw</i>)	4	PA; LD; SP
PENICILLINS - DRUGS FOR INFECTIONS		
*AMINOPENICILLINS*** - ANTIBIOTICS		
<i>amoxicillin oral capsule</i>	1 or 1a*	
<i>amoxicillin oral suspension reconstituted</i>	1 or 1a*	
<i>amoxicillin oral tablet</i>	1 or 1a*	
<i>amoxicillin oral tablet chewable</i>	1 or 1a*	
<i>ampicillin oral capsule</i>	1 or 1a*	
<i>ampicillin sodium injection solution reconstituted</i>	2	
<i>ampicillin sodium intravenous solution reconstituted</i>	2	
*NATURAL PENICILLINS*** - ANTIBIOTICS		
<i>penicillin g potassium injection solution reconstituted</i>	2	
<i>penicillin g sodium injection solution reconstituted</i>	2	
<i>penicillin v potassium oral solution reconstituted</i>	1 or 1b*	
<i>penicillin v potassium oral tablet</i>	1 or 1b*	
<i>pfizerpen injection solution reconstituted</i>	2	
*PENICILLIN COMBINATIONS*** - ANTIBIOTICS		
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet</i>	1 or 1b*	
<i>ampicillin-sulbactam sodium injection solution reconstituted</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted</i>	2	
AUGMENTIN ORAL SUSPENSION RECONSTITUTED (<i>amoxicillin-pot clavulanate</i>)	2	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted</i>	2	
*PENICILLINASE-RESISTANT PENICILLINS*** - ANTIBIOTICS		
<i>dicloxacillin sodium oral capsule</i>	1 or 1b*	
<i>nafcillin sodium injection solution reconstituted</i>	2	
<i>nafcillin sodium intravenous solution reconstituted</i>	2	
<i>oxacillin sodium injection solution reconstituted</i>	2	
<i>oxacillin sodium intravenous solution reconstituted</i>	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROGESTINS - HORMONES		
*PROGESTINS*** - DRUGS FOR WOMEN		
<i>norethindrone acetate</i> (Gallifrey Oral Tablet)	1 or 1b*	
<i>medroxyprogesterone acetate oral tablet</i>	1 or 1a*	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	1 or 1b*	
<i>norethindrone acetate oral tablet</i>	1 or 1b*	
<i>progesterone intramuscular oil</i>	1 or 1b*	
<i>progesterone oral capsule</i>	1 or 1b*	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS FOR THE NERVOUS SYSTEM		
*AGENTS FOR OPIOID WITHDRAWAL*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>lofexidine hcl oral tablet</i>	2	QL (16 tablets per 1 day)
*ALCOHOL DETERRENTS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>acamprosate calcium oral tablet delayed release</i>	2	QL (6 tablet per 1 day)
<i>disulfiram oral tablet</i>	1 or 1b*	
*ANTI-CATAPLECTIC AGENTS*** - DRUGS FOR SLEEP DISORDER		
<i>sodium oxybate oral solution</i>	4	PA; LD; QL (18 mL per 1 day)
*ANTIDEMENTIA AGENT COMBINATIONS*** - DRUGS FOR ALZHEIMER'S DISEASE		
<i>memantine hcl-donepezil hcl oral capsule extended release 24 hour</i>	2	QL (1 capsule per 1 day)
*BENZODIAZEPINES & TRICYCLIC AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>chlordiazepoxide-amitriptyline oral tablet</i>	1 or 1b*	
*CHOLINOMIMETICS - ACHE INHIBITORS*** - DRUGS FOR ALZHEIMER'S DISEASE		
<i>donepezil hcl oral tablet 10 mg, 23 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>donepezil hcl oral tablet 5 mg</i>	1 or 1b*	DO
<i>donepezil hcl oral tablet dispersible</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg</i>	2	QL (1 capsule per 1 day)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 8 mg</i>	2	DO
<i>galantamine hydrobromide oral solution</i>	2	QL (6 mL per 1 day)
<i>galantamine hydrobromide oral tablet 12 mg, 8 mg</i>	2	QL (2 tablets per 1 day)
<i>galantamine hydrobromide oral tablet 4 mg</i>	2	DO
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg</i>	2	DO
<i>rivastigmine tartrate oral capsule 4.5 mg, 6 mg</i>	2	QL (2 capsules per 1 day)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 9.5 mg/24hr</i>	2	QL (1 patch per 1 day)
<i>rivastigmine transdermal patch 24 hour 4.6 mg/24hr</i>	2	QL (1 gram per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*MOVEMENT DISORDER DRUG THERAPY*** - DRUGS FOR THE NERVOUS SYSTEM		
AUSTEDO ORAL TABLET 12 MG, 9 MG (<i>deutetrabenazine</i>)	4	PA; QL (4 tablets per 1 day); SP
AUSTEDO ORAL TABLET 6 MG (<i>deutetrabenazine</i>)	4	PA; DO; SP
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR (<i>deutetrabenazine</i>)	4	PA; QL (1 tablet per 1 day); SP
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK (<i>deutetrabenazine</i>)	4	PA; QL (1 kit per 1 one-time fill); SP
INGREZZA ORAL CAPSULE 40 MG (<i>valbenazine tosylate</i>)	4	PA; LD; DO; SP
INGREZZA ORAL CAPSULE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 capsule per 1 day); SP
INGREZZA ORAL CAPSULE SPRINKLE 40 MG (<i>valbenazine tosylate</i>)	4	PA; LD; DO; SP
INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 capsule per 1 day); SP
INGREZZA ORAL CAPSULE THERAPY PACK (<i>valbenazine tosylate</i>)	4	PA; LD; QL (1 pack per 1 one-time fill); SP
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA; QL (8 tablets per 1 day); SP
<i>tetrabenazine oral tablet 25 mg</i>	4	PA; QL (4 tablets per 1 day); SP
*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>teriflunomide oral tablet</i>	4	PA; QL (1 tablet per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR MULTIPLE SCLEROSIS		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK (<i>cladribine</i>)	4	PA; LD; QL (2 packs per 46 weekss); SP
*MULTIPLE SCLEROSIS AGENTS - INTERFERONS*** - DRUGS FOR MULTIPLE SCLEROSIS		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (<i>interferon beta-1a</i>)	4	PA; QL (4 kits per 28 days); SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (<i>interferon beta-1a</i>)	4	PA; QL (4 kits per 28 days); SP
BETASERON SUBCUTANEOUS KIT (<i>interferon beta-1b</i>)	4	PA; QL (15 kits per 30 days); SP

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (2 syringes per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>peginterferon beta-1a</i>)	4	PA; LD; QL (1 ML per 28 days); SP
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>interferon beta-1a</i>)	4	PA; QL (12 ML per 28 days); SP
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (<i>interferon beta-1a</i>)	4	PA; QL (4.2 ML per 28 days); SP
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>interferon beta-1a</i>)	4	PA; QL (12 syringes per 28 days); SP
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (<i>interferon beta-1a</i>)	4	PA; QL (1 pack per 1 fill); SP
*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	1 or 1b*	PA; QL (14 capsules per 365 days); SP
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	1 or 1b*	PA; QL (2 capsules per 1 day); SP
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack</i>	1 or 1b*	PA; QL (1 kit per 365 days); SP
VUMERITY ORAL CAPSULE DELAYED RELEASE (<i>diroximel fumarate</i>)	4	PA; LD; QL (4 capsules per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>dalfampridine er oral tablet extended release 12 hour</i>	1 or 1b*	PA; QL (2 tablets per 1 day); SP
*MULTIPLE SCLEROSIS AGENTS**** - DRUGS FOR MULTIPLE SCLEROSIS		
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (<i>glatiramer acetate</i>)	4	PA; QL (12 syringe per 28 days); SP
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml</i>	4	PA; QL (1 syringe per 1 day); SP
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	4	PA; QL (12 syringe per 28 days); SP
<i>glatopa subcutaneous solution prefilled syringe 20 mg/ml</i>	4	PA; QL (1 syringe per 1 day); SP
<i>glatopa subcutaneous solution prefilled syringe 40 mg/ml</i>	4	PA; QL (12 syringe per 28 days); SP
*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR ALZHEIMER'S DISEASE		
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 7 mg</i>	2	DO
<i>memantine hcl er oral capsule extended release 24 hour 21 mg, 28 mg</i>	2	QL (1 capsule per 1 day)
<i>memantine hcl oral solution</i>	2	QL (10 mL per 1 day)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>memantine hcl oral tablet 10 mg</i>	2	QL (2 tablets per 1 day)
<i>memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg</i>	2	QL (1 tablet per 6 months)
<i>memantine hcl oral tablet 5 mg</i>	2	DO
*PHENOTHIAZINES & TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION		
<i>perphenazine-amitriptyline oral tablet</i>	1 or 1b*	AL
*POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN		
<i>gabapentin (once-daily) oral tablet</i>	2	PA; DO
<i>pregabalin er oral tablet extended release 24 hour 165 mg, 82.5 mg</i>	2	PA; DO
<i>pregabalin er oral tablet extended release 24 hour 330 mg</i>	2	PA; QL (2 tablets per 1 day)
*PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS*** - DRUGS FOR DEPRESSION		
<i>fluoxetine hcl (pmd) oral tablet 10 mg</i>	1 or 1b*	DO
<i>fluoxetine hcl (pmd) oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>pimozide oral tablet 1 mg</i>	1 or 1b*	AL; QL (10 tablets per 1 day)
<i>pimozide oral tablet 2 mg</i>	1 or 1b*	AL; QL (5 tablets per 1 day)
*SMOKING DETERRENENTS*** - DRUGS FOR DEPRESSION		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour</i>	1 or 1b*; \$0	PA; QL (2 tablets per 1 day)
NICOTROL NS NASAL SOLUTION (<i>nicotine</i>)	2; \$0	PA; QL (4 mL per 1 day)
<i>varenicline tartrate (starter) oral tablet therapy pack</i>	2; \$0	QL (53 dose pack per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg</i>	2; \$0	PA; QL (2 tablets per 1 day)
<i>varenicline tartrate oral tablet 1 mg</i>	2; \$0	PA; QL (2 tablet per 1 day)
<i>varenicline tartrate(continue) oral tablet</i>	2; \$0	PA; QL (2 tablet per 1 day)
*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS*** - DRUGS FOR MULTIPLE SCLEROSIS		
<i>fingolimod hcl oral capsule</i>	4	PA; QL (1 capsule per 1 day); SP
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (4 tablets per 1 day); SP
MAYZENT ORAL TABLET 1 MG, 2 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 tablet per 1 day); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 pack per 1 one time fill); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
ZEPOSIA ORAL CAPSULE (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 capsule per 1 day); SP

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK (<i>ozanimod hcl</i>)	4	PA; LD; QL (1 pack per 1 fill); SP
*THIENBENZODIAZEPINES & SSRIS*** - DRUGS FOR SEVERE MENTAL DISORDERS		
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg</i>	1 or 1b*	AL; QL (1 capsule per 1 day)
<i>olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg</i>	1 or 1b*	DO; AL
*VASOMOTOR SYMPTOM AGENTS - SSRIS*** - DRUGS FOR THE NERVOUS SYSTEM		
<i>paroxetine mesylate oral capsule</i>	1 or 1b*	
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS		
*CYSTIC FIBROSIS AGENT - COMBINATIONS*** - DRUGS FOR CYSTIC FIBROSIS		
TRIKAFTA ORAL TABLET THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	4	PA; LD; QL (1 carton per 28 days); SP
TRIKAFTA ORAL THERAPY PACK (<i>elexacaftor-tezacaftor-ivacaft</i>)	4	PA; LD; QL (1 carton per 28 days); SP
*HYDROLYTIC ENZYMES*** - DRUGS FOR THE LUNGS		
PULMOZYME INHALATION SOLUTION (<i>dornase alfa</i>)	4	PA; LD; QL (150 mL per 30 days); SP
*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR THE LUNGS		
OFEV ORAL CAPSULE (<i>nintedanib esylate</i>)	4	PA; LD; QL (2 capsules per 1 day); SP
*PULMONARY FIBROSIS AGENTS*** - DRUGS FOR THE LUNGS		
<i>pirfenidone oral capsule</i>	4	PA; QL (9 capsule per 1 day); SP
<i>pirfenidone oral tablet 267 mg</i>	4	PA; QL (9 tablets per 1 day); SP
<i>pirfenidone oral tablet 534 mg</i>	4	PA; QL (3 tablets per 1 day)
<i>pirfenidone oral tablet 801 mg</i>	4	PA; QL (3 tablets per 1 day); SP
SULFONAMIDES - DRUGS FOR INFECTIONS		
*SULFONAMIDES*** - ANTIBIOTICS		
<i>sulfadiazine oral tablet</i>	2	
TETRACYCLINES - DRUGS FOR INFECTIONS		
*TETRACYCLINES*** - ANTIBIOTICS		
<i>demeclocycline hcl oral tablet</i>	2	
<i>doxy 100 intravenous solution reconstituted</i>	2	QL (2 vials per 1 day)
<i>doxycycline hyclate intravenous solution reconstituted</i>	2	QL (2 vials per 1 day)
<i>doxycycline hyclate oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>doxycycline monohydrate oral capsule 150 mg</i>	3	ST; QL (1 capsule per 1 day)
<i>doxycycline monohydrate oral suspension reconstituted</i>	1 or 1b*	QL (600 mL per 30 days)

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>doxycycline monohydrate oral tablet 150 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>minocycline hcl oral capsule 100 mg, 75 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>minocycline hcl oral capsule 50 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>minocycline hcl oral tablet 100 mg, 75 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>minocycline hcl oral tablet 50 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>mondoxyne nl oral capsule</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>tetracycline hcl oral capsule</i>	1 or 1b*	QL (4 capsules per 1 day)
THYROID AGENTS - HORMONES		
*ANTITHYROID AGENTS*** - DRUGS FOR THYROID		
<i>methimazole oral tablet</i>	1 or 1a*	
<i>propylthiouracil oral tablet</i>	1 or 1b*	
*THYROID HORMONES*** - DRUGS FOR THYROID		
<i>levo-t oral tablet</i>	1 or 1b*	
<i>levothyroxine sodium oral capsule</i>	2	
<i>levothyroxine sodium oral tablet</i>	1 or 1a*	
<i>levoxyl oral tablet</i>	1 or 1a*	
<i>liothyronine sodium</i> (Liomny Oral Tablet)	1 or 1b*	
<i>liothyronine sodium intravenous solution</i>	1 or 1b*	
<i>liothyronine sodium oral tablet</i>	1 or 1b*	
<i>unithroid oral tablet</i>	1 or 1a*	
TOXOIDS - BIOLOGICAL AGENTS		
*TOXOID COMBINATIONS*** - VACCINES		
ADACEL INTRAMUSCULAR SUSPENSION (<i>tetanus-diphth-acell pertussis</i>)	2; \$0	
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tetanus-diphth-acell pertussis</i>)	2; \$0	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tetanus-diphth-acell pertussis</i>)	2; \$0	
DAPTACEL INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	2; \$0	
INFANRIX INTRAMUSCULAR SUSPENSION (<i>diphth-acell pertussis-tetanus</i>)	2; \$0	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	2; \$0	
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-hepatitis b recomb-ipv</i>)	2; \$0	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>dtap-ipv-hib vaccine</i>)	2; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION (<i>dtap-ipv vaccine</i>)	2; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv vaccine</i>)	2; \$0	
TENIVAC INTRAMUSCULAR SUSPENSION (<i>tetanus-diphtheria toxoids td</i>)	2; \$0	
VAXELIS INTRAMUSCULAR SUSPENSION (<i>dtap-ipv-hib-hepatitis b recmb</i>)	2	
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	2	
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR THE STOMACH		
*ANTICHOLINERGIC COMBINATIONS*** - DRUGS FOR STOMACH CRAMPS		
<i>chlordiazepoxide-clidinium oral capsule</i>	1 or 1b*	
*ANTISPASMODICS*** - DRUGS FOR STOMACH CRAMPS		
<i>dicyclomine hcl intramuscular solution</i>	2	
<i>dicyclomine hcl oral capsule</i>	1 or 1a*	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	1 or 1a*	
<i>dicyclomine hcl oral tablet 20 mg</i>	1 or 1a*	
*H-2 ANTAGONISTS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>cimetidine hcl oral solution</i>	1 or 1b*	
<i>cimetidine oral tablet 300 mg, 400 mg, 800 mg</i>	1 or 1b*	
<i>famotidine (pf) intravenous solution</i>	1 or 1b*	
<i>famotidine intravenous solution</i>	1 or 1b*	
<i>famotidine oral suspension reconstituted</i>	1 or 1b*	
<i>famotidine oral tablet 40 mg</i>	1 or 1b*	
<i>famotidine premixed intravenous solution</i>	1 or 1b*	
<i>nizatidine oral capsule</i>	1 or 1b*	
*MISC. ANTI-ULCER*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>sucralfate oral suspension</i>	2	
<i>sucralfate oral tablet</i>	1 or 1b*	
*PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>esomeprazole magnesium oral capsule delayed release 40 mg</i>	1 or 1b*	
<i>esomeprazole magnesium oral packet</i>	1 or 1b*	
<i>lansoprazole oral capsule delayed release 15 mg</i>	1 or 1b*	BE
<i>lansoprazole oral capsule delayed release 30 mg</i>	1 or 1b*	
<i>omeprazole oral capsule delayed release</i>	1 or 1b*	
<i>pantoprazole sodium oral tablet delayed release</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*QUATERNARY ANTICHOLINERGICS*** - DRUGS FOR STOMACH CRAMPS		
<i>glycopyrrolate injection solution</i>	1 or 1b*	
<i>glycopyrrolate oral solution</i>	2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1 or 1b*	
<i>glycopyrrolate pf +rfid injection solution prefilled syringe</i>	1 or 1b*	
GLYCOPYRROLATE PF INJECTION SOLUTION PREFILLED SYRINGE 0.2 MG/ML, 0.4 MG/2ML	1 or 1b*	
<i>methscopolamine bromide oral tablet</i>	1 or 1b*	
*ULCER ANTI-INFECTIVE W/ BISMUTH COMBINATIONS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>bis subcit-metronid-tetracyc oral capsule</i>	2	ST; QL (1 pack per 1 fill)
<i>bismuth/metronidaz/tetracyclin oral capsule</i>	2	ST; QL (1 pack per 1 fill)
*ULCER DRUGS - PROSTAGLANDINS*** - DRUGS FOR ULCERS AND STOMACH ACID		
<i>misoprostol oral tablet</i>	1 or 1a*	\$0 for Fully insured members in California
URINARY ANTISPASMODICS - DRUGS FOR THE URINARY SYSTEM		
*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)*** - DRUGS FOR THE BLADDER		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>fesoterodine fumarate er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>oxybutynin chloride oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>oxybutynin chloride oral tablet 2.5 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>oxybutynin chloride oral tablet 5 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>solifenacin succinate oral tablet</i>	2	QL (1 tablet per 1 day)
<i>tolterodine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>tolterodine tartrate oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>tropium chloride er oral capsule extended release 24 hour</i>	2	QL (1 capsule per 1 day)
<i>tropium chloride oral tablet</i>	2	QL (2 tablets per 1 day)
*URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>mirabegron er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (<i>mirabegron</i>)	3	PA; QL (3 bottles per 30 days)
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** - DRUGS FOR THE BLADDER		
<i>bethanechol chloride oral tablet</i>	2	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug BE= Benefit Exclusion DO=Dose Optimization LD=Limited Distribution OC=Oral Chemotherapy PA=Prior Authorization QL=Quantity Limit SP=Specialty Pharmacy ST=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** - DRUGS FOR THE BLADDER		
<i>flavoxate hcl oral tablet</i>	1 or 1b*	
VACCINES - BIOLOGICAL AGENTS		
*BACTERIAL VACCINES*** - VACCINES		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	2; \$0	
BCG VACCINE INJECTION SOLUTION RECONSTITUTED	2; \$0	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b recomb omv adj</i>)	2; \$0	
BIOTHRAX INTRAMUSCULAR SUSPENSION (<i>anthrax vaccine adsorbed</i>)	2	
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>pneumococcal 21-valent conjuga</i>)	2; \$0	
HIBERIX INJECTION SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	2; \$0	
MENQUADFI INTRAMUSCULAR SOLUTION (<i>mening acy&w-135 tetanus conj</i>)	2; \$0	
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	2; \$0	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	2; \$0	
PEDVAX HIB INTRAMUSCULAR SUSPENSION (<i>haemophilus b polysac conj vac</i>)	2; \$0	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	2; \$0	
<i>penmenvy intramuscular suspension reconstituted</i>	2; \$0	
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE (<i>pneumococcal vac polyvalent</i>)	2; \$0	
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 20-val conj vacc</i>)	2; \$0	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>meningococcal b vac (recomb)</i>)	2; \$0	
TYPHIM VI INTRAMUSCULAR SOLUTION (<i>typhoid vi polysaccharide vacc</i>)	2	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>typhoid vi polysaccharide vacc</i>)	2	
VAXCHORA ORAL SUSPENSION RECONSTITUTED (<i>cholera vac live attenuated</i>)	2	
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>pneumococcal 15-val conj vacc</i>)	2; \$0	
VIVOTIF ORAL CAPSULE DELAYED RELEASE (<i>typhoid vaccine</i>)	2	
*VIRAL VACCINE COMBINATIONS*** - VACCINES		
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	2; \$0	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	2; \$0	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hepatitis a-hep b recomb vac</i>)	2; \$0	
*VIRAL VACCINES*** - VACCINES		
ABRYSCO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>rsv pre-fusion f a&b vac rcmb</i>)	2; \$0	QL (1 injection per 1 lifetime)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (<i>smallpox vaccine</i>)	2; \$0	
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	2; \$0	QL (1 mL per 1 one-time fill)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rsvpref3 vac recomb adjuvanted</i>)	2; \$0	PA; AL; QL (1 injection per 1 lifetime)
AUDENZ INTRAMUSCULAR EMULSION (<i>influenza a (h5n1) subunit adj</i>)	2; \$0	
AUDENZ INTRAMUSCULAR PREFILLED SYRINGE (<i>influenza a (h5n1) subunit adj</i>)	2; \$0	
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>dengue virus vaccine live tetr</i>)	2	
ENGERIX-B INJECTION SUSPENSION (<i>hepatitis b vac recombinant</i>)	2; \$0	
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE (<i>hepatitis b vac recombinant</i>)	2; \$0	
ERVEBO INTRAMUSCULAR SUSPENSION (<i>ebola zaire virus vaccine live</i>)	2	
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac a&b surf ant adj</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>influenza vac recombinant ha</i>)	2; \$0	QL (1 fill per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>influenza vac tiss-cult subunt</i>)	2; \$0	QL (1 fill per 180 days)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac tiss-cult subunt</i>)	2; \$0	QL (1 fill per 180 days)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	2; \$0	QL (1 fill per 180 days)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza vac split high-dose</i>)	2; \$0	QL (1 mL per 1 one-time fill)

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	2; \$0	QL (1 mL per 1 one-time fill)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>influenza virus vacc split pf</i>)	2; \$0	QL (1 mL per 1 one-time fill)
GARDASIL 9 INTRAMUSCULAR SUSPENSION (<i>hpv 9-valent recomb vaccine</i>)	2; \$0	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hpv 9-valent recomb vaccine</i>)	2; \$0	
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hepatitis a vaccine</i>)	2; \$0	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (<i>hepatitis b vac recomb adj</i>)	2; \$0	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies virus vaccine, hdc</i>)	2	
IPOL INJECTION SUSPENSION (<i>poliovirus vaccine inactivated</i>)	2; \$0	
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>chikungunya virus vaccine live</i>)	2	
IXIARO INTRAMUSCULAR SUSPENSION (<i>japanese encephalitis vac inac</i>)	2	
JYNNEOS SUBCUTANEOUS SUSPENSION (<i>smallpox & monkeypox vac, live</i>)	2; \$0	
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>rsv mrna pre-f virus vaccine</i>)	2; \$0	AL; QL (1 syringe per 1 lifetime)
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies vaccine, pcec</i>)	2	
RECOMBIVAX HB INJECTION SUSPENSION (<i>hepatitis b vac recombinant</i>)	2; \$0	
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (<i>hepatitis b vac recombinant</i>)	2; \$0	
ROTARIX ORAL SUSPENSION (<i>rotavirus vaccine live oral</i>)	2; \$0	
ROTATEQ ORAL SOLUTION (<i>rotavirus vac live pentavalent</i>)	2; \$0	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>zoster vac recomb adjuvanted</i>)	2; \$0	
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>covid-19 mrna virus vaccine</i>)	2; \$0	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>tick-borne encephalitis vacc</i>)	2	
VAQTA INTRAMUSCULAR SUSPENSION (<i>hepatitis a vaccine</i>)	2; \$0	
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>hepatitis a vaccine</i>)	2; \$0	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VARIVAX INJECTION SUSPENSION RECONSTITUTED (<i>varicella virus vaccine live</i>)	2; \$0	
VIMKUNYA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>chikungunya virus vac rcmb vlp</i>)	2	
YF-VAX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>yellow fever vaccine</i>)	2	
VAGINAL AND RELATED PRODUCTS - DRUGS FOR WOMEN		
*IMIDAZOLE-RELATED ANTIFUNGALS*** - DRUGS FOR INFECTIONS		
<i>miconazole 3 vaginal suppository</i>	1 or 1b*	
<i>terconazole vaginal cream 0.4 %</i>	1 or 1b*	QL (90 grams per 30 days)
<i>terconazole vaginal cream 0.8 %</i>	1 or 1b*	QL (40 grams per 30 days)
<i>terconazole vaginal suppository</i>	1 or 1b*	QL (6 suppositories per 30 days)
*VAGINAL ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS		
CLEOCIN VAGINAL SUPPOSITORY (<i>clindamycin phosphate</i>)	2	
<i>clindamycin phosphate vaginal cream</i>	1 or 1b*	
<i>metronidazole vaginal gel</i>	1 or 1b*	
VANAZOLE VAGINAL GEL (<i>metronidazole</i>)	1 or 1b*	
*VAGINAL CONTRACEPTIVE PH MODULATOR - COMBINATIONS*** - DRUGS FOR WOMEN		
PHEXXI VAGINAL GEL (<i>lactic ac-citric ac-pot bitart</i>)	3	
*VAGINAL ESTROGENS*** - DRUGS FOR WOMEN		
<i>estradiol vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
PREMARIN VAGINAL CREAM (<i>estrogens, conjugated</i>)	2	QL (1 gm per 1 day)
<i>yuvafem vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
*VAGINAL PROGESTINS*** - DRUGS FOR WOMEN		
ENDOMETRIN VAGINAL INSERT (<i>progesterone</i>)	2	PA
VASOPRESSORS - DRUGS FOR THE HEART		
*ANAPHYLAXIS THERAPY AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>epinephrine (anaphylaxis) injection solution</i>	1 or 1b*	
<i>epinephrine injection solution auto-injector</i>	1 or 1b*	QL (2 pens per 1 fill)
*NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>droxidopa oral capsule 100 mg</i>	4	PA; QL (3 capsules per 1 day); SP
<i>droxidopa oral capsule 200 mg, 300 mg</i>	4	PA; QL (6 capsules per 1 day); SP
*VASOPRESSORS*** - DRUGS FOR SERIOUS ALLERGIC REACTION		
<i>midodrine hcl oral tablet</i>	2	

BRAND=Brand drug **generic**=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMINS - DRUGS FOR NUTRITION		
*VITAMIN B-1*** - DRUGS FOR NUTRITION		
<i>thiamine hcl injection solution</i>	1 or 1b*	
*VITAMIN D*** - DRUGS FOR NUTRITION		
<i>ergocalciferol oral capsule</i>	1 or 1a*	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	1 or 1a*	
*VITAMIN K*** - DRUGS FOR NUTRITION		
<i>phytonadione injection solution</i>	1 or 1b*	
<i>phytonadione oral tablet</i>	2	
<i>vitamin k1 injection solution</i>	1 or 1b*	

BRAND=Brand drug *generic*=generic drug *Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a***=Drugs with the lowest cost share **Tier 1 or 1b***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **BE**= Benefit Exclusion **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 10012025

Index

<i>abacavir sulfate</i>	65	<i>alyacen 7/7/7</i>	78	<i>ashlyna</i>	77
<i>abacavir sulfate-lamivudine</i>	64	<i>alyq</i>	72	<i>aspirin-dipyridamole er</i>	97
Abigale	92	<i>amantadine hcl</i>	60	ATABEX EC	110
Abigale Lo	92	<i>ambrisentan</i>	71	ATABEX OB	110
<i>abiraterone acetate</i>	54	<i>amethyst</i>	77	<i>atazanavir sulfate</i>	65
Abirtega	54	<i>amikacin sulfate</i>	20	<i>atenolol</i>	68
ABRYSVO	127	<i>amiloride hcl</i>	88	<i>atenolol-chlorthalidone</i>	51
ACAM2000	127	<i>amiloride-hydrochlorothiazide</i>	88	<i>atomoxetine hcl</i>	18
<i>acamprosate calcium</i>	118	<i>aminocaproic acid</i>	99	<i>atorvastatin calcium</i>	47
<i>acarbose</i>	39	<i>aminophylline</i>	32	<i>atovaquone</i>	52
<i>accutane</i>	81	<i>aminosyn ii</i>	112	<i>atovaquone-proguanil hcl</i>	53
<i>acebutolol hcl</i>	68	<i>amiodarone hcl</i>	29	<i>atracurium besylate</i>	112
<i>acetaminophen</i>	23	<i>amitriptyline hcl</i>	38	ATROVENT HFA	31
<i>acetaminophen-codeine</i>	24	<i>amlodipine besy-benazepril hcl</i>	48	<i>aubra eq</i>	74
<i>acetazolamide</i>	88	<i>amlodipine besylate</i>	69	AUDENZ	127
<i>acetazolamide er</i>	88	<i>amlodipine besylate-valsartan</i>	49	AUGMENTIN	117
<i>acetazolamide sodium</i>	88	<i>amlodipine-atorvastatin</i>	71	<i>aurovela 1.5/30</i>	74
<i>acetic acid</i>	95, 116	<i>amlodipine-olmesartan</i>	49	<i>aurovela 1/20</i>	74
<i>acetylcysteine</i>	43, 80	<i>amlodipine-valsartan-hctz</i>	50	<i>aurovela 24 fe</i>	74
<i>acitretin</i>	82, 83	<i>amnesteem</i>	81	<i>aurovela fe 1.5/30</i>	74
ACTHIB	126	Amnesteem	81	<i>aurovela fe 1/20</i>	74
ACTIMMUNE	57	<i>amoxapine</i>	38	AUSTEDO	119
<i>acyclovir</i>	66, 84	<i>amoxicillin</i>	117	AUSTEDO XR	119
<i>acyclovir sodium</i>	67	<i>amoxicillin-pot clavulanate</i>	117	AUSTEDO XR PATIENT	
ADACEL	123	<i>amoxicillin-pot clavulanate er</i>	117	TITRATION	119
<i>adapalene</i>	81	<i>amphetamine sulfate</i>	18	AVASTIN	59
<i>adapalene-benzoyl peroxide</i>	81	<i>amphetamine-dextroamphet er</i>	18	AVERI	74
<i>adefovir dipivoxil</i>	66	<i>amphetamine-dextroamphetamine</i>	18	<i>aviane</i>	74
ADEMPAS	71	<i>amphet-dextroamphet 3-bead er</i>	18	AVONEX PEN	119
<i>adenosine</i>	28	<i>amphotericin b</i>	45	AVONEX PREFILLED	119
<i>afirmelle</i>	74	<i>amphotericin b liposome</i>	45	AVSOLA	95
AFLURIA	127	<i>ampicillin</i>	117	<i>ayuna</i>	74
AFLURIA PRESERVATIVE FREE	127	<i>ampicillin sodium</i>	117	<i>azasan</i>	108
AIMOVIG	104	<i>ampicillin-sulbactam sodium</i>	117	<i>azathioprine</i>	108
AJOVY	104	<i>anagrelide hcl</i>	97	<i>azelaic acid</i>	87
<i>ak-fluor</i>	114	ANASCORP	116	<i>azelastine hcl</i>	112, 113
<i>ala-cort</i>	84	<i>anastrozole</i>	57	<i>azelastine-fluticasone</i>	111
<i>albendazole</i>	27	ANNOVERA	77	<i>azithromycin</i>	101
<i>albuterol sulfate</i>	30	ANTIVENIN LATRODECTUS		<i>aztreonam</i>	52
ALBUTEROL SULFATE	30	MACTANS	116	<i>azurette</i>	73
<i>albuterol sulfate hfa</i>	30	ANTIVENIN MICRURUS FULVIUS	116	<i>bac (butalbital-acetamin-caff)</i>	24
<i>alclometasone dipropionate</i>	84	<i>apap-caff-dihydrocodeine</i>	24	<i>bacitracin</i>	113
ALECENSA	54	<i>apomorphine hcl</i>	60	<i>bacitracin-polymyxin b</i>	113
<i>alendronate sodium</i>	89	<i>apraclonidine hcl</i>	114	<i>bacitra-neomycin-polymyxin-hc</i>	115
<i>alfuzosin hcl er</i>	95	<i>aprepitant</i>	44, 45	<i>baclofen</i>	111
<i>aliskiren fumarate</i>	51	<i>apri</i>	74	<i>balsalazide disodium</i>	93
<i>allopurinol</i>	96	APTIVUS	65	<i>balziva</i>	74
<i>allopurinol sodium</i>	96	<i>aq insulin syringe</i>	103	BAQSIMI ONE PACK	39
<i>almotriptan malate</i>	105	<i>aqinject pen needle</i>	103	BAQSIMI TWO PACK	39
<i>alogliptin benzoate</i>	39	<i>aquastat</i>	106	BARACLUDGE	66
<i>alogliptin-metformin hcl</i>	39	Aquastat Sfr	106	BCG VACCINE	126
<i>alogliptin-pioglitazone</i>	40	<i>aranelle</i>	78	<i>bd heparin posiflush</i>	33
<i>alose tron hcl</i>	93	ARANESP (ALBUMIN FREE)	98	BD INSULIN SYRINGE	103
<i>alprazolam</i>	28	AREXVY	127	BD INSULIN SYRINGE	
<i>alprazolam er</i>	28	<i>arformoterol tartrate</i>	30	MICROFINE	103
<i>alprazolam xr</i>	28	<i>argyle sterile saline</i>	95	BD INSULIN SYRINGE U-500	103
<i>alprostadil</i>	71	<i>argyle sterile water</i>	107	<i>bd posiflush</i>	106
<i>altafluor benox</i>	114	<i>aripiprazole</i>	63	Bd Posiflush Safescrub	106
<i>altavera</i>	74	<i>armodafinil</i>	19	BD SAFETYGLIDE INSULIN	
ALUNBRIG	55	ARNUITY ELLIPTA	32	SYRINGE	103
<i>alvimopan</i>	94	<i>ascomp-codeine</i>	24	<i>benazepril hcl</i>	48
<i>alyacen 1/35</i>	74	<i>asenapine maleate</i>	62	<i>benazepril-hydrochlorothiazide</i>	48

<i>benzonatate</i>	80	<i>butorphanol tartrate</i>	26	<i>chateal eq</i>	74
<i>benzoyl peroxide-erythromycin</i>	81	BYOOVIZ	115	<i>chloramphenicol sod succinate</i>	52
<i>benzphetamine hcl</i>	19	<i>cabergoline</i>	89	<i>chlordiazepoxide hcl</i>	28
<i>benztropine mesylate</i>	60	CABOMETYX	56	<i>chlordiazepoxide-amitriptyline</i>	118
BERINERT	96	<i>caffeine citrate</i>	19	<i>chlordiazepoxide-clidinium</i>	124
<i>betaine</i>	90	<i>calcipotriene</i>	83	<i>chlorhexidine gluconate</i>	108
<i>betamethasone dipropionate</i>	84	<i>calcipotriene-betameth diprop</i>	87	<i>chlorprocaine hcl (pf)</i>	101
<i>betamethasone dipropionate aug</i>	84	<i>calcitonin (salmon)</i>	89	<i>chloroquine phosphate</i>	53
<i>betamethasone valerate</i>	84	<i>calcitrene</i>	83	<i>chlorothiazide sodium</i>	88
BETASERON	119	<i>calcitriol</i>	84, 90	<i>chlorpromazine hcl</i>	62, 63
<i>betaxolol hcl</i>	68, 112	<i>calcium acetate</i>	94	CHLORPROMAZINE HCL	62, 63
<i>bethanechol chloride</i>	125	<i>calcium acetate (phos binder)</i>	94	<i>chlorthalidone</i>	88
BETOPTIC-S	112	CALQUENCE	55	<i>chlorzoxazone</i>	111
<i>bexarotene</i>	59, 87	<i>camila</i>	78	<i>cholestyramine</i>	46
BEXSERO	126	<i>camrese</i>	77	<i>cholestyramine light</i>	46
<i>bicalutamide</i>	54	<i>camrese lo</i>	77	<i>ciclodan</i>	82
BIJUVA	92	<i>candesartan cilexetil</i>	50	<i>ciclopirox</i>	82
BIKTARVY	64	<i>candesartan cilexetil-hctz</i>	49	<i>ciclopirox olamine</i>	82
<i>bimatoprost</i>	115	<i>capecitabine</i>	54	<i>cilostazol</i>	97
BIOTHRAX	126	CAPLYTA	61	CIMDUO	64
<i>bis subcit-metronid-tetracyc</i>	125	CAPRELSA	56	CIMERLI	115
<i>bismuth/metronidaz/tetracyclin</i>	125	<i>captopril</i>	48	<i>cimetidine</i>	124
<i>bisoprolol fumarate</i>	68	<i>captopril-hydrochlorothiazide</i>	48	<i>cimetidine hcl</i>	124
<i>bisoprolol-hydrochlorothiazide</i>	51	CAPVAXIVE	126	<i>cinacalcet hcl</i>	89
<i>blisovi 24 fe</i>	74	<i>carbamazepine</i>	34	<i>ciprofloxacin hcl</i>	92, 113, 116
<i>blisovi fe 1.5/30</i>	74	<i>carbamazepine er</i>	34	<i>ciprofloxacin in d5w</i>	92
<i>blisovi fe 1/20</i>	74	<i>carbidopa</i>	60	<i>ciprofloxacin-dexamethasone</i>	116
BOOSTRIX	123	<i>carbidopa-levodopa</i>	60	<i>ciprofloxacin-fluocinolone pf</i>	116
<i>bosentan</i>	71	<i>carbidopa-levodopa er</i>	60	<i>cisatracurium besylate</i>	112
BOSULIF	55	<i>carbidopa-levodopa-entacapone</i>	60	<i>cisatracurium besylate (pf)</i>	112
<i>b-plex</i>	109	<i>carbinoxamine maleate</i>	45	<i>citalopram hydrobromide</i>	37
BREO ELLIPTA	29	<i>carbinoxamine maleate er</i>	45	<i>claravis</i>	81
Breyna	29	<i>carboprost tromethamine</i>	116	<i>clarithromycin</i>	101
BREZTRI AEROSPHERE	29	<i>carbzah</i>	45	<i>clarithromycin er</i>	101
<i>briellyn</i>	74	<i>carglumic acid</i>	90	<i>clemastine fumarate</i>	45
BRILINTA	97	<i>carisoprodol</i>	111	CLEOCIN	129
<i>brimonidine tartrate</i>	87, 115	<i>carteolol hcl</i>	112	CLIMARA PRO	92
<i>brimonidine tartrate-timolol</i>	112	<i>cartia xt</i>	69	Clindacin	81
<i>brinzolamide</i>	114	<i>carvedilol</i>	67	<i>clindacin etz</i>	81
BRIXADI	26	<i>carvedilol phosphate er</i>	67	<i>clindacin-p</i>	81
BRIXADI (WEEKLY)	26	CAYA	102	<i>clindamycin hcl</i>	52
<i>bromfenac sodium</i>	114	<i>cefaclor</i>	72, 73	<i>clindamycin palmitate hcl</i>	52
<i>bromfenac sodium (once-daily)</i>	114	CEFACTOR ER	72	<i>clindamycin phos (once-daily)</i>	81
<i>bromocriptine mesylate</i>	60	<i>cefadroxil</i>	72	<i>clindamycin phos (twice-daily)</i>	81
<i>budesonide</i>	27, 32, 79	<i>cefazolin sodium</i>	72	<i>clindamycin phos-benzoyl perox</i>	81
<i>budesonide er</i>	79	<i>cefdinir</i>	73	<i>clindamycin phosphate</i>	52, 81, 129
<i>budesonide-formoterol fumarate</i>	29	<i>cefepime hcl</i>	73	<i>clindamycin phosphate in d5w</i>	52
<i>bumetanide</i>	88	<i>cefixime</i>	73	<i>clindamycin-tretinoin</i>	81
<i>bupivacaine hcl (pf)</i>	101	<i>cefotetan disodium</i>	73	<i>clinisol sf</i>	112
<i>bupivacaine-epinephrine (pf)</i>	101	<i>cefoxitin sodium</i>	73	<i>clinpro 5000</i>	109
<i>buprenorphine</i>	26	<i>cefprozil</i>	73	<i>clobazam</i>	34
<i>buprenorphine hcl</i>	26	<i>ceftazidime</i>	73	<i>clobetasol propionate</i>	84, 85
<i>buprenorphine hcl-naloxone hcl</i>	26	<i>ceftriaxone sodium</i>	73	<i>clobetasol propionate e</i>	84
<i>bupropion hcl</i>	37	<i>ceftriaxone sodium in dextrose</i>	73	<i>clobetasol propionate emulsion</i>	84
<i>bupropion hcl er (smoking det)</i>	121	<i>cefuroxime axetil</i>	73	<i>clodan</i>	85
<i>bupropion hcl er (sr)</i>	37	<i>cefuroxime sodium</i>	73	Clomid	91
<i>bupropion hcl er (xl)</i>	37	<i>celecoxib</i>	22	<i>clomiphene citrate</i>	91
<i>buspirone hcl</i>	28	<i>cephalexin</i>	72	<i>clomipramine hcl</i>	38
<i>butalbital-acetaminophen</i>	24	CERDELGA	98	<i>clonazepam</i>	34
<i>butalbital-apap-caff-cod</i>	24	<i>cetirizine hcl</i>	46	<i>clonidine</i>	51
<i>butalbital-apap-caffeine</i>	24	<i>cevimeline hcl</i>	109	<i>clonidine hcl</i>	50, 51
<i>butalbital-asa-caff-codeine</i>	24	<i>charlotte 24 fe</i>	74	<i>clonidine hcl er</i>	18
<i>butalbital-aspirin-caffeine</i>	24			<i>clopidogrel bisulfate</i>	97

<i>clorazepate dipotassium</i>	28	<i>deblitane</i>	78	DILANTIN.....	36
<i>clotrimazole</i>	108	<i>deferasirox</i>	43	<i>diltiazem hcl</i>	69
<i>clotrimazole-betamethasone</i>	82	<i>deferasirox granules</i>	43	<i>diltiazem hcl er</i>	69
<i>clozapine</i>	62	<i>deferiprone</i>	43	<i>diltiazem hcl er beads</i>	69
C-NATE DHA.....	110	<i>dehydrated alcohol</i>	72	<i>diltiazem hcl er coated beads</i>	69
<i>coal tar</i>	87	<i>delyla</i>	74	<i>dilt-xr</i>	69
<i>codeine sulfate</i>	24	<i>demeclocycline hcl</i>	122	<i>dimethyl fumarate</i>	120
<i>colchicine</i>	96	DENGVAXIA.....	127	<i>dimethyl fumarate starter pack</i>	120
<i>colchicine-probenecid</i>	96	<i>denta 5000 plus</i>	109	<i>diphenhydramine hcl</i>	46
<i>colesevelam hcl</i>	46	<i>dentagel</i>	109	<i>diphenoxylate-atropine</i>	43
<i>colestipol hcl</i>	46	DEPO-SUBQ PROVERA 104.....	78	<i>dipyridamole</i>	97
<i>colistimethate sodium (cba)</i>	52	DEPO-TESTOSTERONE.....	26	<i>disopyramide phosphate</i>	29
COMBIPATCH.....	92	DESCOVY.....	64	<i>disulfiram</i>	118
COMBIVENT RESPIMAT.....	29	<i>desflurane</i>	95	<i>divalproex sodium</i>	36
COMETRIQ (100 MG DAILY DOSE).....	56	<i>desipramine hcl</i>	38	<i>divalproex sodium er</i>	36
COMETRIQ (140 MG DAILY DOSE).....	56	<i>desloratadine</i>	46	<i>dobutamine hcl</i>	71
COMETRIQ (60 MG DAILY DOSE).....	57	<i>desmopressin ace spray refrig</i>	91	<i>dofetilide</i>	29
COMIRNATY.....	127	<i>desmopressin acetate</i>	91	<i>dolishale</i>	77
COMIRNATY 5-11 YEARS.....	127	<i>desmopressin acetate pf</i>	91	<i>donepezil hcl</i>	118
COMPLETE NATAL DHA.....	110	<i>desmopressin acetate spray</i>	91	<i>dorzolamide hcl</i>	114
COMPLETENATE.....	110	<i>desogestrel-ethinyl estradiol</i>	73	<i>dorzolamide hcl-timolol mal</i>	112
<i>compro</i>	63	<i>desonide</i>	85	<i>dorzolamide hcl-timolol mal pf</i>	112
CO-NATAL FA.....	110	<i>desvenlafaxine succinate er</i>	38	<i>dotti</i>	92
CONCEPT DHA.....	110	<i>dexameth sod phos (pf) +rfid</i>	79	DOVATO.....	64
CONCEPT OB.....	110	<i>dexamethasone</i>	79	<i>doxazosin mesylate</i>	51
<i>constulose</i>	101	DEXAMETHASONE INTENSOL.....	79	<i>doxepin hcl</i>	38, 82, 100
COPAXONE.....	120	DEXAMETHASONE SOD PHOS		<i>doxercalciferol</i>	90
COSENTYX.....	83	(PF).....	79	<i>doxy 100</i>	122
COSENTYX (300 MG DOSE).....	83	<i>dexamethasone sod phos +rfid</i>	79	<i>doxycycline hyclate</i>	122
COSENTYX SENSOREADY (300		<i>dexamethasone sodium phosphate</i> 79, 115		<i>doxycycline monohydrate</i>	122, 123
MG).....	83	DEXAMETHASONE SODIUM		<i>doxylamine-pyridoxine</i>	44
COSENTYX SENSOREADY PEN.....	83	PHOSPHATE.....	79	<i>dronabinol</i>	44
COSENTYX UNOREADY.....	83	DEXCOM G6 RECEIVER.....	102	<i>droperidol</i>	28
CREON.....	87	DEXCOM G6 SENSOR.....	102	DROPSAFE SAFETY	
CROFAB.....	116	DEXCOM G6 TRANSMITTER.....	102	SYRINGE/NEEDLE.....	103
<i>cromolyn sodium</i>	30, 93, 113	DEXCOM G7 15 DAY SENSOR.....	102	<i>drospiren-eth estrad-levomefol</i>	74
<i>croton</i>	87	DEXCOM G7 RECEIVER.....	102	<i>drospirenone-ethinyl estradiol</i>	74
<i>cryselle-28</i>	74	DEXCOM G7 SENSOR.....	102	DROXIA.....	98
<i>curity sterile saline</i>	95	<i>dexmedetomidine hcl</i>	100	<i>droxidopa</i>	129
CUTAQUIG.....	116	<i>dexmedetomidine hcl in nacl</i>	100	<i>duloxetine hcl</i>	38
<i>cyanocobalamin</i>	98	<i>dexmethylphenidate hcl</i>	19	DUPIXENT.....	84
<i>cyclobenzaprine hcl</i>	111	<i>dexmethylphenidate hcl er</i>	19	<i>dutasteride</i>	95
<i>cyclopentolate hcl</i>	113	<i>dextroamphetamine sulfate</i>	18	<i>dutasteride-tamsulosin hcl</i>	96
<i>cyclophosphamide</i>	58	<i>dextroamphetamine sulfate er</i>	18	<i>e.e.s. 400</i>	101
<i>cycloserine</i>	53	<i>dextrose</i>	112	<i>easygel</i>	109
<i>cyclosporine</i>	107, 114	<i>dextrose in lactated ringers</i>	105	<i>ec-naproxen</i>	22
<i>cyclosporine modified</i>	107	<i>dextrose-sodium chloride</i>	105	<i>econazole nitrate</i>	86
<i>cyproheptadine hcl</i>	46	<i>diazepam</i>	28, 34	EDURANT.....	65
<i>cyred eq</i>	74	<i>diazepam intensol</i>	28	EDURANT PED.....	65
CYSTARAN.....	115	<i>diazoxide</i>	39	<i>efavirenz</i>	65
<i>dalfampridine er</i>	120	<i>dichlorphenamide</i>	88	<i>efavirenz-emtricitab-tenofo df</i>	64
<i>danazol</i>	26	<i>diclofenac potassium</i>	22	<i>efavirenz-lamivudine-tenofovir</i>	64
<i>dantrolene sodium</i>	111	<i>diclofenac sodium</i>	22, 82, 114	<i>eletriptan hydrobromide</i>	105
<i>dapagliflozin pro-metformin er</i>	42	<i>diclofenac sodium er</i>	22	<i>elinest</i>	74
<i>dapagliflozin propanediol</i>	42	<i>diclofenac-misoprostol</i>	22	ELIQUIS.....	33
<i>dapsone</i>	52, 81	<i>dicloxacillin sodium</i>	117	ELIQUIS DVT/PE STARTER PACK.....	33
DAPTACEL.....	123	<i>dicyclomine hcl</i>	124	<i>elite-ob</i>	110
<i>darifenacin hydrobromide er</i>	125	<i>diethylpropion hcl</i>	19	ELIXOPHYLLIN.....	32
<i>darunavir</i>	65	<i>diethylpropion hcl er</i>	19	ELLA.....	77
<i>dasatinib</i>	55	<i>diflunisal</i>	24	<i>eltrombopag olamine</i>	99
<i>dasetta 1/35 (28)</i>	74	<i>difluprednate</i>	115	<i>eluryng</i>	77
<i>dasetta 7/7/7</i>	78	<i>digoxin</i>	70, 71	EMBECTA INSULIN SYRINGE.....	103
<i>daysee</i>	77	<i>dihydroergotamine mesylate</i>	105		

EMBECTA INSULIN SYRINGE U-500.....	103	<i>etonogestrel-ethinyl estradiol</i>	77	<i>fluorescein-benoxinate</i>	114
EMGALITY.....	104	<i>etoposide</i>	58	<i>fluoridex</i>	109
EMGALITY (300 MG DOSE).....	104	<i>etravirine</i>	65	<i>fluoridex daily renewal</i>	109
<i>emtricitabine</i>	65	EUCRISA.....	86	<i>fluoridex enhanced whitening</i>	109
<i>emtricitabine-tenofovir df</i>	64	EVAMIST.....	92	<i>fluorimax 5000</i>	109
<i>emtricitab- rilpivir-tenofov df</i>	64	<i>everolimus</i>	56, 108	<i>fluorometholone</i>	115
EMTRIVA.....	65	<i>exemestane</i>	57	<i>fluorouracil</i>	82
Emzahn.....	78	EYLEA.....	116	<i>fluoxetine hcl</i>	37
<i>enalapril maleate</i>	48	EYLEA HD.....	115	<i>fluoxetine hcl (pmdd)</i>	121
<i>enalaprilat</i>	48	<i>ezetimibe</i>	47	<i>fluphenazine decanoate</i>	63
<i>enalapril-hydrochlorothiazide</i>	48	<i>ezetimibe-simvastatin</i>	47	<i>fluphenazine hcl</i>	63
ENBREL.....	23	<i>falmina</i>	74	<i>flurazepam hcl</i>	99
ENBREL MINI.....	23	<i>famciclovir</i>	67	<i>flurbiprofen</i>	22
ENBREL SURECLICK.....	23	<i>famotidine</i>	124	<i>flurbiprofen sodium</i>	114
<i>endocet</i>	26	<i>famotidine (pf)</i>	124	<i>fluticasone furoate ellipta</i>	32
ENDOMETRIN.....	129	<i>famotidine premixed</i>	124	<i>fluticasone furoate-vilanterol</i>	30
ENGERIX-B.....	127	FARXIGA.....	42	<i>fluticasone propionate</i>	85, 112
Enilloring.....	77	FASENRA.....	31	<i>fluticasone propionate diskus</i>	32
<i>enoxaparin sodium</i>	33	FASENRA PEN.....	31	<i>fluticasone propionate hfa</i>	32
<i>enpresse-28</i>	78	<i>febuxostat</i>	96	<i>fluticasone-salmeterol</i>	30
<i>enskyce</i>	74	Feirza 1.5/30.....	74	<i>fluvastatin sodium</i>	47
<i>entacapone</i>	61	Feirza 1/20.....	74	<i>fluvoxamine maleate</i>	37
<i>entecavir</i>	66	<i>felbamate</i>	36	<i>fluvoxamine maleate er</i>	37
ENTRESTO.....	71	<i>felodipine er</i>	69	FLUZONE.....	128
ENTYVIO.....	94	FEMCAP.....	102	FLUZONE HIGH-DOSE.....	127
<i>enulose</i>	94	FEMLYV.....	74	<i>foliac acid</i>	98
EPCLUSA.....	66	<i>fenofibrate</i>	47	FOLIVANE-OB.....	110
EPIDIOLEX.....	34	<i>fenofibrate micronized</i>	47	<i>fomepizole</i>	43
<i>epinastine hcl</i>	113	<i>fenofibric acid</i>	47	<i>fondaparinux sodium</i>	33
<i>epinephrine</i>	129	<i>fentanyl</i>	24	<i>formoterol fumarate</i>	30
<i>epinephrine (anaphylaxis)</i>	129	FENTANYL CITRATE (PF).....	24	FOSAMAX PLUS D.....	89
<i>epiphenone</i>	51	<i>fentanyl citrate (pf)</i>	24	<i>fosamprenavir calcium</i>	65
<i>eptifibatide</i>	97	FERAHEME.....	99	<i>fosaprepitant dimeglumine</i>	45
<i>ergocalciferol</i>	130	<i>ferric citrate</i>	94	<i>fosfomycin tromethamine</i>	52
<i>ergotamine-caffeine</i>	104	FERRLECIT.....	99	<i>fosinopril sodium</i>	48, 49
ERIVEDGE.....	56	<i>ferumoxytol</i>	99	<i>fosinopril sodium-hctz</i>	48
ERLEADA.....	54	<i>fesoterodine fumarate er</i>	125	<i>fosphenytoin sodium</i>	36
<i>erlotinib hcl</i>	56	<i>fidaxomicin</i>	102	FRAGMIN.....	33
<i>errin</i>	78	<i>finasteride</i>	87, 95	<i>fraiche 5000 dental</i>	109
ERVEBO.....	127	<i>fingolimod hcl</i>	121	FREESTYLE LIBRE 14 DAY READER.....	102
<i>ery</i>	81	Finzala.....	74	FREESTYLE LIBRE 14 DAY SENSOR.....	103
<i>erythromycin</i>	81, 102	FIRMAGON.....	58	FREESTYLE LIBRE 2 PLUS SENSOR.....	103
<i>erythromycin base</i>	102	FIRMAGON (240 MG DOSE).....	58	FREESTYLE LIBRE 2 READER.....	103
<i>erythromycin ethylsuccinate</i>	102	<i>flavoxate hcl</i>	126	FREESTYLE LIBRE 2 SENSOR.....	103
<i>erythromycin lactobionate</i>	102	<i>flecainide acetate</i>	29	FREESTYLE LIBRE 3 PLUS SENSOR.....	103
<i>escitalopram oxalate</i>	37	FLUAD.....	127	FREESTYLE LIBRE 3 READER.....	103
<i>eslicarbazepine acetate</i>	34	FLUARIX.....	127	FREESTYLE LIBRE 3 SENSOR.....	103
<i>esmolol hcl</i>	68	FLUBLOK.....	127	FREESTYLE LIBRE READER.....	103
<i>esomeprazole magnesium</i>	124	FLUCELVAX.....	127	<i>fresenius propoven</i>	95
<i>estarylla</i>	74	<i>fluconazole</i>	45	<i>frovatriptan succinate</i>	105
<i>estazolam</i>	99	<i>fluconazole in sodium chloride</i>	45	<i>furosemin</i>	88
<i>estradiol</i>	92, 129	<i>flucytosine</i>	45	FUZEON.....	64
<i>estradiol valerate</i>	92	<i>fludrocortisone acetate</i>	80	<i>fyavolv</i>	92
<i>estradiol-norethindrone acet</i>	92	FLULAVAL.....	127	<i>gabapentin</i>	34
<i>eszopiclone</i>	100	<i>flumazenil</i>	43	<i>gabapentin (once-daily)</i>	121
<i>ethacrynic acid</i>	88	FLUMIST.....	127	<i>galantamine hydrobromide</i>	118
<i>ethambutol hcl</i>	53	<i>fluocinolone acetonide</i>	85, 116	<i>galantamine hydrobromide er</i>	118
<i>ethosuximide</i>	36	<i>fluocinolone acetonide body</i>	85	Galbriela.....	74
<i>ethynodiol diac-eth estradiol</i>	74	<i>fluocinolone acetonide scalp</i>	85	Gallifrey.....	118
<i>etodolac</i>	22	<i>fluocinonide</i>	85		
<i>etodolac er</i>	22	<i>fluocinonide emulsified base</i>	85		
<i>etomidate</i>	95	<i>fluorescein</i>	114		
		<i>fluorescein sodium</i>	114		

GAMUNEX-C.....	117	<i>heparin sodium (porcine) pf</i>	33	<i>incassia</i>	78
GARDASIL 9.....	128	HEPLISAV-B.....	128	<i>indapamide</i>	88
<i>gatifloxacin</i>	113	HERCEPTIN.....	55	<i>indomethacin</i>	22
GAVILYTE-C.....	100	HERCEPTIN HYLECTA.....	57	<i>indomethacin er</i>	22
<i>gavilyte-g</i>	100	<i>hetastarch-nacl</i>	97	INFANRIX.....	123
Gavilyte-N With Flavor Pack.....	100	HIBERIX.....	126	INFED.....	99
<i>gefitinib</i>	56	<i>hidex 6-day</i>	79	INFLIXIMAB.....	95
<i>gemfibrozil</i>	47	HIZENTRA.....	117	INGREZZA.....	119
<i>gemmily</i>	74	HUMALOG.....	40	INLYTA.....	59
<i>generlac</i>	94	HUMALOG JUNIOR KWIKPEN.....	40	INSULIN LISPRO.....	40
<i>gengraf</i>	107	HUMALOG KWIKPEN.....	40	INSULIN LISPRO (1 UNIT DIAL).....	40
GENOTROPIN.....	90	HUMALOG MIX 50/50 KWIKPEN.....	40	INSULIN LISPRO JUNIOR	
GENOTROPIN MINIQUICK.....	90	HUMALOG MIX 75/25.....	40	KWIKPEN.....	40
<i>gentamicin in saline</i>	20	HUMALOG MIX 75/25 KWIKPEN.....	40	INSULIN LISPRO PROT & LISPRO...	40
<i>gentamicin sulfate</i>	20, 82, 113	HUMATROPE.....	90	<i>insulin syringe-needle u-100</i>	103
GENVOYA.....	64	HUMIRA (2 PEN).....	21	INSULIN SYRINGE-NEEDLE U-100	103
GILOTRIF.....	56	HUMIRA (2 SYRINGE).....	21	INTELENCE.....	65
<i>glatiramer acetate</i>	120	HUMIRA-CD/UC/HS STARTER.....	21	<i>introvale</i>	77
<i>glatopa</i>	120	HUMIRA-PSORIASIS/UVEIT		IPOL.....	128
<i>glimepiride</i>	42	STARTER.....	21	<i>ipratropium bromide</i>	31, 112
<i>glipizide</i>	42	HUMULIN R U-500 KWIKPEN.....	40	<i>ipratropium-albuterol</i>	30
<i>glipizide er</i>	42	HYCANTIN.....	59	IQIRVO.....	94
<i>glipizide-metformin hcl</i>	42	<i>hydralazine hcl</i>	51	<i>irbesartan</i>	50
GLUCAGON EMERGENCY.....	39	<i>hydrochlorothiazide</i>	88	<i>irbesartan-hydrochlorothiazide</i>	50
<i>glyburide</i>	43	<i>hydrocod poli-chlorphe poli er</i>	80	<i>iron sucrose</i>	99
<i>glyburide micronized</i>	42	<i>hydrocodone bitartrate er</i>	24	ISENTRESS.....	64
<i>glyburide-metformin</i>	42	<i>hydrocodone bit-homatrop mbr</i>	80	<i>isibloom</i>	75
<i>glycine</i>	96	<i>hydrocodone-acetaminophen</i>	24	<i>isoflurane</i>	95
<i>glycine urologic</i>	96	<i>hydrocodone-ibuprofen</i>	24	<i>isoniazid</i>	53
<i>glycopyrrolate</i>	125	<i>hydrocortisone</i>	27, 79, 85	<i>isosorb dinitrate-hydralazine</i>	71
GLYCOPYRROLATE PF.....	125	<i>hydrocortisone (perianal)</i>	27	<i>isosorbide dinitrate</i>	27
<i>glycopyrrolate pf +rfid</i>	125	<i>hydrocortisone ace-pramoxine</i>	27	<i>isosorbide mononitrate er</i>	27
<i>glydo</i>	86	<i>hydrocortisone sod suc (pf)</i>	79	<i>isotretinoin</i>	81
GLYXAMBI.....	41	<i>hydrocortisone-acetic acid</i>	116	<i>isradipine</i>	70
GONAL-F.....	90	<i>hydromet</i>	80	<i>itraconazole</i>	45
GONAL-F RFF REDIJECT.....	90	<i>hydromorphone hcl</i>	24, 25	<i>ivabradine hcl</i>	72
<i>granisetron hcl</i>	44	<i>hydromorphone hcl er</i>	24	<i>ivermectin</i>	27, 87
<i>griseofulvin microsize</i>	45	<i>hydromorphone hcl pf</i>	25	IXCHIQ.....	128
<i>griseofulvin ultramicrosize</i>	45	<i>hydroxocobalamin acetate</i>	98	IXIARO.....	128
<i>guanfacine hcl</i>	51	HYDROXYCHLOROQUINE		<i>jaimiess</i>	77
<i>guanfacine hcl er</i>	18	SULFATE.....	53	JAKAFI.....	58
GVOKE HYPOPEN 1-PACK.....	39	<i>hydroxychloroquine sulfate</i>	53	<i>jantoven</i>	32
GVOKE HYPOPEN 2-PACK.....	39	<i>hydroxyurea</i>	57	JANUMET.....	40
GVOKE KIT.....	39	<i>hydroxyzine hcl</i>	28	JANUMET XR.....	40
GVOKE PFS.....	39	<i>hydroxyzine pamoate</i>	28	JANUVIA.....	39
HAEGARDA.....	96	<i>ibandronate sodium</i>	89	JARDIANCE.....	42
<i>hailey 1.5/30</i>	75	IBRANCE.....	57	<i>jasmiel</i>	75
<i>hailey 24 fe</i>	75	<i>ibu</i>	22	Javygtor.....	91
<i>hailey fe 1.5/30</i>	75	<i>ibuprofen</i>	22	<i>jencycla</i>	78
<i>hailey fe 1/20</i>	75	<i>ibutilide fumarate</i>	29	<i>jinteli</i>	92
<i>halobetasol propionate</i>	85	<i>icatibant acetate</i>	96	<i>jolessa</i>	77
Haloette.....	77	<i>iclevia</i>	77	Joyeaux.....	75
<i>haloperidol</i>	62	<i>icosapent ethyl</i>	46	<i>juleber</i>	75
<i>haloperidol decanoate</i>	62	ILEVRO.....	114	<i>junel 1.5/30</i>	75
<i>haloperidol lactate</i>	62	<i>imatinib mesylate</i>	55	<i>junel 1/20</i>	75
HARVONI.....	66	IMBRUVICA.....	55, 56	<i>junel fe 1.5/30</i>	75
HAVRIX.....	128	<i>imipenem-cilastatin</i>	52	<i>junel fe 1/20</i>	75
<i>heather</i>	78	<i>imipramine hcl</i>	38	<i>junel fe 24</i>	75
<i>heparin (porcine) in nacl</i>	33	<i>imipramine pamoate</i>	38	<i>just right 5000</i>	109
<i>heparin na (pork) lock flsh pf</i>	33	<i>imiquimod</i>	86	JYNNEOS.....	128
<i>heparin sod (porcine) in d5w</i>	33	<i>imiquimod pump</i>	86	<i>kaitlib fe</i>	75
<i>heparin sod (pork) lock flush</i>	33	IMOVAX RABIES.....	128	KALBITOR.....	97
<i>heparin sodium (porcine)</i>	33	<i>inatal gt</i>	110	<i>kalliga</i>	75

KANJINTI.....	55	LENVIMA (24 MG DAILY DOSE).....	59	<i>loperamide hcl</i>	43
<i>kariva</i>	73	LENVIMA (4 MG DAILY DOSE).....	59	<i>lopinavir-ritonavir</i>	64
KCL (0.149%) IN NACL.....	105	LENVIMA (8 MG DAILY DOSE).....	60	<i>lorazepam</i>	28
<i>kcl (0.149%) in nacl</i>	105	<i>lessina</i>	75	<i>lorazepam intensol</i>	28
KCL (0.298%) IN NACL.....	105	<i>letrozole</i>	57	<i>loryna</i>	75
<i>kcl in dextrose-nacl</i>	105	<i>leucovorin calcium</i>	58	<i>losartan potassium</i>	50
<i>kelnor 1/35</i>	75	LEUKERAN.....	58	<i>losartan potassium-hctz</i>	50
<i>ketamine hcl</i>	95	<i>leuprolide acetate</i>	58	LOTEMAX.....	115
<i>ketoconazole</i>	45, 86	<i>levabuterol hcl</i>	30, 31	<i>loteprednol etabonate</i>	115
<i>ketodan</i>	86	<i>levabuterol tartrate</i>	31	<i>lovastatin</i>	47
<i>ketoprofen er</i>	22	<i>levamlodipine maleate</i>	70	<i>low-ogestrel</i>	75
<i>ketorolac tromethamine</i>	22, 114	<i>levetiracetam</i>	35	<i>loxapine succinate</i>	62
KETOROLAC TROMETHAMINE.....	22	<i>levetiracetam er</i>	35	<i>lo-zumandimine</i>	75
KINRIX.....	123	<i>levobunolol hcl</i>	113	<i>lubiprostone</i>	93
KISQALI (200 MG DOSE).....	57	<i>levocarnitine</i>	89	LUCENTIS.....	116
KISQALI (400 MG DOSE).....	57	<i>levocarnitine sf</i>	89	<i>luliconazole</i>	86
KISQALI (600 MG DOSE).....	57	<i>levocetirizine dihydrochloride</i>	46	LUMIGAN.....	115
Klayesta.....	82	<i>levofloxacin</i>	92, 113	<i>lurasidone hcl</i>	61
<i>klor-con</i>	106	<i>levofloxacin in d5w</i>	92	<i>lutera</i>	75
<i>klor-con 10</i>	106	<i>levonest</i>	78	<i>lyleq</i>	78
<i>klor-con m10</i>	106	<i>levonorgest-eth est & eth est</i>	77	<i>lyllana</i>	92
<i>klor-con m15</i>	106	<i>levonorgest-eth estrad 91-day</i>	77	LYNPARZA.....	59
<i>klor-con m20</i>	106	<i>levonorgest-eth estradiol-iron</i>	75	LYSODREN.....	54
KLOXXADO.....	43	<i>levonorgestrel-ethinyl estrad</i>	75, 77	LYUMJEV.....	40
Kourzeq.....	109	<i>levonorg-eth estrad triphasic</i>	78	LYUMJEV KWIKPEN.....	40
K-PHOS.....	106	<i>levora 0.15/30 (28)</i>	75	<i>lyza</i>	78
KRISTALOSE.....	101	<i>levorphanol tartrate</i>	25	MAGELLAN INSULIN SAFETY	
<i>kurvelo</i>	75	<i>levo-t</i>	123	SYR.....	103
<i>labetalol hcl</i>	67, 68	<i>levothyroxine sodium</i>	123	MAGNESIUM SULFATE.....	106
<i>lacosamide</i>	34	<i>levoxyI</i>	123	<i>malathion</i>	87
<i>lactated ringers</i>	105, 107	<i>l-glutamine</i>	98	<i>manganese chloride</i>	106
LACTULOSE.....	101	<i>lidocaine</i>	86	<i>mannitol</i>	88
<i>lactulose</i>	101	<i>lidocaine hcl</i>	86, 101, 108	MARATHON MEDICAL PENTIPS...103	
<i>lactulose encephalopathy</i>	94	<i>lidocaine hcl (cardiac)</i>	29	<i>maraviroc</i>	64
LAGEVRIO.....	67	<i>lidocaine hcl (cardiac) pf</i>	29	<i>marlissa</i>	75
<i>lamivudine</i>	65, 66	<i>lidocaine hcl (pf)</i>	101	MATULANE.....	57
<i>lamivudine-zidovudine</i>	64	<i>lidocaine hcl urethral/mucosal</i>	86	<i>matzim la</i>	70
<i>lamotrigine</i>	34	<i>lidocaine in d5w</i>	29	MAVENCLAD (10 TABS).....	119
<i>lamotrigine er</i>	34	<i>lidocaine viscous hcl</i>	108	MAVENCLAD (4 TABS).....	119
<i>lamotrigine starter kit-blue</i>	34	<i>lidocaine-epinephrine</i>	101	MAVENCLAD (5 TABS).....	119
<i>lamotrigine starter kit-green</i>	35	<i>lidocaine-epinephrine (pf)</i>	101	MAVENCLAD (6 TABS).....	119
<i>lamotrigine starter kit-orange</i>	35	<i>lidocaine-prilocaine</i>	87	MAVENCLAD (7 TABS).....	119
LANOXIN PEDIATRIC.....	71	<i>linezolid</i>	52	MAVENCLAD (8 TABS).....	119
LANREOTIDE ACETATE.....	91	LINZESS.....	93	MAVENCLAD (9 TABS).....	119
<i>lansoprazole</i>	124	Liomny.....	123	MAYZENT.....	121
<i>lanthanum carbonate</i>	94	<i>liothyronine sodium</i>	123	MAYZENT STARTER PACK.....	121
LANTUS.....	40	<i>liraglutide</i>	41	<i>meclizine hcl</i>	44
LANTUS SOLOSTAR.....	40	<i>lisdexamfetamine dimesylate</i>	18	<i>meclufenamate sodium</i>	22
<i>lapatinib ditosylate</i>	57	<i>lisinopril</i>	49	<i>medroxyprogesterone acetate</i>	78, 118
<i>larin 1.5/30</i>	75	<i>lisinopril-hydrochlorothiazide</i>	48	<i>mefenamic acid</i>	22
<i>larin 1/20</i>	75	<i>lithium</i>	61	<i>mefloquine hcl</i>	53
<i>larin 24 fe</i>	75	<i>lithium carbonate</i>	61	<i>megestrol acetate</i>	59, 118
<i>larin fe 1.5/30</i>	75	<i>lithium carbonate er</i>	61	MEKINIST.....	56
<i>larin fe 1/20</i>	75	<i>lmd in d5w</i>	97	Meleya.....	78
<i>latanoprost</i>	115	<i>lmd in nacl</i>	97	<i>meloxicam</i>	22
<i>leena</i>	78	LO LOESTRIN FE.....	73	<i>memantine hcl</i>	120, 121
<i>leflunomide</i>	23	<i>loestrin 1.5/30 (21)</i>	75	<i>memantine hcl er</i>	120
<i>lenalidomide</i>	107	<i>loestrin 1/20 (21)</i>	75	<i>memantine hcl-donepezil hcl</i>	118
LENVIMA (10 MG DAILY DOSE).....	59	<i>loestrin fe 1.5/30</i>	75	MENQUADFI.....	126
LENVIMA (12 MG DAILY DOSE).....	59	<i>loestrin fe 1/20</i>	75	MENVEO.....	126
LENVIMA (14 MG DAILY DOSE).....	59	<i>lofexidine hcl</i>	118	<i>mepredine hcl</i>	25
LENVIMA (18 MG DAILY DOSE).....	59	<i>lojaimiess</i>	77	<i>meprobamate</i>	28
LENVIMA (20 MG DAILY DOSE).....	59	LOKELMA.....	108	<i>mercaptapurine</i>	54

<i>meropenem</i>	52	<i>minocycline hcl</i>	123	<i>neomycin-bacitracin zn-polymyx</i>	114
<i>merzee</i>	75	<i>minoxidil</i>	51	<i>neomycin-polymyxin b gu</i>	95
<i>mesalamine</i>	93	Minzoya	76	<i>neomycin-polymyxin-dexameth</i>	115
<i>mesalamine er</i>	93	<i>mirabegron er</i>	125	<i>neomycin-polymyxin-gramicidin</i>	114
<i>mesalamine-cleanser</i>	93	<i>mirtazapine</i>	36, 37	<i>neomycin-polymyxin-hc</i>	115, 116
<i>mesna</i>	59	<i>misoprostol</i>	125	<i>neo-polycin</i>	114
<i>metformin hcl</i>	39	<i>mitigo</i>	25	<i>neo-polycin hc</i>	115
<i>metformin hcl er</i>	39	M-M-R II	126	<i>neucac</i>	81
<i>methadone hcl</i>	25	M-NATAL PLUS	110	NEULASTA	98
<i>methadone hcl intensol</i>	25	MNEXSPIKE	128	NEULASTA ONPRO	98
<i>methadose</i>	25	<i>modafinil</i>	20	<i>nevirapine</i>	65
<i>methazolamide</i>	88	<i>moexipril hcl</i>	49	<i>nevirapine er</i>	65
<i>methenamine hippurate</i>	53	<i>molindone hcl</i>	62	NEXTSTELLIS	76
<i>methergine</i>	116	<i>mometasone furoate</i>	85, 112	<i>niacin (antihyperlipidemic)</i>	47
<i>methimazole</i>	123	<i>mondoxyne nl</i>	123	<i>niacin er (antihyperlipidemic)</i>	47
<i>methocarbamol</i>	111	<i>monoject flush syringe</i>	106	<i>niacor</i>	47
<i>methohexital sodium</i>	95	MONOJECT INSULIN SYRINGE	104	<i>nicardipine hcl</i>	70
<i>methotrexate sodium</i>	54	<i>monoject sodium chloride flush</i>	106	NICOTROL NS	121
<i>methotrexate sodium (pf)</i>	54	MONOJECT ULTRA COMFORT		<i>nifedipine</i>	70
<i>methoxsalen rapid</i>	83	SYRINGE	104	<i>nifedipine er</i>	70
<i>methscopolamine bromide</i>	125	<i>mono-lynyah</i>	76	<i>nifedipine er osmotic release</i>	70
<i>methsuximide</i>	36	<i>montelukast sodium</i>	31	<i>nikki</i>	76
<i>methyldopa</i>	51	<i>morphine sulfate</i>	25	<i>nilotinib hcl</i>	55
<i>methylene blue</i>	43	<i>morphine sulfate (concentrate)</i>	25	<i>nilutamide</i>	54
<i>methylergonovine maleate</i>	116	<i>morphine sulfate (pf)</i>	25	<i>nimodipine</i>	70
<i>methylphenidate</i>	20	<i>morphine sulfate er</i>	25	<i>nisoldipine er</i>	70
<i>methylphenidate hcl</i>	20	<i>morphine sulfate er beads</i>	25	<i>nitazoxanide</i>	52
<i>methylphenidate hcl er</i>	20	MOUNJARO	41	<i>nitisinone</i>	90
<i>methylphenidate hcl er (cd)</i>	19	<i>moxifloxacin hcl</i>	93, 113	NITRO-DUR	27
<i>methylphenidate hcl er (la)</i>	20	<i>moxifloxacin hcl (2x day)</i>	113	<i>nitrofurantoin</i>	53
<i>methylphenidate hcl er (osm)</i>	20	MRESVIA	128	<i>nitrofurantoin macrocrystal</i>	53
METHYLPHENIDATE HCL ER		<i>multiple electro type 1 ph 5.5</i>	105	<i>nitrofurantoin monohyd macro</i>	53
(OSM)	20	<i>multiple electro type 1 ph 7.4</i>	106	<i>nitroglycerin</i>	27, 28
<i>methylphenidate hcl er (xr)</i>	20	<i>multivitamin w/fluoride</i>	109	<i>nitroglycerin in d5w</i>	27
<i>methylprednisolone</i>	79	<i>multi-vitamin/fluoride</i>	109	NIVA-PLUS	110
<i>methylprednisolone sodium succ</i>	79	<i>multi-vitamin/fluoride/iron</i>	109	<i>nizatidine</i>	124
<i>metoclopramide hcl</i>	93	<i>mupirocin</i>	82	<i>nora-be</i>	78
<i>metolazone</i>	89	MVASI	60	<i>norelgestromin-eth estradiol</i>	77
<i>metoprolol succinate er</i>	68	<i>mycophenolate mofetil</i>	107	<i>norethin ace-eth estrad-fe</i>	76
<i>metoprolol tartrate</i>	68	<i>mycophenolate sodium</i>	107	<i>norethindrone</i>	78
<i>metoprolol-hydrochlorothiazide</i>	51	<i>mycophenolic acid</i>	107	<i>norethindrone acetate</i>	118
<i>metronidazole</i>	51, 87, 129	MYLERAN	53	<i>norethindrone acet-ethinyl est</i>	76
<i>metyrosine</i>	49	MYRBETRIQ	125	<i>norethindrone-eth estradiol</i>	92
<i>mexiletine hcl</i>	29	<i>na ferric gluc cplx in sucrose</i>	99	<i>norethin-eth estradiol-fe</i>	76
Mibelas 24 Fe	75	<i>na sulfate-k sulfate-mg sulf</i>	100	<i>norgesic</i>	111
<i>miconazole 3</i>	129	<i>nabumetone</i>	23	NORGESIC FORTE	111
<i>microgestin 1.5/30</i>	75	<i>nadolol</i>	68	<i>norgestimate-eth estradiol</i>	76
<i>microgestin 1/20</i>	76	<i>nafcellin sodium</i>	117	<i>norgestim-eth estrad triphasic</i>	78
<i>microgestin fe 1.5/30</i>	76	<i>naftifine hcl</i>	82	<i>norlyroc</i>	78
<i>microgestin fe 1/20</i>	76	<i>nalbuphine hcl</i>	26	<i>normal saline flush</i>	107
<i>midazolam hcl</i>	100	<i>naloxone hcl</i>	43, 44	NORPACE CR	29
<i>midazolam hcl (pf)</i>	100	<i>naltrexone hcl</i>	44	<i>nortrel 0.5/35 (28)</i>	76
<i>midazolam hcl (pf) +rfid</i>	99	<i>naproxen</i>	23	<i>nortrel 1/35 (21)</i>	76
<i>midazolam-sodium chloride (pf)</i>	100	<i>naproxen dr</i>	23	<i>nortrel 1/35 (28)</i>	76
<i>midodrine hcl</i>	129	<i>naproxen sodium</i>	23	<i>nortrel 7/7/7</i>	78
<i>mifepristone</i>	41, 89	<i>naratriptan hcl</i>	105	<i>nortriptyline hcl</i>	38
<i>migergot</i>	105	NATAZIA	78	NOVAREL	90
<i>miglitol</i>	39	<i>nateglinide</i>	41	NUBEQA	54
<i>miglustat</i>	98	<i>neбивolol hcl</i>	68	NUCALA	31
<i>mili</i>	76	Nebusal	80	NURTEC	104
<i>milrinone lactate</i>	71	<i>necon 0.5/35 (28)</i>	76	<i>nyamyc</i>	82
<i>milrinone lactate in dextrose</i>	71	<i>nefazodone hcl</i>	37	<i>nylia 1/35</i>	76
<i>mimvey</i>	92	<i>neomycin sulfate</i>	20	<i>nylia 7/7/7</i>	78

<i>nystatin</i>	45, 82	<i>oxymorphone hcl</i>	25	<i>phosphorous</i>	106
<i>nystatin-triamcinolone</i>	82	<i>oxymorphone hcl er</i>	25	<i>phospho-trin k500</i>	106
<i>nystop</i>	82	<i>oxytocin</i>	116	<i>physiolyte</i>	107
OCTAGAM.....	117	OZEMPIC (0.25 OR 0.5 MG/DOSE)....	41	<i>physiosol irrigation</i>	108
OFEV.....	122	OZEMPIC (1 MG/DOSE).....	41	<i>phytonadione</i>	130
<i>ofloxacin</i>	93, 113, 116	OZEMPIC (2 MG/DOSE).....	41	<i>pilocarpine hcl</i>	109, 113
<i>olanzapine</i>	63, 64	<i>pacerone</i>	29	<i>pimecrolimus</i>	86
<i>olanzapine-fluoxetine hcl</i>	122	<i>paliperidone er</i>	61	<i>pimozide</i>	121
<i>olmesartan medoxomil</i>	50	<i>palonosetron hcl</i>	44	<i>pimtree</i>	73
<i>olmesartan medoxomil-hctz</i>	50	<i>pantoprazole sodium</i>	124	<i>pindolol</i>	68
<i>olmesartan-amlodipine-hctz</i>	50	<i>paricalcitol</i>	90	<i>pioglitazone hcl</i>	43
<i>olopatadine hcl</i>	112	<i>paroxetine hcl</i>	37	<i>pioglitazone hcl-glimepiride</i>	43
<i>omega-3-acid ethyl esters</i>	46	<i>paroxetine hcl er</i>	37	<i>pioglitazone hcl-metformin hcl</i>	43
<i>omeprazole</i>	124	<i>paroxetine mesylate</i>	122	<i>piperacillin sod-tazobactam so</i>	117
OMNIPOD 5 DEXG7G6 INTRO GEN		PAXLOVID (150/100).....	66	<i>pirfenidone</i>	122
5.....	103	PAXLOVID (300/100 & 150/100).....	66	<i>piroxicam</i>	23
OMNIPOD 5 DEXG7G6 PODS GEN		PAXLOVID (300/100).....	66	PLEGRIDY.....	120
5.....	103	<i>pazopanib hcl</i>	57	PLEGRIDY STARTER PACK.....	120
OMNIPOD 5 LIBRE2 G6 INTRO		PEDIARIX.....	123	<i>plenamine</i>	112
GEN5.....	103	PEDVAX HIB.....	126	PNEUMOVAX 23.....	126
OMNIPOD 5 LIBRE2 PLUS G6		<i>peg 3350-kcl-na bicarb-nacl</i>	100	<i>pnv 27-ca/fe/fa</i>	110
PODS.....	103	<i>peg-3350/electrolytes</i>	100	<i>pnv prenatal plus multivit+dha</i>	110
OMNIPOD DASH INTRO (GEN 4)...	103	<i>peg-3350/electrolytes/ascorbat</i>	100	<i>pnv-dha</i>	111
OMNIPOD DASH PDM (GEN 4).....	103	<i>peg-kcl-nacl-nasulf-na asc-c</i>	100	<i>pnv-select</i>	110
OMNIPOD DASH PODS (GEN 4).....	103	PEN NEEDLES.....	104	<i>podofilox</i>	86
<i>ondansetron</i>	44	PENBRAYA.....	126	<i>polocaine</i>	101
<i>ondansetron hcl</i>	44	<i>peniclovir</i>	84	<i>polocaine-mpf</i>	101
<i>ondansetron hcl +rfid</i>	44	<i>penicillamine</i>	107	<i>polycin</i>	114
ONE VITE WOMENS PLUS.....	110	<i>penicillin g potassium</i>	117	<i>polymyxin b sulfate</i>	52
OPSUMIT.....	72	<i>penicillin g sodium</i>	117	<i>polymyxin b-trimethoprim</i>	114
OPVEE.....	44	<i>penicillin v potassium</i>	117	POMALYST.....	56
OPZELURA.....	84	<i>penmenvy</i>	126	<i>portia-28</i>	76
<i>oralone</i>	109	PENTACEL.....	123	<i>posaconazole</i>	45
ORENCIA.....	23	<i>pentamidine isethionate</i>	51	<i>potassium chloride</i>	106
ORENCIA CLICKJECT.....	23	PENTASA.....	93	<i>potassium chloride crys er</i>	106
ORENITRAM.....	71	<i>pentazocine-naloxone hcl</i>	26	<i>potassium chloride er</i>	106
ORENITRAM MONTH 1.....	71	PENTIPS.....	104	<i>potassium citrate er</i>	95
ORENITRAM MONTH 2.....	71	<i>pentobarbital sodium</i>	99	<i>potassium cl in dextrose 5%</i>	105
ORENITRAM MONTH 3.....	71	<i>pentoxifylline er</i>	97	<i>potassium phosphates</i>	106
ORGOVYX.....	58	<i>perampanel</i>	33	<i>pramipexole dihydrochloride</i>	60
ORILISSA.....	89	<i>perindopril erbumine</i>	49	<i>pramipexole dihydrochloride er</i>	60
<i>orlistat</i>	19	<i>periogard</i>	108	PRAMOSONE.....	87
Ormalvi.....	88	<i>permethrin</i>	87	<i>prasugrel hcl</i>	97
<i>orphenadrine citrate</i>	111	<i>perphenazine</i>	63	<i>pravastatin sodium</i>	47
<i>orphenadrine citrate er</i>	111	<i>perphenazine-amitriptyline</i>	121	<i>praziquantel</i>	27
ORPHENADRINE-ASPIRIN-		<i>pfizerpen</i>	117	<i>prazosin hcl</i>	51
CAFFEINE.....	111	PHEBURANE.....	91	<i>prednisolone</i>	79
<i>orphengesic forte</i>	111	<i>phendimetrazine tartrate</i>	19	<i>prednisolone acetate</i>	115
Orquidea.....	78	<i>phenelzine sulfate</i>	37	<i>prednisolone sodium phosphate</i>	79, 80
<i>oseltamivir phosphate</i>	67	<i>phenobarbital</i>	99	<i>prednisone</i>	80
<i>osmitrol</i>	88	<i>phenobarbital sodium</i>	99	<i>pregabalin</i>	35
OTEZLA.....	23	<i>phenoxybenzamine hcl</i>	49	<i>pregabalin er</i>	121
<i>oxacillin sodium</i>	117	<i>phentermine hcl</i>	19	PREMARIN.....	92, 129
<i>oxaprozin</i>	23	<i>phentolamine mesylate</i>	49	PREMPHASE.....	92
<i>oxazepam</i>	28	<i>phenylephrine hcl</i>	113	PREMPRO.....	92
<i>oxcarbazepine</i>	35	PHENYTEK.....	36	<i>prena 1 true</i>	111
<i>oxcarbazepine er</i>	35	<i>phenytoin</i>	36	PRENATAL.....	110
<i>oxiconazole nitrate</i>	86	<i>phenytoin infatabs</i>	36	PRENATAL 19.....	110
<i>oxybutynin chloride</i>	125	<i>phenytoin sodium</i>	36	<i>prenatal 19</i>	110
<i>oxybutynin chloride er</i>	125	<i>phenytoin sodium extended</i>	36	PRENATAL PLUS.....	110
<i>oxycodone hcl</i>	25	PHEXXI.....	129	PRENATAL PLUS	
OXYCODONE-ACETAMINOPHEN...26		<i>philitih</i>	76	VITAMIN/MINERAL.....	110
<i>oxycodone-acetaminophen</i>	26	<i>phospha 250 neutral</i>	106	PRENATAL-U.....	110

<i>prevalite</i>	46	RASUVO	21	<i>selenium sulfide</i>	84
PREVNAR 20	126	REBIF	120	SE-NATAL 19	110
PREZISTA	65	REBIF REBIDOSE	120	<i>sensorcaine</i>	101
PRIFTIN	53	REBIF REBIDOSE TITRATION		<i>sensorcaine/epinephrine</i>	101
<i>primidone</i>	35	PACK	120	<i>sensorcaine-mpf</i>	101
PRIORIX	127	REBIF TITRATION PACK	120	<i>sensorcaine-mpf/epinephrine</i>	101
PRO COMFORT PEN NEEDLES	104	<i>reclipsen</i>	76	SEREVENT DISKUS	31
PROAIR RESPICLICK	31	RECOMBIVAX HB	128	<i>sertraline hcl</i>	37
<i>probenecid</i>	96	RELENZA DISKHALER	67	<i>setlakin</i>	77
<i>procainamide hcl</i>	29	REMICADE	95	<i>sevelamer carbonate</i>	94
<i>procentra</i>	18	<i>remifentanyl hcl</i>	25	<i>sevelamer hcl</i>	94
<i>prochlorperazine</i>	63	<i>repaglinide</i>	41	<i>sevoflurane</i>	95
<i>prochlorperazine edisylate</i>	63	REPATHA	47	<i>sf</i>	109
<i>prochlorperazine maleate</i>	63	REPATHA SURECLICK	48	<i>sf 5000 plus</i>	109
PROCRIT	98	RESTASIS	114	<i>sharobel</i>	78
PROCTOCORT	27	RESTASIS MULTIDOSE	114	SHINGRIX	128
<i>procto-med hc</i>	27	RETACRIT	98	<i>sildenafil citrate</i>	72
<i>proctosol hc</i>	27	REVLIMID	107	<i>silodosin</i>	95
<i>proctozone-hc</i>	27	<i>revonto</i>	111	<i>silver sulfadiazine</i>	84
<i>progesterone</i>	118	REXTOVY	44	SIMBRINZA	112
PROLIA	91	REXULTI	63	SIMLANDI (1 PEN)	21
<i>promethazine hcl</i>	46	REYATAZ	65	SIMLANDI (2 PEN)	21
<i>promethazine-codeine</i>	80	<i>ribavirin</i>	66, 67	SIMLANDI (2 SYRINGE)	21
<i>promethazine-dm</i>	80	RIDAURA	22	<i>simliya</i>	73
<i>promethazine-phenylephrine</i>	80	<i>rifabutin</i>	53	<i>simpesse</i>	77
<i>promethegan</i>	46	<i>rifampin</i>	53	SIMPONI	21
<i>propafenone hcl</i>	29	<i>riluzole</i>	112	SIMPONI ARIA	21
<i>propafenone hcl er</i>	29	<i>rimantadine hcl</i>	67	<i>simvastatin</i>	47
<i>proparacaine hcl</i>	114	<i>ringers</i>	106	<i>sirolimus</i>	108
<i>propofol</i>	95	RINVOQ	21	SKYRIZI	83, 94
<i>propranolol hcl</i>	68	RINVOQ LQ	21	SKYRIZI PEN	83
<i>propranolol hcl er</i>	68	<i>risedronate sodium</i>	89	SKYTROFA	90
<i>propylthiouracil</i>	123	<i>risperidone</i>	61	SLYND	78
PROQUAD	127	<i>risperidone microspheres er</i>	61	<i>sodium acetate</i>	105
<i>protamine sulfate</i>	97	<i>ritonavir</i>	65	<i>sodium bicarbonate</i>	105
<i>protriptyline hcl</i>	39	<i>rivaroxaban</i>	33	<i>sodium chloride</i>	80, 96, 107
PROVIDA OB	110	<i>rivastigmine</i>	118	<i>sodium chloride (pf)</i>	107
<i>prucalopride succinate</i>	93	<i>rivastigmine tartrate</i>	118	<i>sodium fluoride</i>	106, 109
PRURADIK	87	<i>rivelsa</i>	77	<i>sodium fluoride 5000 enamel</i>	108
<i>pseudoeph-bromphen-dm</i>	80	<i>rizatriptan benzoate</i>	105	<i>sodium fluoride 5000 plus</i>	109
Pulmosal	80	<i>rocuronium bromide</i>	112	<i>sodium fluoride 5000 ppm</i>	109
PULMOZYME	122	<i>roflumilast</i>	31	<i>sodium fluoride 5000 sensitive</i>	108
<i>pyrazinamide</i>	53	<i>ropinirole hcl</i>	61	<i>sodium oxybate</i>	118
<i>pyridostigmine bromide</i>	53	<i>ropinirole hcl er</i>	60	<i>sodium phenylbutyrate</i>	91
<i>pyridostigmine bromide er</i>	53	<i>ropivacaine hcl</i>	101	<i>sodium phosphates</i>	106
<i>pyrimethamine</i>	53	ROPIVACAINE HCL	101	<i>sodium polystyrene sulfonate</i>	108
QUADRACEL	123, 124	<i>rosuvastatin calcium</i>	47	<i>sodium tetradecyl sulfate</i>	108
<i>quazepam</i>	100	Rosyrax	77	SODIUM THIOSULFATE	43
<i>quetiapine fumarate</i>	62	ROTARIX	128	<i>solifenacin succinate</i>	125
<i>quetiapine fumarate er</i>	62	ROTATEQ	128	SOLQUA	41
<i>quinapril hcl</i>	49	<i>roweepra</i>	35	SOLTAMOX	54
<i>quinapril-hydrochlorothiazide</i>	48	RUCONEST	96	SOLU-CORTEF	80
<i>quinidine gluconate er</i>	29	<i>rufinamide</i>	35	SOMATULINE DEPOT	91
<i>quinidine sulfate</i>	29	RYBELSUS	41	SOMAVERT	89
<i>quinine sulfate</i>	53	<i>sacubitril-valsartan</i>	71	<i>sorafenib tosylate</i>	57
QULIPTA	104	<i>sajazir</i>	96	<i>sotalol hcl</i>	68
QVAR REDHALER	32	<i>saline flush</i>	107	<i>sotalol hcl (af)</i>	68
RABAVERT	128	<i>sapropterin dihydrochloride</i>	91	SOTRADECOL	108
<i>raloxifene hcl</i>	91	<i>scopolamine</i>	44	<i>sotradecol</i>	108
<i>ramelteon</i>	100	SELARSDI	83, 94	SPIKEVAX	128
<i>ramipril</i>	49	SELECT-OB	110	SPIKEVAX 6M-11Y	128
<i>ranolazine er</i>	27	<i>selegiline hcl</i>	60	<i>spinosad</i>	87
<i>rasagiline mesylate</i>	60	SELENIUM ACID	107	SPIRIVA RESPIMAT	31

<i>spironolactone</i>	88	<i>temazepam</i>	100	<i>tramadol hcl er</i>	25
<i>spironolactone-hctz</i>	88	<i>temozolomide</i>	58	<i>tramadol-acetaminophen</i>	26
<i>sprintec 28</i>	76	<i>tencon</i>	24	<i>trandolapril</i>	49
<i>sps (sodium polystyrene sulf)</i>	108	TENIVAC	124	<i>trandolapril-verapamil hcl er</i>	48
<i>sronyx</i>	76	<i>tenofovir disoproxil fumarate</i>	66	<i>tranexamic acid</i>	99
<i>ssd</i>	84	<i>terazosin hcl</i>	51	<i>tranylcypromine sulfate</i>	37
STELARA	83, 94	<i>terbutaline hcl</i>	45	<i>travoprost (bak free)</i>	115
<i>sterile water for irrigation</i>	108	<i>terbutaline sulfate</i>	31	<i>trazodone hcl</i>	37
STIOLTO RESPIMAT	30	<i>terconazole</i>	129	TRELEGY ELLIPTA	30
STIVARGA	57	<i>teriflunomide</i>	119	TRELSTAR MIXJECT	58
STRENSIQ	90	<i>terrell</i>	95	TREMFYA	83, 94
<i>streptomycin sulfate</i>	20	<i>testosterone</i>	26, 27	TREMFYA ONE-PRESS	83
STRIBILD	64	<i>testosterone cypionate</i>	26	TREMFYA PEN	83, 94
<i>subvenite</i>	35	<i>testosterone enanthate</i>	26	<i>treprostinil</i>	71
<i>subvenite starter kit-blue</i>	35	<i>tetrabenazine</i>	119	TRESIBA	41
<i>subvenite starter kit-green</i>	35	<i>tetracaine hcl</i>	114	TRESIBA FLEXTOUCH	40
<i>subvenite starter kit-orange</i>	35	<i>tetracycline hcl</i>	123	<i>tretinoin</i>	59, 81
<i>sucralfate</i>	124	TEZSPIRE	32	<i>tretinoin microsphere</i>	81
SUFENTANIL CITRATE	25	THALOMID	107	<i>tretinoin microsphere pump</i>	81
<i>sulconazole nitrate</i>	86	THEO-24	32	TREXALL	54
<i>sulfacetamide sodium</i>	115	<i>theophylline</i>	32	<i>trezix</i>	24
<i>sulfacetamide sodium (acne)</i>	81	<i>theophylline er</i>	32	<i>triamcinolone acetonide</i>	80, 85, 109
<i>sulfacetamide-prednisolone</i>	115	<i>thiamine hcl</i>	130	<i>triamterene</i>	88
<i>sulfadiazine</i>	122	<i>thioridazine hcl</i>	63	<i>triamterene-hctz</i>	88
<i>sulfamethoxazole-trimethoprim</i>	52	<i>thiothixene</i>	64	<i>triazolam</i>	100
<i>sulfasalazine</i>	94	THRIVITE RX	110	Tridacaine Ii	86
<i>sulfatrim pediatric</i>	52	<i>tiadylt er</i>	70	Tridacaine Iii	86
<i>sulindac</i>	23	<i>tiagabine hcl</i>	36	<i>triderm</i>	85
<i>sumatriptan</i>	105	<i>ticagrelor</i>	97	<i>trientine hcl</i>	107
<i>sumatriptan succinate</i>	105	TICOVAC	128	<i>tri-estarylla</i>	79
<i>sumatriptan succinate refill</i>	105	<i>tilia fe</i>	78	<i>trifluoperazine hcl</i>	63
<i>sunitinib malate</i>	57	<i>timolol hemihydrate</i>	113	<i>trifluridine</i>	114
<i>sure comfort pen needles</i>	104	<i>timolol maleate</i>	68, 113	<i>trihexyphenidyl hcl</i>	60
SURE COMFORT PEN NEEDLES	104	<i>timolol maleate (once-daily)</i>	113	TRIJARDY XR	41
SUTAB	100	<i>timolol maleate ocudose</i>	113	TRIKAFTA	122
<i>syeda</i>	76	<i>timolol maleate pf</i>	113	<i>tri-legest fe</i>	79
SYNAREL	90	<i>tinidazole</i>	51	<i>tri-linyah</i>	79
SYNJARDY	42	<i>tiopronin</i>	96	<i>tri-lo-estarylla</i>	79
SYNJARDY XR	42	<i>tiotropium bromide</i>	31	<i>tri-lo-marzia</i>	79
TABLOID	54	<i>tirofiban hcl in nacl</i>	97	<i>tri-lo-mili</i>	79
<i>tacrolimus</i>	86, 108	TIVICAY	64	<i>tri-lo-sprintec</i>	79
<i>tadalafil</i>	72	TIVICAY PD	64	<i>trimethobenzamide hcl</i>	44
<i>tadalafil (pah)</i>	72	<i>tizanidine hcl</i>	111	TRIMETHOPRIM	51
TAFINLAR	55	TOBRADEX	115	<i>tri-mili</i>	79
<i>tafluprost (pf)</i>	115	<i>tobramycin</i>	20, 113	<i>trimipramine maleate</i>	39
TAKHZYRO	97	<i>tobramycin sulfate</i>	20, 21	TRINATAL RX 1	110
TALTZ	83	<i>tobramycin-dexamethasone</i>	115	<i>trinate</i>	110
<i>tamoxifen citrate</i>	54	<i>tolcapone</i>	60	TRINTELLIX	37
<i>tamsulosin hcl</i>	95	<i>tolmetin sodium</i>	23	<i>tri-sprintec</i>	79
<i>taperdex 12-day</i>	80	<i>tolterodine tartrate</i>	125	TRIUMEQ	64
<i>taperdex 6-day</i>	80	<i>tolterodine tartrate er</i>	125	TRIUMEQ PD	64
<i>taperdex 7-day</i>	80	<i>tolvaptan</i>	91	<i>tri-vite/fluoride</i>	109
<i>tarina 24 fe</i>	76	<i>topiramate</i>	35	<i>tri-vylibra</i>	79
<i>tarina fe 1/20 eq</i>	76	<i>topiramate er</i>	35	<i>tri-vylibra lo</i>	79
TARON-C DHA	110	<i>toremifene citrate</i>	54	<i>tropicamide</i>	113
<i>tasimelteon</i>	100	Torpenz	56	<i>trosipium chloride</i>	125
<i>tavorole</i>	86	<i>torsepide</i>	88	<i>trosipium chloride er</i>	125
<i>taysofy</i>	76	TOUJEO MAX SOLOSTAR	40	TRULICITY	41
<i>tazarotene</i>	84	TOUJEO SOLOSTAR	40	TRUMENBA	126
<i>tazicef</i>	73	<i>tovet</i>	85	Turqoz	76
<i>telmisartan</i>	50	TRACLEER	72	TWIIST REFILL KIT	103
<i>telmisartan-amlodipine</i>	49	<i>tramadol hcl</i>	25, 26		
<i>telmisartan-hctz</i>	50	<i>tramadol hcl (er biphasic)</i>	25		

TWIIST REFILL KIT/INFUSION SET		ZEPBOUND	19
.....	103	ZEPOSIA	121
TWIIST STARTER KIT	103	ZEPOSIA 7-DAY STARTER PACK	121
TWINRIX	127	ZEPOSIA STARTER KIT	122
TWIRLA	77	<i>zidovudine</i>	65
TYBLUME	76	ZILXI	87
Tydemy	76	ZIMHI	44
TYPHIM VI	126	<i>zinc sulfite</i>	107
UBRELVY	104	<i>ziprasidone hcl</i>	61
UDENYCA	98	<i>ziprasidone mesylate</i>	61
UDENYCA ONBODY	98	ZOLINZA	56
ULTICARE INSULIN SAFETY SYR	104	<i>zolmitriptan</i>	105
ULTICARE INSULIN SYRINGE	104	<i>zolpidem tartrate</i>	100
ULTICARE PEN NEEDLES	104	<i>zolpidem tartrate er</i>	100
ULTICARE SHORT PEN NEEDLES	104	<i>zonisamide</i>	35
<i>umeclidinium-vilanterol</i>	30	<i>zovia 1/35 (28)</i>	77
<i>unithroid</i>	123	<i>zumandimine</i>	77
UPTRAVI	72	ZYLET	115
UPTRAVI TITRATION	72		
<i>ursodiol</i>	93		
<i>ustekinumab</i>	83		
VABYSMO	113		
<i>valacyclovir hcl</i>	67		
<i>valganciclovir hcl</i>	66		
<i>valproate sodium</i>	36		
<i>valproic acid</i>	36		
VALSARTAN	50		
<i>valsartan</i>	50		
<i>valsartan-hydrochlorothiazide</i>	50		
Valtya 1/50	76		
<i>vancomycin hcl</i>	52		
VANCOMYCIN HCL	52		
VANDAZOLE	129		
VAQTA	128		
<i>ildenafil hcl</i>	72		
<i>varenicline tartrate</i>	121		
<i>varenicline tartrate (starter)</i>	121		
<i>varenicline tartrate(continue)</i>	121		
VARIVAX	129		
VASCEPA	46		
<i>vasopressin</i>	92		
<i>vasopressin +rfid</i>	91		
VAXCHORA	126		
VAXELIS	124		
VAXNEUVANCE	126		
<i>vecuronium bromide</i>	112		
<i>velivet</i>	79		
VEMLIDY	66		
<i>venlafaxine hcl</i>	38		
<i>venlafaxine hcl er</i>	38		
VENOFER	99		
Venxxiva	96		
<i>verapamil hcl</i>	70		
<i>verapamil hcl er</i>	70		
VERZENIO	58		
<i>vestura</i>	76		
<i>vienna</i>	76		
<i>vigabatrin</i>	36		
<i>vigadrone</i>	36		
Vigadrone	36		
<i>vilazodone hcl</i>	37		
VIMKUNYA	129		
VIOKACE	87		
<i>viorele</i>	73		
VIREAD	66		
VITAFOL GUMMIES	110		
<i>vitamin d (ergocalciferol)</i>	130		
<i>vitamin k1</i>	130		
VITRAKVI	57		
VIVITROL	44		
VIVOTIF	126		
<i>volnea</i>	73		
<i>voriconazole</i>	45		
VOSEVI	66		
VRAYLAR	61		
VUMERITY	120		
<i>vyfemla</i>	76		
<i>vylibra</i>	76		
WAKIX	19		
<i>warfarin sodium</i>	32		
<i>water for irrigation, sterile</i>	108		
<i>wera</i>	76		
<i>wesnatal dha complete</i>	111		
WESTAB PLUS	110		
WIDE-SEAL DIAPHRAGM 60	102		
WIDE-SEAL DIAPHRAGM 65	102		
WIDE-SEAL DIAPHRAGM 70	102		
WIDE-SEAL DIAPHRAGM 75	102		
WIDE-SEAL DIAPHRAGM 80	102		
WIDE-SEAL DIAPHRAGM 85	102		
WIDE-SEAL DIAPHRAGM 90	102		
WIDE-SEAL DIAPHRAGM 95	102		
<i>wixela inhub</i>	30		
<i>wymzya fe</i>	76		
XALKORI	55		
Xarah Fe	79		
XARELTO	33		
XARELTO STARTER PACK	33		
XELJANZ	21		
XELJANZ XR	21		
Xelria Fe	77		
XEMBIFY	117		
XGEVA	91		
XIFAXAN	51, 52		
XIGDUO XR	42		
XIIDRA	113		
XOFLUZA (40 MG DOSE)	67		
XOFLUZA (80 MG DOSE)	67		
XOLAIR	30		
XTANDI	54		
<i>xulane</i>	77		
XULTOPHY	41		
XYOSTED	27		
Yargesa	98		
YF-VAX	129		
<i>yuvafem</i>	129		
<i>zafemy</i>	77		
<i>zafirlukast</i>	31		
<i>zaleplon</i>	100		
ZARXIO	98		
ZEGALOGUE	39		
ZEJULA	59		
ZELBORAF	55		
<i>zenatane</i>	82		
ZENPEP	88		
<i>zenzedi</i>	19		

For information about your pharmacy benefit, log in at [anthem.com/ca](https://www.anthem.com/ca).

You'll find the most up-to-date drug list and details about your benefits.

If you still have questions, we're here. Just call the Member Services number on your ID card.

Speech and hearing impaired (TDD/TTY) users

Call 1-800-221-6915, Monday through Friday, 8:30 a.m. to 5 p.m.ET.



Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸੇਵਾ ਸੰਖਿਆ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo

Bee ná ahoót'í t'áá ni nizaad k'ehjí níká a'doowó t'áá jík'e. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí béésh bee hane'í bikáá' áá jì' hodiílnih. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí béésh bee hane'í bikáá' áá jì' hodiílnih. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.