Summary of Formulary Benefits
The information in this document will help you understand the prescription drug benefits offered under this plan and allow you to compare these benefits to those offered by other plans. Information in this summary will help you compare the value and scope of formulary benefits.
How to Find Information on the Cost of Prescription Drugs
This document and the Drug List will help you understand your options. This document will answer questions about:
1. Covered medications under Community Health Choice plans formulary
2. Lower cost medication options
3. Development of the formulary
4. Appeals
5. Medical management

Community Health Choice offers web-based tool to determine cost sharing for drugs on Community Health Choice's formulary. Cost-sharing information reflects a consumer's share of the cost. This cost excludes any deductible requirement. It is calculated using the most current price of the drugs. This is based on the plan's actual cost-allowed amount.
A formulary is a list of brand and generic drugs that are covered by your plan. You can obtain more information about your pharmacy benefits by visiting our website at https://www.communityhealthchoice.org.

Community Health Choice requires Members to use generic medications when available. The Member will pay the applicable tier copay plus the cost difference between the brand and generic if a brand name drug is dispensed when a generic is available. This is regardless of whether or not the doctor's prescription indicates the branded medication should be dispensed. This amount will not apply to the Member's deductible or maximum out of pocket. The Provider must submit a prior authorization for medical necessity of branded medications when an equivalent generic alternative is available.
You can view a comparison of pharmacy benefits for each plan on our website at https://www.communityhealthchoice.org.
You can also view the summary and benefit, along with evidence-of-coverage documents for Our plans, at https://www.communityhealthchoice.org.

Drugs by Cost-Sharing Tier

Tier Name	
1	5%
2	57%
3	8%
4	3%
5	1%
6	0%
NC	23%
EXC (excluded)	4%

How Prescription Drugs are Covered

The Community Health Choice formulary is a closed formulary. This means some drugs are excluded or not covered. The formulary is developed and maintained by a Pharmacy and Therapeutics (P&T) Committee.

The Community Health Choice delegated P&T Committee meets quarterly to review new drugs and new information on existing drugs available in the market. The Committee consists of appropriate licensed clinicians. It includes medical professionals employed by Community Health Choice's delegated PBM Navitus, as well as those currently practicing in the community. The task of the Committee is to review scientific evidence balancing the effectiveness and side effects of the drugs. The Committee's review, recommendations, and approval are based on information presented through peer-reviewed journals and treatment guidelines. This evidence based
literature may come from private parties (e g. pharmaceutical companies) or public parties (e.g., government and/or medical associations).

The Committee evaluates the overall value of a medication to determine its placement on the formulary.

The committee may make a decision on:

1. Adding/removing a drug
2. Tier placement
3. Adding/removing utilization management (UM) rules such as step therapy (ST), quantity limits (QL), and prior authorization (PA).

The committee may also choose to exclude a medication from being covered in the formulary. All committee members are bound by a non-conflict-of-interest agreement that requires members to notify the committee if there is a financial stake that may affect their decisions.

Right to Appeal

Contact Community Health Choice at 713.295.2294 or 1.855.315.5386 if you need to make a complaint or file an appeal. If your issue or concern is not resolved by calling Community, you have the right to file a written appeal with Community . Please send the appeal request and related information from your doctor to:

MAIL
Community Health Choice, Inc., Attn: Appeals Coordinator
4888 Loop Central Dr. Suite 600, Houston, TX 77081
FAX
Community Health Choice, Inc., 713.295.7033
Attn: Appeals Coordinator

Continuation of Coverage

New members will be permitted a one-time override if medically necessary for medications that require a PA (or ST). The override will be placed for a 30 day-supply while the prescriber requests a PA. The intent of the one-time override is to allow the Provider to submit a prior authorization request to Navitus for review.

Off-Label Drug Use
You have the right to seek review by an independent review organization if a claim is denied as being experimental or investigational. Refer to the Appeals, Complaints and External Review Rights provision in the General Provisions section of this contract for more information.
Prescription Drug Exclusions - Unless expressly stated otherwise, no benefit will be provided for, or on account of, the following items:
1. Any drug prescribed for intended use other than for indications approved by the FDA or Offlabel indications recognized through peer-reviewed medical literature
2. Any drug, medicine or medication that is labeled either "caution-limited by federal law to investigational use" or “experimental or investigational”

Cost Sharing
What you expect to pay depends on the type of drugs your doctor prescribes. Each drug is placed in a tier. Different tiers have different copay levels. Tier structures are developed to encourage you to use quality products at the most cost-effective option for you. The lower-cost option does not represent a lower-quality product. It is simply the best cost option considering covered products within that treatment category. You can be assured that drugs provided through your pharmacy benefit have been through rigorous processes before being approved by the FDA.
The Gold 001 plan does not have a deductible. All our other plans have a combined pharmacy and medical deductible. Unless the plan allows for a drug to bypass deductible, the pharmacy deductible must be met in full before the plan will begin to pay for benefits.
- Tier 1 = Preferred generics and certain low-cost brands
- Tier 2 = Preferred brands and non-preferred generics
- Tier 3 = Non-preferred brands and some high-cost, non-preferred generics
- Tier 4 (listed as SP) = Specialty medications
- Tier 5 (listed as M) = Drugs typically covered through medical benefit
- Tier 6 (listed as $0) = $0 Cost-share preventive drugs

The mail-order service allows you to receive up to a 90-day supply of maintenance medications. This program is part of your pharmacy benefit and is voluntary.

Generics First Requirement
Community Health Choice requires Members to use generic medications when available. The Member will pay the applicable tier copay plus the cost difference between the brand and generic if a brand name drug is dispensed when a generic is available. This is regardless of if the doctor’s prescription indicates the branded medication should be dispensed. This amount will not apply to the Member’s deductible or maximum out of pocket. The Provider must submit a prior authorization for medical necessity of branded medications when an equivalent generic alternative is available.

Utilization Management Requirements
Drug coverage review is used to encourage appropriate and cost-effective use of prescription drugs by allowing coverage only when certain conditions are met. Some reasons for precertification
may include:
• Compliance with dosing guidelines
• Avoiding duplicate therapies
• Helping healthcare providers check medically accepted criteria that helps ensure high efficacy and low side effects
Community Health Choice implements approval criteria based on FDA-approved labeling, national guidelines, and current standards of care.

Clinical Prior Authorization (PA): PA criteria assess requirements such as appropriateness of indication, age, dose, lab values, and others for that specific prescription drug.

Quantity Limits (QL): Community Health Choice limits the quantity and dosing of certain drugs to be consistent with recommended doses approved by the U.S. Food & Drug Administration (FDA). The quantity limit can include limits on the number of doses per day, maximum daily dose based on labeled dosing, and quantity over time. This may include the number of prescription fills per month or year.

Step Therapy (ST): Step Therapy promotes the appropriate use of effective but lower-cost drugs first. Prerequisite drugs are FDA-approved to treat the same condition as the corresponding step-therapy drugs.

Restricted to Specialist (RS): Limits prescribing of certain high-cost or high-risk drugs to certain prescribers who specialize in treating the associated disease states.

Some pre-certification processes are automated. If we have your complete information for review in our system, the prior-authorization approval may be issued automatically at the pharmacy. When the information we have for you does not meet approval criteria, your pharmacy may notify your doctor of the rejection and PA requirement, in which case your doctor may choose either to make changes to obtain coverage for a similar drug OR request a prior approval of that specific drug. The most common automated PA is the step-therapy requirement. This is when the pharmacy system checks for a previously filled drug that meets the requirement. Coverage determinations will be issued by mail within 72 hours from the time of request for the first level of standard determination request (or within 24 hours for expedited requests). If approved, the corresponding tier copayment will apply for that specific drug. If denied, you may still fill the prescribed drug, but you will have to pay the complete cost of the drug. Community Health Choice's Pharmacy Benefit Manager (Navitus Health Solutions) performs our initial precertification drug reviews.

Community Health Choice is committed to providing high-quality, accessible healthcare services to a diverse population. Community Health Choice offers translated materials and interpretation services to ensure clear and effective communication with all members, regardless of their primary language. Community Health Choice trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes. Community Health Choice provides oral and written notice to consumers with limited English proficiency (LEP) in their preferred language informing them of their right to receive language assistance services and how to get them.

Search Tip:
This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

Community Health Choice Select Formulary

Alphabetical Index

Last Updated 9/1/2026

Drug Name	Special Code	Tier	Category
abacavir soln (ZIAGEN equiv)	-	5	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	2	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	2	ANTIVIRALS
ABILIFY ASIMTUFII INJ 720MG/2.4ML (aripiprazole im er susp prefilled syringe equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY ASIMTUFII INJ 960MG/3.2ML (aripiprazole im er susp prefilled syringe equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY MAINTENA INJ	-	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY MYCITE PACK	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY MYCITE TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ABILIFY TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
abiraterone tab 250mg (ZYTIGA equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABRILADA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ABRYSVO INJ (QL= 1 dose/lifetime)	QL-VAC	1	VACCINES
ABSORICA CAP	-	NC	DERMATOLOGICALS
ABSORICA LD CAP	-	NC	DERMATOLOGICALS
ABSTRAL SL TAB	-	NC	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	2	ANTIDIABETICS
ACCOLATE TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ACCRUFER CAP	-	NC	HEMATOPOIETIC AGENTS
ACCU-CHEK GUIDE CARE METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE ME KIT	OTC	1	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
ACCUPRIL TAB	-	NC	ANTIHYPERTENSIVES
ACCURETIC TAB	-	NC	ANTIHYPERTENSIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
acebutolol cap (SECTRAL equiv)	-	2	BETA BLOCKERS
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	2	ANALGESICS - OPIOID
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC	MIGRAINE PRODUCTS
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC	MIGRAINE PRODUCTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	3	DIURETICS
acetazolamide tab	-	2	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	2	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	2	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	2	COUGH / COLD / ALLERGY
ACIPHEX SPRINKLE CAP	-	NC	ULCER DRUGS
ACIPHEX TAB	-	NC	ULCER DRUGS
acitretin cap (SORIATANE equiv)	-	3	DERMATOLOGICALS
ACTEMRA ACTPEN INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA IV INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ACTEMRA SC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ACTHAR GEL AUTO-INJECTOR	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHAR GEL INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHIB INJ, HIBERIX INJ	VAC	1	VACCINES
ACTICLATE TAB 75MG, 150MG	-	NC	TETRACYCLINES
ACTIGALL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ACTIQ LOZENGE	-	NC	ANALGESICS - OPIOID
ACTIVELLA TAB	-	NC	ESTROGENS
ACTIVITE TAB	-	NC	MULTIVITAMINS
ACTONEL TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTOPLUS MET TAB	-	NC	ANTIDIABETICS
ACTOS TAB	-	NC	ANTIDIABETICS
ACULAR (LS) OPHTH SOLN	-	NC	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ACULAR (LS) OPHTH SOLN 0.4%	-	NC	OPHTHALMIC AGENTS
ACUVAIL OPHTH SOLN	-	4	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	2	ANTIVIRALS
acyclovir cream (ZOVIRAX equiv)	-	NC	DERMATOLOGICALS
acyclovir oint (ZOVIRAX equiv)	-	2	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	2	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	2	ANTIVIRALS
ACZONE GEL	-	NC	DERMATOLOGICALS
ADACEL/BOOSTRIX INJ	VAC	1	TOXOIDS
ADAGEN INJ	-	NC	BIOLOGICALS MISC
ADALAT CC TAB	-	NC	CALCIUM CHANNEL BLOCKERS
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fill; 1 fill/plan year)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ 10/0.1ML	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIC equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK INJ (SIMLANDI equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADAPALENE SOLN	-	NC	DERMATOLOGICALS
adapalene cream (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
ADAPALENE PAD	-	NC	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	3	DERMATOLOGICALS
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC	DERMATOLOGICALS
ADASUVE INHALER	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ADAZIN CREAM	-	NC	DERMATOLOGICALS
ADBRY INJ (QL= 2 inj/28 days)	MSP-PA-QL	5	DERMATOLOGICALS
ADBRY INJ (QL= 4 inj/28 days)	MSP-PA-QL	5	DERMATOLOGICALS
ADCIRCA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ADDERALL TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ADDERALL XR CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
adefovir dipivoxil tab (HEPSERA equiv)	-	NC	ANTIVIRALS
ADEMPAS TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ADIPEX-P CAP	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ADLARITY PATCH	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ADMELOG INJ, HUMALOG INJ	-	NC	ANTIDIABETICS
ADMELOG SOLOSTAR, HUMALOG TEMPO PEN	-	NC	ANTIDIABETICS
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC	VASOPRESSORS
ADRENALIN SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
ADVAIR DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVATE, KOVALTRY INJ	-	EX C	HEMATOLOGICAL AGENTS - MISC.
ADVICOR TAB	-	NC	ANTIHYPERLIPIDEMICS
ADYNOVATE INJ	-	EX C	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ADZENYS ER SUSP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ADZENYS XR ODT	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
AEMCOLO TAB	-	NC	ANTI-INFECTIVE AGENTS MISC.
AEROCHAMBER	OTC	3	MEDICAL DEVICES AND SUPPLIES
AEROCHAMBER SUPPLIES	-	3	MEDICAL DEVICES AND SUPPLIES
AEROSPAN INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AFINITOR DISPERZ TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AFSTYLA KIT	-	EX C	HEMATOLOGICAL AGENTS - MISC.
AGAMREE SUSP	-	NC	CORTICOSTEROIDS
AGRYLIN CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
AIMOVIG INJ	-	NC	MIGRAINE PRODUCTS
AIRDUO POWDER INHALER W/SENSOR	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRDUO RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRSUPRA INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AJOVY INJ	-	NC	MIGRAINE PRODUCTS
AKEEGA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AKLIEF CREAM	-	NC	DERMATOLOGICALS
AKYNZEO CAP	-	NC	ANTIEMETICS
ALA-SCALP LOTION	-	NC	DERMATOLOGICALS
albendazole tab (ALBENZA equiv)	-	4	ANTHELMINTICS
ALBENZA TAB	-	NC	ANTHELMINTICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
albuterol HFA (18gm) inhaler (VENTOLIN equiv) (QL= 2 inhalers/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol HFA (6.7gm, 8.5gm) inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALCAINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
alclometasone cream (ACLOVATE equiv)	-	3	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ALCLOMETASONE OINT	-	3	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv)	-	3	DERMATOLOGICALS
ALCOHOL SWABS	OTC	2	MEDICAL DEVICES AND SUPPLIES
ALCORTIN A GEL	-	NC	DERMATOLOGICALS
ALDACTAZIDE TAB	-	NC	DIURETICS
ALDACTAZIDE TAB 50-50MG	-	4	DIURETICS
ALDACTONE TAB	-	NC	DIURETICS
ALDARA CREAM	-	NC	DERMATOLOGICALS
ALDURAZYME INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alendronate sodium oral soln (FOSAMAX equiv)	-	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ALEVICYN SOLN DERMAL	-	NC	DERMATOLOGICALS
alfuzosin SR tab (UROXATRAL equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
ALHEMO INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ALINIA TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
aliskiren tab (TEKTURNA equiv)	-	NC	ANTIHYPERTENSIVES
ALKERAN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALKINDI SPRINKLE CAP	-	NC	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	5	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	5	CORTICOSTEROIDS
ALLEGRA ODT	OTC	NC	ANTIHISTAMINES
allopurinol tab (ZYLOPRIM equiv)	-	2	GOUT AGENTS
allopurinol tab 200mg	-	NC	GOUT AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ALLZITAL TAB	-	NC	ANALGESICS - NONNARCOTIC
almotriptan tab (QL= 9 tabs/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
ALOCRIL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ALOGLIPTIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN TAB, NESINA TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-METFORMIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-PIOGILTAZONE TAB	-	NC	ANTIDIABETICS
ALOQUIN GEL	-	NC	DERMATOLOGICALS
ALORA PATCH	-	4	ESTROGENS
alosetron tab (LOTRONEX equiv)	-	4	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.15%	-	NC	OPHTHALMIC AGENTS
ALPHANATE, HUMATE-P INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
ALPHANINE SD INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
alprazolam ER tab (XANAX XR equiv)	-	3	ANTIANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	4	ANTIANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	2	ANTIANXIETY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ALPROLIX INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
ALREX OPHTH SUSP	-	3	OPHTHALMIC AGENTS
ALREX OPHTH SUSP 0.2%	-	3	OPHTHALMIC AGENTS
ALTABAX OINT	-	NC	DERMATOLOGICALS
ALTACE CAP	-	NC	ANTIHYPERTENSIVES
ALTAFRIN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
ALTOPREV TAB	-	NC	ANTIHYPERLIPIDEMICS
ALTRENO LOTION	-	NC	DERMATOLOGICALS
ALTUVIIIO INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
ALUNBRIG PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALVAIZ TAB	-	NC	HEMATOPOIETIC AGENTS
ALVESCO INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
alvimopan cap (ENTEREG equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
ALYFTREK TAB	-	NC	RESPIRATORY AGENTS - MISC.
ALYFTREK TAB 4-20-50MG	-	NC	RESPIRATORY AGENTS - MISC.
ALZAIR NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
amantadine cap (SYMMETREL equiv)	-	2	ANTIPARKINSON AGENTS
amantadine soln (AMANTADINE equiv)	-	2	ANTIPARKINSON AND RELATED THERAPY AGENTS
amantadine tab	-	3	ANTIPARKINSON AGENTS
AMARYL TAB	-	NC	ANTIDIABETICS
AMBIEN CR TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
AMBIEN TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
AMCINONIDE CREAM 0.1%	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AMCINONIDE LOTION	-	4	DERMATOLOGICALS
AMCINONIDE OINTMENT	-	NC	DERMATOLOGICALS
amethyst tab (LYBREL equiv)	-	1	CONTRACEPTIVES
AMICAR SOLN	-	NC	HEMOSTATICS
AMICAR TAB	-	NC	HEMOSTATICS
amiloride tab (MIDAMOR equiv)	-	2	DIURETICS
AMILORIDE/HCTZ TAB	-	NC	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	NC	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	3	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	3	HEMOSTATICS
amiodarone tab (CORDARONE equiv)	-	2	ANTIARRHYTHMICS
AMITIZA CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	2	ANTIDEPRESSANTS
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AMJEVITA INJ (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
amlodipine tab (NORVASC equiv)	-	2	CALCIUM CHANNEL BLOCKERS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
amlodipine/atorvastatin tab (CADUET equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	2	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only)	-	2	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only)	-	2	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	3	DERMATOLOGICALS
amoxapine tab (AMOXAPINE equiv)	-	2	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	2	PENICILLINS
AMOXICILLIN CHEW	-	2	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	2	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	2	PENICILLINS
AMOXICILLIN/CLAVULANATE CHEW TAB	-	3	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	2	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	2	PENICILLINS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv)	-	4	PENICILLINS
amphetamine er odt (ADZENYS XR equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine tab (EVEKEO equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
AMPHOTERICIN B IV SOLN	-	NC	ANTIFUNGALS
ampicillin cap (AMPICILLIN equiv)	-	2	PENICILLINS
AMPYRA TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AMRIX CAP	-	NC	MUSCULOSKELETAL THERAPY AGENTS
AMZEEQ FOAM	-	NC	DERMATOLOGICALS
ANADROL TAB	-	4	ANDROGENS-ANABOLIC
ANAFRANIL CAP	-	NC	ANTIDEPRESSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
anagrelide cap (AGRYLIN equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM HC CREAM 2.5-1%	-	NC	ANORECTAL AND RELATED PRODUCTS
ANALPRAM-E KIT	-	4	ANORECTAL AGENTS
ANALPRAM-HC CREAM	-	NC	ANORECTAL AND RELATED PRODUCTS
ANAPROX TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ANASPAZ ODT	-	NC	ULCER DRUGS
ANASTIA LOTION	-	NC	DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANCOBON CAP	-	NC	ANTIFUNGALS
ANDEMBRY INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ANDROGEL 1% 25MG	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 1.25GM	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 2.5GM	-	NC	ANDROGENS-ANABOLIC
ANDROGEL PUMP 1.62%	-	NC	ANDROGENS-ANABOLIC
ANGELIQ TAB	-	NC	ESTROGENS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ANNOVERA RING (QL= 1 ring/year)	QL	1	CONTRACEPTIVES
ANORO ELLIPTA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANTABUSE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC	ANTIHYPERLIPIDEMICS
ANTARA CAP, LOFIBRA CAP	-	NC	ANTIHYPERLIPIDEMICS
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC	OTIC AGENTS
ANUCORT-HC SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
ANUSOL-HC CREAM	-	NC	ANORECTAL AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL	4	ANTIEMETICS
ANZUPGO CREAM	-	NC	DERMATOLOGICALS
APADAZ TAB	-	NC	ANALGESICS - OPIOID
APAP/CODEINE SOLN	-	3	ANALGESICS - OPIOID
APEXICON E CREAM (PSORCON E equiv)	-	NC	DERMATOLOGICALS
APIDRA INJ	-	NC	ANTIDIABETICS
APIDRA SOLOSTAR INJ	-	NC	ANTIDIABETICS
APLENZIN TAB	-	NC	ANTIDEPRESSANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
APOKYN INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
apomorphine inj (APOKYN equiv)	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
APRACLONIDINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	3	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	3	ANTIEMETICS
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	3	ANTIEMETICS
APRETUDE SUSP (QL= 7 inj/year)	PA-QL	1	ANTIVIRALS
APRISO CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
APRIZIO PAK KIT	-	NC	DERMATOLOGICALS
APTIOM TAB	-	NC	ANTICONVULSANTS
APTIVUS CAP	-	NC/ 3P	ANTIVIRALS
AQNEURSA PACKET FOR SUSPENSION	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AQVESME TAB 100MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
ARAKODA TAB	-	NC	ANTIMALARIALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ARALAST/PROLASTIN/ZEMAIRA INJ	-	NC	RESPIRATORY AGENTS - MISC.
ARANELLE TAB	-	1	CONTRACEPTIVES
aranelle tab (TRI-NORINYL equiv)	-	1	CONTRACEPTIVES
ARANESP INJ	-	NC	HEMATOPOIETIC AGENTS
ARAVA TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARAZLO LOTION	-	NC	DERMATOLOGICALS
ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older)	PA-QL	4	ANTIHYPERTENSIVES
ARCALYST INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARCAPTA NEOHALER	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AREXVY INJ (QL= 1 dose/lifetime)	QL-VAC	1	VACCINES
arformoterol tartrate neb soln (BROVANA equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARICEPT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ARICEPT TAB 23MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	5	AMINOGLYCOSIDES
ARIMIDEX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
aripiprazole ODT (ABILIFY equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	PA	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ARISTADA INJ	-	6	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ARIXTRA INJ	-	NC	ANTICOAGULANTS
ARMLUPEG INJ	-	NC	HEMATOPOIETIC AGENTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMOUR THYROID TAB, NATURE THYROID TAB	-	2	THYROID AGENTS
ARNUITY ELLIPTA INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AROMASIN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ARTHROTEC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARYNTA SOLN	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ASACOL HD TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ASACOL HD TAB, MESALAMINE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	PA-QL	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ASMANEX HFA INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg (Covered for male members age 45-79 years; Covered for female members (no age restriction))	OTC	1	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg	OTC	1	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for male members age 45-79 years; Covered for female members age 55-79 years)	OTC	1	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1	ANALGESICS - NONNARCOTIC
aspirin/dipyridamole cap (AGGRENOX equiv)	-	3	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ASPIRIN/OMEPRAZOLE ER TAB	-	4	HEMATOLOGICAL AGENTS - MISC.
ASPRUZYO SPRINKLE GRANULES	-	NC	ANTIANGINAL AGENTS
ASTAGRAF XL CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ASTAMED MYO CAP	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
ASTELIN NASAL SPRAY, ASTEPRO NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
ATACAND HCT TAB	-	NC	ANTIHYPERTENSIVES
ATACAND TAB	-	NC	ANTIHYPERTENSIVES
atazanavir cap (REYATAZ equiv)	-	3	ANTIVIRALS
ATELVIA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
atenolol tab (TENORMIN equiv)	-	2	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	2	ANTIHYPERTENSIVES
ATIVAN TAB	-	NC	ANTIANXIETY AGENTS
ATMEKSI SUSP	-	NC	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
atomoxetine cap (STRATTERA equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ATONCY SOLN, ATOMOXETINE HCL SOLN	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ATORVALIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	4	ANTIHYPERLIPIDEMICS
atorvastatin tab (LIPITOR equiv)	-	1	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	3	ANTI-INFECTIVE AGENTS MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	2	ANTIMALARIALS
ATRALIN GEL 0.05%	-	NC	DERMATOLOGICALS
ATRIPLA TAB	-	NC/ 3P	ANTIVIRALS
atropine inj	M	6	ULCER DRUGS
atropine ophth oint	-	2	OPHTHALMIC AGENTS
ATROPINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	2	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ATROPINE SUL INJ	M	6	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ATROPINE SUL SOLN 1% OPHTH	-	2	OPHTHALMIC AGENTS
ATROPINE SULFATE INJ	--M	6	ULCER DRUGS
ATROPINE SULFATE OPHTH OINT	-	2	OPHTHALMIC AGENTS
ATROVENT HFA AERO	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ATTRUBY PACK	-	NC	CARDIOVASCULAR AGENTS - MISC.
AUBAGIO TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUGMENTIN ES-600 SUSP	-	NC	PENICILLINS
AUGMENTIN SUSP	-	4	PENICILLINS
AUGMENTIN TAB	-	NC	PENICILLINS
AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AURANOFIN CAP, RIDAURA CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AURYXIA TAB	-	4	GASTROINTESTINAL AGENTS - MISC.
AUSTEDO TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO TITRATION PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB (QL= 1 tab/day)	MSP-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/2 days)	MSP-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days)	MSP-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUVELITY TAB	-	NC	ANTIDEPRESSANTS
AUVELITY TAB TITRATION PACK	-	NC	ANTIDEPRESSANTS
AUVI-Q INJ	-	NC	VASOPRESSORS
AVALIDE TAB	-	NC	ANTIHYPERTENSIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
avanafil tab (STENDRA equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
AVAPRO TAB	-	NC	ANTIHYPERTENSIVES
AVAR AEROSOL FOAM	-	NC	DERMATOLOGICALS
AVAR CLEANSE LIQ 10-5%	-	3	DERMATOLOGICALS
AVAR PAD	-	NC	DERMATOLOGICALS
AVAR-E EMOLL CREAM	-	NC	DERMATOLOGICALS
AVAR-E LS CREAM 10-2%	-	NC	DERMATOLOGICALS
AVELOX TAB	-	NC	FLUOROQUINOLONES
AVERI TAB	-	1	CONTRACEPTIVES
aviane tab (ALESSE equiv)	-	1	CONTRACEPTIVES
AVMAPKI FAKZYNJA CO-PACK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVODART CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
AVONEX INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVTOZMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
AWIQLI FLEX INJ	-	NC	ANTIDIABETICS
AXERT TAB	-	NC	MIGRAINE PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AXID CAP	-	NC	ULCER DRUGS
AYGESTIN TAB	-	NC	PROGESTINS
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZASITE SOLN	-	3	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	2	ASSORTED CLASSES
azathioprine tab 100mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azathioprine tab 75mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azelaic acid gel (FINACEA equiv)	-	2	DERMATOLOGICALS
azelastine nasal spray 0.1% (ASTELIN equiv)	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine nasal spray 0.15% (ASTEPRO equiv)	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	2	OPHTHALMIC AGENTS
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZELEX CREAM	-	NC	DERMATOLOGICALS
AZENASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZESCHEW TAB 13-1MG	-	4	MULTIVITAMINS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AZESCO TAB	-	NC	MULTIVITAMINS
AZILECT TAB	-	NC	ANTIPARKINSON AGENTS
azilsartan medoxomil tab (EDARBI equiv)	-	NC	ANTIHYPERTENSIVES
azithromycin susp (ZITHROMAX equiv)	-	2	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	2	MACROLIDES
AZOPT OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
AZSTARYS CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
AZULFIDINE EN TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
AZULFIDINE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
BACIT/POLYMY OPHTH OINT	-	2	OPHTHALMIC AGENTS
BACITRACIN OPHTH OINT	-	3	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	2	OPHTHALMIC AGENTS
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	2	OPHTHALMIC AGENTS
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	2	OPHTHALMIC AGENTS
BACLOFEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
baclofen oral soln 10MG/5ML (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	4	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization required for members age 9 years and older)	PA	4	MUSCULOSKELETAL THERAPY AGENTS
baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older)	PA	4	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN SOLN	-	NC	MUSCULOSKELETAL THERAPY AGENTS
baclofen susp (BACLOFEN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab (BACLOFEN equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab 15mg	-	NC	MUSCULOSKELETAL THERAPY AGENTS
BACTRIM DS TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
BACTROBAN CREAM	-	NC	DERMATOLOGICALS
BAFIERTAM CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BALCOLTRA TAB	-	1	CONTRACEPTIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
balsalazide cap (COLAZAL equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BANZEL SUSP	-	NC	ANTICONVULSANTS
BANZEL TAB	-	NC	ANTICONVULSANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	3	ANTIDIABETICS
BARACLUDE SOLN	-	NC	ANTIVIRALS
BARACLUDE TAB	-	NC	ANTIVIRALS
BASAGLAR KWIKPEN	-	NC	ANTIDIABETICS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	3	FLUOROQUINOLONES
BAXFENDY TAB	-	NC	ANTIHYPERTENSIVES
BCG INJ	VAC	EXC	VACCINES
B-D INSULIN SYRINGE	--OTC	2	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
b-donna tab (DONNATAL equiv)	-	NC	ULCER DRUGS
BECONASE AQ NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or mometasone)	QL-ST	4	NASAL AGENTS - SYSTEMIC AND TOPICAL
BELBUCA FILM	-	NC	ANALGESICS - OPIOID
BELLADONNA ALKALOID/OPIUM SUPP	-	3	ULCER DRUGS
BELSOMRA TAB	-	NC	HYPNOTICS
benazepril tab (LOTENSIN equiv)	-	2	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	2	ANTIHYPERTENSIVES
BENEFIX INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
BENICAR HCT TAB	-	NC	ANTIHYPERTENSIVES
BENICAR TAB	-	NC	ANTIHYPERTENSIVES
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	MSP-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
BENLYSTA INJ (QL= 4 inj/28 day)	MSP-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
BENTIVITE TAB	-	NC	HEMATOPOIETIC AGENTS
BENTYL CAP	-	NC	ULCER DRUGS
BENTYL SYRUP	-	NC	ULCER DRUGS
BENZACLIN GEL	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BENZAMYCIN GEL	-	NC	DERMATOLOGICALS
BENZAMYCIN GEL PACK	-	NC	DERMATOLOGICALS
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	3	ANTHELMINTICS
BENZOCAINE/LIDOCAINE/TETRACAINE OINT	-	NC	DERMATOLOGICALS
benzonatate cap (TESSALON equiv)	-	2	COUGH / COLD / ALLERGY
BENZONATATE CAP 150MG	-	NC	COUGH / COLD / ALLERGY
benzonatate cap 150mg (ZONATUSS equiv)	-	NC	COUGH / COLD / ALLERGY
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC	DERMATOLOGICALS
benzphetamine tab	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
benztropine tab	-	2	ANTIPARKINSON AGENTS
bepotastine ophth soln (BEPREVE equiv)	-	4	OPHTHALMIC AGENTS
BERINERT INJ (Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, or Walgreens 888-347-3416)	LD-PA	5	HEMATOLOGICAL AGENTS - MISC.
BESER KIT 0.05%	-	NC	DERMATOLOGICALS
BESIFLOXACIN OPHTH SUSP, BESIVANCE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BESREMI PEN INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BETAGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
betaine powder for oral solution (CYSTADANE equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BETAMETH VALERATE LOTION	-	2	DERMATOLOGICALS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	2	DERMATOLOGICALS
BETAMETHASONE AUGMENTED GEL	-	3	DERMATOLOGICALS
betamethasone augmented gel	-	NC	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	3	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	2	DERMATOLOGICALS
betamethasone diproprionate cream (DIPROSONE CREAM equiv)	-	2	DERMATOLOGICALS
betamethasone diproprionate lotion	-	2	DERMATOLOGICALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
betamethasone diproprionate oint (DIPROSONE OINT equiv)	-	3	DERMATOLOGICALS
betamethasone valerate cream	-	2	DERMATOLOGICALS
betamethasone valerate foam (LUXIQ FOAM equiv)	-	NC	DERMATOLOGICALS
betamethasone valerate lotion	-	2	DERMATOLOGICALS
betamethasone valerate oint	-	2	DERMATOLOGICALS
BETAPACE AF TAB	-	NC	BETA BLOCKERS
BETAPACE TAB	-	NC	BETA BLOCKERS
BETASERON INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BETAXOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
betaxolol ophth soln (BETOPTIC-S equiv)	-	2	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	2	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	2	URINARY ANTISPASMODICS
BETHKIS NEB SOLN, TOBI NEB SOLN	-	NC	AMINOGLYCOSIDES
BETIMOL OPHTH SOLN 0.25%	-	3	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	3	OPHTHALMIC AGENTS
BEVESPI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BEXAGLIFLOZN TAB	-	NC	ANTIDIABETICS
bexarotene cap (TARGRETIN equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bexarotene gel (TARGRETIN equiv)	MSP-PA	2	DERMATOLOGICALS
BEXSERO INJ	VAC	1	VACCINES
BEYAZ TAB	-	4	CONTRACEPTIVES
BEYFORTUS INJ	VAC	1	PASSIVE IMMUNIZING AND TREATMENT AGENTS
BIAFINE EMULSION	-	NC	DERMATOLOGICALS
BIAXIN TAB	-	NC	MACROLIDES
bicalutamide tab (CASODEX equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIDIL TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
BIFERARX TAB	-	NC	HEMATOPOIETIC AGENTS
BIJUVA CAP	-	NC	ESTROGENS
BIKTARVY TAB	-	NC/3P	ANTIVIRALS
BILTRICIDE TAB	-	NC	ANTHELMINTICS
BIMATOPROST OPHTH SOLN (QL= 2.5ml/30 days)	QL	3	OPHTHALMIC AGENTS
bimatoprost ophth soln (LATISSE equiv)	-	EXC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BIMZELX INJ	-	NC	DERMATOLOGICALS
BIMZELX INJ 320MG/2ML	-	NC	DERMATOLOGICALS
BIMZELX SYRINGE	-	NC	DERMATOLOGICALS
BIMZELX SYRINGE 320MG/2ML	-	NC	DERMATOLOGICALS
BINOSTO TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
bismuth/metro/tetra cap (PYLERA equiv)	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
BISOPROLOL FUMARATE TAB	-	NC	BETA BLOCKERS
bisoprolol tab (ZEBETA equiv)	-	2	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	NC	ANTIHYPERTENSIVES
BLANCHE CREAM	-	EXC	DERMATOLOGICALS
BLEPH-10 OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
BLUJEPA TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
BONIVA TAB 150MG	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		**generic** =small letters		**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BONSITY INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.
bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
BOSULIF CAP	MSP-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOSULIF TAB	MSP-PA-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bosutinib tab (BOSULIF equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BP 10-1 EMU	-	NC	DERMATOLOGICALS
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREKIYA INJ	-	NC	MIGRAINE PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BREO ELLIPTA INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREXAFEMME TAB	-	NC	ANTIFUNGALS
BREZTRI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREZTRI AEROSPHERE INHALER 160-18-4.8 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	3	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	2	OPHTHALMIC AGENTS
brimonidine tartrate gel (MIRVASO equiv)	-	EXC	DERMATOLOGICALS
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	3	OPHTHALMIC AGENTS
brimonidine/timolol ophth soln (COMBIGAN equiv)	-	3	OPHTHALMIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BRINSUPRI TAB	-	NC	RESPIRATORY AGENTS - MISC.
brinzolamide ophth susp (AZOPT equiv)	-	3	OPHTHALMIC AGENTS
BRISDELLE CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
brivaracetam inj (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
brivaracetam oral soln 10mg/ml (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
brivaracetam tab (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
BRIVIACT INJ	-	NC	ANTICONVULSANTS
BRIVIACT SOLN 10MG/ML	-	NC	ANTICONVULSANTS
BRIVIACT TAB	-	NC	ANTICONVULSANTS
bromfenac ophth soln (BROMDAY equiv)	-	3	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	3	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	3	ANTIPARKINSON AGENTS
BROMSITE DROP 0.075%	-	NC	OPHTHALMIC AGENTS
BRONCHITOL CAP	-	NC	RESPIRATORY AGENTS - MISC.
BROVANA NEB SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BROVEX PEB LIQUID	OTC	NC	COUGH / COLD / ALLERGY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BRUKINSA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRUKINSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRYHALI LOTION	-	NC	DERMATOLOGICALS
BRYNOVIN SOLN	-	NC	ANTIDIABETICS
B-SERENE PAD	-	NC	HEMATOPOIETIC AGENTS
BUCAPSOL CAP	-	NC	ANTIANXIETY AGENTS
budesonide ER tab (QL=1 tab/day)	PA-QL	4	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv (QL= 2 bottles/fill)	OTC-QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	PA	4	ANORECTAL AND RELATED PRODUCTS
budesonide SR cap (ENTOCORT EC equiv)	-	3	CORTICOSTEROIDS
budesonide/formoterol inhaler (SYMBICORT equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
bumetanide tab (BUMEX equiv)	-	2	DIURETICS
BUNAVAIL FILM	-	NC	ANALGESICS - OPIOID

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BUPHENYL POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BUPHENYL TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC	ANALGESICS - OPIOID
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	4	ANALGESICS - OPIOID
buprenorphine SL tab (SUBUTEX equiv)	-	NC	ANALGESICS - OPIOID
buprenorphine/naloxone sl film (SUBOXONE equiv)	-	2	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv	-	2	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	2	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	2	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv)	-	2	ANTIDEPRESSANTS
BUPROPION XL TAB, FORFIVO XL TAB	-	NC	ANTIDEPRESSANTS
buspirone tab (BUSPAR equiv)	-	2	ANTIANXIETY AGENTS
BUSPIRONE TAB	-	NC	ANTIANXIETY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BUTALBITAL/ACETAMINOPHEN CAP	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine soln	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	NC	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC	ANALGESICS - NONNARCOTIC
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	3	ANALGESICS - OPIOID
BUTRANS PATCH	-	NC	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ	-	NC	ANTIDIABETICS
BYDUREON INJ	-	NC	ANTIDIABETICS
BYDUREON PEN INJ	-	NC	ANTIDIABETICS
BYLVAY CAP 1200MCG (QL= 2 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
BYLVAY CAP 400MCG (QL= 6 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 200MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
BYNFEZIA PEN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BYQLOVI OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
BYQLOVI SUSP	-	NC	OPHTHALMIC AGENTS
BYSANTI TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
BYSANTI TITRATION PACK	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
BYSTOLIC TAB	-	NC	BETA BLOCKERS
BYVALSON TAB	-	NC	ANTIHYPERTENSIVES
CABENUVA IM SUSP	-	NC/ 3P	ANTIVIRALS
CABENUVA SUSP 600MG-900MG/3ML	-	NC/ 3P	ANTIVIRALS
cabergoline tab (DOSTINEX equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
CABLIVI INJ KIT	-	NC	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CABOMETYX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CABTREO GEL	-	NC	DERMATOLOGICALS
CADUET TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
CAFCIT INJ	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB	-	4	MIGRAINE PRODUCTS
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB 1-100MG	-	NC	MIGRAINE PRODUCTS
caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger)	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
CALAN SR TAB	-	NC	CALCIUM CHANNEL BLOCKERS
calcipotriene cream (DOVONEX CREAM equiv)	-	3	DERMATOLOGICALS
calcipotriene cream (TRIONEX equiv)	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC	DERMATOLOGICALS
calcipotriene oint	-	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
calcipotriene soln (DOVONEX SOLN equiv)	-	3	DERMATOLOGICALS
CALCIPOTRIENE SOLN 0.005%	-	3	DERMATOLOGICALS
calcipotriene/betamethasone dipropionate susp	-	NC	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcitonin inj (MIACALCIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitonin nasal spray (MIACALCIN equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL OINT	-	4	DERMATOLOGICALS
calcitriol soln (ROCALTROL equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
calcium acetate tab (ELIPHOS equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	2	MEDICAL DEVICES AND SUPPLIES
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306, Onco360 877-662-6633, or Walgreens 888-347-3416)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALSODORE PAK	-	NC	DERMATOLOGICALS
CAMBIA POWDER	-	NC	MIGRAINE PRODUCTS
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	2	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	2	ANTIHYPERTENSIVES
CAPASTAT INJ	M	6	ANTIMYCOBACTERIAL AGENTS
capecitabine tab (XELODA equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	NC	DERMATOLOGICALS
CAPLYTA CAP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
capsaicin/menthol topical patch (SINELEE equiv)	-	NC	DERMATOLOGICALS
captopril tab (CAPOTEN equiv)	-	2	ANTIHYPERTENSIVES
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	NC	ANTIHYPERTENSIVES
CAPVAXIVE INJ	VAC	1	VACCINES
CARAC CREAM	-	3	DERMATOLOGICALS
CARAC CREAM	-	NC	DERMATOLOGICALS
CARAFATE SUSP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
CARAFATE TAB	-	NC	ULCER DRUGS
CARBAGLU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
carbamazepine chew tab (TEGRETOL equiv)	-	2	ANTICONVULSANTS
CARBAMAZEPINE CHEW TAB	-	NC	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	3	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	3	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	2	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
carbamazepine tab (TEGRETOL equiv)	-	2	ANTICONVULSANTS
CARBATROL CAP	-	NC	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	3	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA CAP, RYTARY CAP	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	2	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	2	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	2	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	NC	ANTIPARKINSON AGENTS
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	3	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbinoxamine maleate tab 6mg	-	NC	ANTIHISTAMINES
CARBINOXAMINE SOLN	-	4	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	4	ANTIHISTAMINES
CARBZAH SOLN 4MG/5ML	-	NC	ANTIHISTAMINES
CARDAMYST NASAL SPRAY	-	NC	CALCIUM CHANNEL BLOCKERS
CARDIZEM CD CAP	-	NC	CALCIUM CHANNEL BLOCKERS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CARDIZEM LA TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CARDIZEM TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CARDURA TAB	-	NC	ANTIHYPERTENSIVES
CARDURA XL TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
carglumic acid tab (CARBAGLU equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
carisoprodol tab (SOMA equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol tab 250mg (SOMA equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARMOL LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CARNITOR SOLN	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CARNITOR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CARTEOLOL OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	NC	OPHTHALMIC AGENTS
carvedilol phosphate ER cap (COREG CR equiv)	-	NC	BETA BLOCKERS
carvedilol tab (COREG equiv)	-	2	BETA BLOCKERS
CASODEX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CATAPRES-TTS PATCH	-	NC	ANTIHYPERTENSIVES
CAVHANZA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAYSTON INH SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
CEFACLOR CAP	-	4	CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	4	CEPHALOSPORINS
CEFACLOR ER TAB	-	4	CEPHALOSPORINS
CEFACLOR SUSP	-	4	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	2	CEPHALOSPORINS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cefadroxil susp (DURICEF equiv)	-	2	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	2	CEPHALOSPORINS
CEFADROXIL TAB	-	3	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	2	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	2	CEPHALOSPORINS
cefixime cap (SUPRAX equiv)	-	4	CEPHALOSPORINS
cefixime susp (SUPREX equiv)	-	4	CEPHALOSPORINS
CEFIXIME TAB	-	NC	CEPHALOSPORINS
CEFPODOXIME PROXETIL SUSP	-	4	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	4	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	2	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	2	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	2	CEPHALOSPORINS
CELEBREX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
CELEXA TAB	-	NC	ANTIDEPRESSANTS
CELLCEPT CAP	-	NC	ASSORTED CLASSES
CELLCEPT SUSP	-	NC	ASSORTED CLASSES
CELLCEPT TAB	-	NC	ASSORTED CLASSES
CELONTIN CAP	-	4	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CENTANY OINT	-	4	DERMATOLOGICALS
cephalexin cap (KEFLEX equiv)	-	2	CEPHALOSPORINS
cephalexin cap 750mg (KEFLEX equiv)	-	NC	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	2	CEPHALOSPORINS
cephalexin tab	-	NC	CEPHALOSPORINS
CEQUA (PF) OPHTH SOLN, VEVYE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
CEQUR SIMPLICITY	-	NC	MEDICAL DEVICES AND SUPPLIES
CERDELGA CAP	-	NC	HEMATOPOIETIC AGENTS
CERVICAL CAP	-	1	MEDICAL DEVICES AND SUPPLIES
cesia tab (CYCLESSA equiv)	-	1	CONTRACEPTIVES
cetirizine chew tab (ZYRTEC equiv)	OTC	NC	ANTIHISTAMINES
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETROTIDE KIT	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETYLEV TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cevimeline cap (EVOXAC equiv)	-	3	MOUTH / THROAT / DENTAL AGENTS
CHANTIX STARTER PACK	SMKG	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	3	ANTIDOTES
CHENODAL TAB, CTEXLI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
chlordiazepoxide cap (LIBRIUM equiv)	-	NC	ANTIANXIETY AGENTS
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHLORDIAZEPOXIDE/CLIDINIUM CAP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	NC	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS
CHLOROQUINE TAB	-	2	ANTIMALARIALS
chloroquine tab (ARALEN equiv)	-	2	ANTIMALARIALS
CHLORPROMAZINE CONC	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
chlorpromazine hcl conc	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
chlorpromazine tab (THORAZINE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
chlorthalidone tab	-	2	DIURETICS
chlorzoxazone tab	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
chlorzoxazone tab 500mg	-	3	MUSCULOSKELETAL THERAPY AGENTS
CHOLBAM CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
cholecalciferol cap 50000 unit	-	2	VITAMINS
cholestyramine lite powder (QUESTRAN LITE equiv)	-	2	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	2	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	2	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	2	ANTIHYPERLIPIDEMICS
CIALIS TAB	-	EXC	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CIALIS TAB 2.5MG, 5MG	-	NC	CARDIOVASCULAR AGENTS - MISC.
ciclopirox cream (LOPROX CREAM equiv)	-	2	DERMATOLOGICALS
ciclopirox gel (LOPROX GEL equiv)	-	2	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	2	DERMATOLOGICALS
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	3	DERMATOLOGICALS
ciclopirox topical susp (LOPROX SUSP equiv)	-	2	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH OINT	-	4	OPHTHALMIC AGENTS
CILOXAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
CIMDUO TAB	-	3	ANTIVIRALS
cimetidine soln (CIMETIDINE equiv)	-	2	ULCER DRUGS
cimetidine tab (TAGAMET equiv)	OTC	2	ULCER DRUGS
CIMZIA INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
CIMZIA INJ 200MG/ML (QL= 2 inj/28 days)	MSP-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
cinacalcet tab (SENSIPAR equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CIPRO HC OTIC SUSP	-	NC	OTIC AGENTS
CIPRO SUSP	-	4	FLUOROQUINOLONES
CIPRO TAB	-	NC	FLUOROQUINOLONES
CIPRODEX OTIC SUSP	-	NC	OTIC AGENTS
CIPROFLOXACIN 100MG TAB	-	4	FLUOROQUINOLONES
ciprofloxacin hcl otic soln (CETRAXAL equiv)	-	3	OTIC AGENTS
ciprofloxacin ophth soln (CILOXAN equiv)	-	2	OPHTHALMIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	3	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	2	FLUOROQUINOLONES
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	3	OTIC AGENTS
ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv)	-	NC	OTIC AGENTS
CITALOPRAM CAP	-	NC	ANTIDEPRESSANTS
citalopram hydrobromide cap	-	NC	ANTIDEPRESSANTS
citalopram soln (CELEXA equiv)	-	2	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	2	ANTIDEPRESSANTS
CITRANATAL CAP MEDLEY	-	NC	MULTIVITAMINS
CITRULLINE EASY TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cladribine tab therapy pack (MAVENCLAD equiv) (Only available through Walgreens 888-347-3416)	LD	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CLARIFOAM EF FOAM	-	NC	DERMATOLOGICALS
CLARINEX SYRUP	-	4	ANTIHISTAMINES
CLARINEX TAB	-	NC	ANTIHISTAMINES
CLARINEX-D TAB	-	NC	COUGH / COLD / ALLERGY
clarithromycin ER tab (BIAXIN XL equiv)	-	4	MACROLIDES
CLARITHROMYCIN SUSP	-	3	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	2	MACROLIDES
CLARITIN CHEW TAB	OTC	EXC	ANTIHISTAMINES
CLEMASTINE SYRUP	-	NC	ANTIHISTAMINES
CLEMASTINE TAB (GENUS LIFESCIENCES)	-	NC	ANTIHISTAMINES
CLEMASTINE TAB, CLEMASZ TAB	-	4	ANTIHISTAMINES
CLEMSZA TAB 2.68MG	-	NC	ANTIHISTAMINES
CLENIA PLUS SUSP	-	NC	DERMATOLOGICALS
CLENPIQ SOLN	-	NC	LAXATIVES
CLEOCIN CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
CLEOCIN SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CLEOCIN VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
CLEOCIN VAGINAL SUPP (QL= 3 suppositories/fill)	QL	4	VAGINAL PRODUCTS
CLEOCIN-T GEL	-	NC	DERMATOLOGICALS
CLEOCIN-T LOTION	-	NC	DERMATOLOGICALS
CLEOCIN-T PAD	-	NC	DERMATOLOGICALS
CLEOCIN-T SOLN	-	NC	DERMATOLOGICALS
CLIMARA PATCH	-	NC	ESTROGENS
CLIMARA PRO PATCH	-	NC	ESTROGENS
CLINDACIN KIT	-	NC	DERMATOLOGICALS
clindamycin cap (CLEOCIN equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
clindamycin foam (EVOCLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin gel (CLEOCIN GEL equiv)	-	2	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	2	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	2	DERMATOLOGICALS
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	3	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	2	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	QL	2	VAGINAL PRODUCTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	3	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	3	DERMATOLOGICALS
clindamycin/tretinoin gel (ZIANA equiv)	-	NC	DERMATOLOGICALS
CLINDAVIX KIT	-	NC	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	4	VAGINAL AND RELATED PRODUCTS
CLINISTIX TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older)	PA	2	ANTICONVULSANTS
clobazam tab (ONFI equiv)	-	NC	ANTICONVULSANTS
clobetasol E foam (OLUX E equiv)	-	NC	DERMATOLOGICALS
clobetasol foam (OLUX equiv)	-	3	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	-	3	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	2	DERMATOLOGICALS
CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM	-	NC	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	3	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	3	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	2	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
clobetasol propionate soln (TEMOVATE equiv)	-	2	DERMATOLOGICALS
clobetasol shampoo (CLOBEX equiv)	-	3	DERMATOLOGICALS
clobetasol spray (CLOBEX equiv)	-	3	DERMATOLOGICALS
CLOBETAVIX KIT	-	NC	DERMATOLOGICALS
CLOBEX LOTION	-	NC	DERMATOLOGICALS
CLOBEX SHAMPOO	-	NC	DERMATOLOGICALS
CLOBEX SPRAY	-	NC	DERMATOLOGICALS
CLOCORTOLONE CREAM	-	NC	DERMATOLOGICALS
CLODERM CREAM	-	NC	DERMATOLOGICALS
clomiphene citrate tab (CLOMID equiv)	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CLOMIPHENE TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomipramine cap (ANAFRANIL equiv)	-	4	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	4	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	2	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
clonidine patch (CATAPRES-TTS equiv)	-	3	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	2	ANTIHYPERTENSIVES
CLONIDINE TAB	-	NC	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
CLOPIDOGREL THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	NC	ANTIANXIETY AGENTS
CLOTIC SOLN	-	NC	OTIC AGENTS
clotrimazole cream (LOTRIMIN AF equiv)	OTC	NC	DERMATOLOGICALS
clotrimazole soln	-	NC	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	2	DERMATOLOGICALS
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	NC	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	NC	DERMATOLOGICALS
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
CLOZAPINE ODT, FAZACLO ODT	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
clozapine tab (CLOZARIL equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
CLOZARIL TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
COAGADEX INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
COARTEM TAB	-	4	ANTIMALARIALS
COBENFY CAP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
COBENFY CAP STARTER PACK	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
COCAINE HCL SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
CODEINE SULFATE TAB	-	2	ANALGESICS - OPIOID
COLAZAL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
COLCHICINE CAP	-	NC	GOUT AGENTS
colchicine cap (COLCHICINE equiv)	-	NC	GOUT AGENTS
colchicine tab (COLCRYS equiv)	-	2	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	2	GOUT AGENTS
COLCRYS TAB	-	NC	GOUT AGENTS
colesevelam pack (WELCHOL equiv)	-	3	ANTIHYPERLIPIDEMICS
colesevelam tab (WELCHOL equiv)	-	3	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
COLESTID GRANULE	-	NC	ANTIHYPERLIPIDEMICS
COLESTID POWDER PACK	-	NC	ANTIHYPERLIPIDEMICS
COLESTID TAB	-	NC	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	4	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	4	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	2	ANTIHYPERLIPIDEMICS
COLLANEX EXTERNAL POWDER	-	NC	DERMATOLOGICALS
COLY-MYCIN S OTIC SUSP	-	3	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
COMBIPATCH	-	3	ESTROGENS
COMBIVENT RESPIMAT INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
COMBIVIR TAB	-	NC/ 3P	ANTIVIRALS
COMBOGESIC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
COMETRIQ KIT	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	1	VACCINES
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	1	VACCINES

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
COMPLERA TAB	-	4	ANTIVIRALS
COMTAN TAB	-	NC	ANTIPARKINSON AGENTS
CONCEPT DHA CAP	-	2	MULTIVITAMINS
CONCERTA TAB, RITALIN SR TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
CONDYLOX GEL	-	NC	DERMATOLOGICALS
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONSENSI TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONTRACEPTIVE FILM	OTC	1	VAGINAL PRODUCTS
CONTRACEPTIVE GEL	OTC	1	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	1	VAGINAL PRODUCTS
COPAXONE INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CORDARONE TAB	-	NC	ANTIARRHYTHMICS
CORDRAN CREAM	-	NC	DERMATOLOGICALS
CORDRAN CREAM 0.025%	-	NC	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CORDRAN LOTION	-	NC	DERMATOLOGICALS
CORDRAN OINTMENT	-	NC	DERMATOLOGICALS
CORDRAN TAPE	-	4	DERMATOLOGICALS
COREG CR CAP	-	NC	BETA BLOCKERS
COREG TAB	-	NC	BETA BLOCKERS
CORGARD TAB	-	NC	BETA BLOCKERS
CORIFACT KIT	-	EXC	HEMATOLOGICAL AGENTS - MISC.
CORLANOR SOLN (Prior Authorization required for members age 9 years and older)	PA	4	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB	-	4	CARDIOVASCULAR AGENTS - MISC.
CORPHENA ORAL SOLN, RYCLORA ORAL SOLN	-	NC	ANTIHISTAMINES
CORTANE-B OTIC SOLN	-	NC	OTIC AGENTS
CORTEF TAB	-	NC	CORTICOSTEROIDS
CORTENEMA	-	NC	ANORECTAL AGENTS
CORTIC-ND DROPS	-	NC	OTIC AGENTS
CORTIFOAM	-	4	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	3	CORTICOSTEROIDS
CORTROPHIN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CORTROPHIN INJ GEL	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CORVITA 150 TAB	-	NC	HEMATOPOIETIC AGENTS
COSENTYX INJ (1-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ (2-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ 300MG/2ML	-	NC	DERMATOLOGICALS
COSENTYX UNO INJ	-	NC	DERMATOLOGICALS
COSOPT (PF) OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COTEMPLA XR TAB, METHYLPHENIDATE ER TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
COUMADIN TAB	-	NC	ANTICOAGULANTS
COVARYX HS TAB	-	NC	ESTROGENS
COVID-19 TEST	OTC	EXC	DIAGNOSTIC PRODUCTS
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	1	VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	1	VACCINES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	1	VACCINES
COXANTO CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
COZAAR TAB	-	NC	ANTIHYPERTENSIVES
CRENESSITY CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CRENESSITY SOLN	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CREON CAP	-	NC	DIGESTIVE AIDS
CRESEMBA CAP	-	NC	ANTIFUNGALS
CRESTOR TAB	-	NC	ANTIHYPERLIPIDEMICS
CREXONT CAP	-	NC	ANTIPARKINSON AGENTS
CRINONE GEL	PA	3	VAGINAL PRODUCTS
cromolyn conc (GASTROCROM equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
cromolyn neb soln (INTAL equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
cromolyn ophth soln (CROLOM equiv)	-	2	OPHTHALMIC AGENTS
CROMOLYN SODIUM OPHTH SOLN	-	2	OPHTHALMIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CROTAN LOTION	-	NC	DERMATOLOGICALS
cryselle tab	-	1	CONTRACEPTIVES
CUE COVID-19 TEST CARTRIDGE	OTC	EXC	DIAGNOSTIC PRODUCTS
CUE HEALTH MONITOR	OTC	EXC	DIAGNOSTIC PRODUCTS
CUPRIMINE CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
CUTAQUIG INJ	-	NC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
CUTIVATE LOTION	-	NC	DERMATOLOGICALS
CUVITRU INJ	-	NC	PASSIVE IMMUNIZING AGENTS
CUVPOSA SOLN	-	4	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
CUVRIOR TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
cyanocobalamin inj	-	2	HEMATOPOIETIC AGENTS
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	4	HEMATOPOIETIC AGENTS
CYCLOBENZAPRINE COMPOUND KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cyclobenzaprine ER cap (AMRIX equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	4	MUSCULOSKELETAL THERAPY AGENTS
CYCLOGYL OPHTH SOLN	-	4	OPHTHALMIC AGENTS
CYCLOGYL OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
CYCLOMYDRIL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	2	OPHTHALMIC AGENTS
cyclophosphamide cap	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE TAB	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOSERINE CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
CYCLOSET TAB	-	4	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	5	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	5	ASSORTED CLASSES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cyclosporine modified soln (NEORAL equiv)	-	5	ASSORTED CLASSES
cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist)	QL-RS	2	OPHTHALMIC AGENTS
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC	OPHTHALMIC AGENTS
CYFOLEX CAP	-	NC	HEMATOPOIETIC AGENTS
CYKLOKAPRON INJ	-	NC	HEMOSTATICS
CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CYLTEZO INJ (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CYMBALTA CAP	-	NC	ANTIDEPRESSANTS
cyproheptadine syrup	-	2	ANTIHISTAMINES
cyproheptadine tab	-	2	ANTIHISTAMINES
CYSTADANE POWDER (Only available through AnovoRx 844-288-5007)	LD	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	5	OPHTHALMIC AGENTS
CYSTAGON CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days Restricted to Ophthalmology or Optometry Specialist Only available through Walgreens 888-347-3416)	LD-QL-RS	5	OPHTHALMIC AGENTS
CYTOMEL TAB	-	NC	THYROID AGENTS
CYTOTEC TAB	-	NC	ULCER DRUGS
CYTRA K CRYSTALS	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
D.H.E. INJ	-	NC	MIGRAINE PRODUCTS
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	3	ANTICOAGULANTS
dalfampridine ER tab (AMPYRA equiv)	MSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DALIRESP TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
danazol cap (DANOCRINE equiv)	-	3	ANDROGENS-ANABOLIC
DANTRIUM CAP	-	NC	MUSCULOSKELETAL THERAPY AGENTS
dantrolene cap (DANTRIUM equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DANZITEN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
dapagliflozin tab (FARXIGA equiv) (QL= 1 tab/day)	QL	2	ANTIDIABETICS
dapagliflozin-metformin er tab (XIGDUO XR equiv) (QL= 1 tab/day)	QL	2	ANTIDIABETICS
dapagliflozin-metformin er tab 5-1000MG (XIGDUO XR equiv) (QL= 2 tabs/day)	QL	2	ANTIDIABETICS
dapsone gel (ACZONE equiv)	-	NC	DERMATOLOGICALS
dapsone tab	-	2	ANTI-INFECTIVE AGENTS - MISC.
DAPTACEL INJ, INFANRIX INJ	VAC	1	TOXOIDS
DARAPRIM TAB	-	NC	ANTIMALARIALS
darifenacin SR tab (ENABLEX equiv)	-	3	URINARY ANTISPASMODICS
DARTISLA ODT TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
darunavir tab (PREZISTA equiv)	-	3	ANTIVIRALS
dasatinib tab (SPRYCEL equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DAURISMO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DAWNZERA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	5	NEUROMUSCULAR AGENTS
DAYBUE STIX POWDER	-	NC	NEUROMUSCULAR AGENTS
DAYBUE STIX POWDER 8000MG	-	NC	NEUROMUSCULAR AGENTS
DAYPRO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DAYTRANA PATCH	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DAYVIGO TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
DAZOMON GEL	-	NC	DERMATOLOGICALS
DDAVP INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DDAVP NASAL SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
DDAVP TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
DEBACTEROL SOLN	-	NC	MOUTH / THROAT / DENTAL AGENTS
deferasirox granules packet (JADENU equiv)	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (JADENU equiv)	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab for oral susp (EXJADE equiv)	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
deflazacort susp (EMFLAZA equiv)	-	NC	CORTICOSTEROIDS
deflazacort tab (EMFLAZA equiv)	-	NC	CORTICOSTEROIDS
DEGLUDEC FLEXTOUCH INJ	-	NC	ANTIDIABETICS
DEGLUDEC INJ	-	NC	ANTIDIABETICS
DELESTROGEN INJ (QL= 5ml/fill)	QL	4	ESTROGENS
DELSTRIGO TAB	-	3	ANTIVIRALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DELZICOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
demeclocycline tab (DECLOMYCIN equiv)	-	4	TETRACYCLINES
DEMEROL TAB	-	NC	ANALGESICS - OPIOID
DEMSER CAP	-	NC	ANTIHYPERTENSIVES
DENAVIR CREAM	-	NC	DERMATOLOGICALS
DENGVAXIA SUSP	VAC	1	VACCINES
DENTA 5000 CREAM PLUS ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	1	MOUTH / THROAT / DENTAL AGENTS
DEPACON INJ	-	NC	ANTICONVULSANTS
DEPAKENE CAP	-	NC	ANTICONVULSANTS
DEPAKENE SYRUP	-	NC	ANTICONVULSANTS
DEPAKOTE ER TAB	-	NC	ANTICONVULSANTS
DEPAKOTE SPRINKLE CAP	-	NC	ANTICONVULSANTS
DEPAKOTE TAB	-	NC	ANTICONVULSANTS
DEPEN TITRATAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
DEPLIN CAP	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
DEPO-ESTRADIOL IM	-	NC	ESTROGENS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DEPO-MEDROL INJ	-	4	CORTICOSTEROIDS
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	4	CORTICOSTEROIDS
DEPO-PROVERA INJ	-	NC	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	1	CONTRACEPTIVES
DERMACINRX TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
DERMACINRX CREAM	-	NC	DERMATOLOGICALS
DERMACINRX KIT	-	NC	DERMATOLOGICALS
DERMALID PAK	-	NC	DERMATOLOGICALS
DERMA-SMOOTH/FS OIL	-	3	DERMATOLOGICALS
DERMOTIC OIL	-	NC	OTIC AGENTS
DESCOVY TAB	PA	1	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	3	ANTIDEPRESSANTS
DESLORATADINE ODT	-	EXC	ANTIHISTAMINES
DESLORATADINE SOLN	-	EXC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	EXC	ANTIHISTAMINES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DESMODA SOLN	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate inj (DDAVP equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate nasal spray (DDAVP equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESMOPRESSIN NASAL SOLN 1.5MG/ML	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESMOPRESSIN NASAL SPRAY	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESOGEN TAB	-	NC	CONTRACEPTIVES
DESONATE GEL	-	NC	DERMATOLOGICALS
desonide cream (DESOWEN equiv)	-	3	DERMATOLOGICALS
desonide gel	-	NC	DERMATOLOGICALS
desonide lotion	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
desonide oint	-	3	DERMATOLOGICALS
DESOWEN CREAM	-	NC	DERMATOLOGICALS
DESOWEN CREAM KIT	-	NC	DERMATOLOGICALS
DESOWEN LOTION	-	NC	DERMATOLOGICALS
DESOWEN LOTION KIT	-	NC	DERMATOLOGICALS
DESOWEN OINT	-	NC	DERMATOLOGICALS
DESOWEN OINT KIT	-	NC	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	3	DERMATOLOGICALS
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
DESOXIMETASONE GEL	-	NC	DERMATOLOGICALS
desoximetasone oint (TOPICORT equiv)	-	3	DERMATOLOGICALS
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
DESOXYN TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
desvenlafaxine ER tab (PRISTIQ equiv)	-	2	ANTIDEPRESSANTS
DESVENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
DETROL LA CAP	-	NC	URINARY ANTISPASMODICS
DETROL TAB	-	NC	URINARY ANTISPASMODICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DEXAMETHASONE CONC	-	2	CORTICOSTEROIDS
dexamethasone elixir	-	2	CORTICOSTEROIDS
DEXAMETHASONE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
dexamethasone pak (DEXPAK equiv)	-	NC	CORTICOSTEROIDS
DEXAMETHASONE PHOSPHATE INJ	-	2	CORTICOSTEROIDS
DEXAMETHASONE SODIUM PHOSPHATE INJ	-	2	CORTICOSTEROIDS
DEXAMETHASONE SOLN	-	2	CORTICOSTEROIDS
DEXAMETHASONE TAB	-	2	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	2	CORTICOSTEROIDS
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (15-DAY) (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
DEXEDRINE CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DEXILANT DR CAP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
dexlansoprazole DR cap (DEXILANT equiv)	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
dexmethylphenidate tab (FOCALIN equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DEXPAK TAB	-	NC	CORTICOSTEROIDS
DEXTENZA OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	4	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine sulfate tab 15mg (ZENZEDI equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
dextroamphetamine sulfate tab 20mg (ZENZEDI equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine sulfate tab 30mg (ZENZEDI equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
dextromethorphan hbr-quinidine sulfate cap (NUEDEXTA equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DHIVY TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DIABETIC METER (all other diabetic meters)	OTC	NC	MEDICAL DEVICES AND SUPPLIES
DIACOMIT CAP	-	NC	ANTICONVULSANTS
DIACOMIT POWDER PACK	-	NC	ANTICONVULSANTS
DIALYVITE TAB	-	2	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	NC	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	2	MULTIVITAMINS
DIAPHRAGM	-	1	MEDICAL DEVICES AND SUPPLIES
DIASTAT ACDL GEL	-	NC	ANTICONVULSANTS
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	NC	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	2	ANTIANXIETY AGENTS
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	2	ANTIANXIETY AGENTS
diazepam rectal gel (QL= 4 doses/fill)	QL	3	ANTICONVULSANTS
diazepam tab (VALIUM equiv)	-	2	ANTIANXIETY AGENTS
diazoxide susp (PROGLYCEM equiv)	-	4	ANTIDIABETICS
DIBENZYLINE CAP	-	NC	ANTIHYPERTENSIVES
dichlorphenamide tab (KEVEYIS equiv)	-	NC	DIURETICS
DICLEGIS TAB	-	NC	ANTIEMETICS
DICLOFENAC CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	3	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	2	DERMATOLOGICALS
DICLOFENAC PATCH, FLECTOR PATCH	-	NC	DERMATOLOGICALS
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC	MIGRAINE PRODUCTS
diclofenac potassium cap (ZIPSOR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab (CATAFLAM equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium gel kit (VENNGEL equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium ophth soln (VOLTAREN equiv)	-	2	OPHTHALMIC AGENTS
diclofenac sodium soln 2% (PENNSAID equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
diclofenac soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill)	QL	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DICLONA GEL	-	NC	DERMATOLOGICALS
DICLOTREX PAK	-	NC	DERMATOLOGICALS
dicloxacillin cap (DYNAPEN equiv)	-	2	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	2	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	3	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	2	ULCER DRUGS
DICYCLOMINE TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
DIETHYLPROPION ER TAB	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
diethylpropion tab	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DIFFERIN CREAM	-	NC	DERMATOLOGICALS
DIFFERIN GEL	-	NC	DERMATOLOGICALS
DIFFERIN LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DIFFERIN OTC GEL 0.1% (Acne Only - Prior Authorization required for members age 35 years and older)	OTC-PA	2	DERMATOLOGICALS
DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3	MACROLIDES
DIFICID TAB (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3	MACROLIDES
DIFLORASONE CREAM	-	NC	DERMATOLOGICALS
DIFLORASONE CREAM, PSORCON CREAM	-	NC	DERMATOLOGICALS
diflorasone oint	-	NC	DERMATOLOGICALS
DIFLUCAN SUSP	-	NC	ANTIFUNGALS
DIFLUCAN TAB	-	NC	ANTIFUNGALS
diflunisal tab (DOLOBID equiv)	-	2	ANALGESICS - NONNARCOTIC
difluprednate ophth emulsion (DUREZOL equiv)	-	3	OPHTHALMIC AGENTS
digoxin soln (LANOXIN equiv)	-	2	CARDIOTONICS
DIGOXIN SOLN 0.05MG/ML	-	2	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	2	CARDIOTONICS
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC	CARDIOTONICS
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC	MIGRAINE PRODUCTS
dihydroergotamine mesylate nasal spray (MIGRANAL equiv)	-	NC	MIGRAINE PRODUCTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DILACOR XR CAP	-	NC	CALCIUM CHANNEL BLOCKERS
DILANTIN CAP 100MG	-	NC	ANTICONVULSANTS
DILANTIN CAP 30MG	-	3	ANTICONVULSANTS
DILANTIN INFATABS	-	NC	ANTICONVULSANTS
DILANTIN SUSP	-	NC	ANTICONVULSANTS
DILAUDID TAB	-	NC	ANALGESICS - OPIOID
diltiazem ER cap (CARDIZEM CD equiv)	-	2	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	2	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	2	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	3	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	3	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	2	CALCIUM CHANNEL BLOCKERS
dimethyl fumarate DR cap (TECFIDERA equiv)	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIOVAN HCT TAB	-	NC	ANTIHYPERTENSIVES
DIOVAN TAB	-	NC	ANTIHYPERTENSIVES
DIPENTUM CAP	-	4	GASTROINTESTINAL AGENTS - MISC.
diphenhydramine inj (BENADRYL equiv)	-	2	ANTIHISTAMINES
DIPHENOXYLATE/ATROPINE LIQUID	-	4	ANTIDIARRHEAL / PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	2	ANTIDIARRHEALS
DIPROLENE AF CREAM	-	NC	DERMATOLOGICALS
DIPROLENE OINT	-	NC	DERMATOLOGICALS
DIPTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	1	TOXOIDS
dipyridamole tab (PERSANTINE equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
DISKETS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2	ANALGESICS - OPIOID
disopyramide cap (NORPACE equiv)	-	2	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
disulfiram tab 500mg	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DITROPAN XL TAB	-	NC	URINARY ANTISPASMODICS
DIURIL SUSP	-	3	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	2	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	2	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	2	ANTICONVULSANTS
DIVIGEL GEL	-	NC	ESTROGENS
DIVIGEL GEL, ELESTRIN GEL	-	NC	ESTROGENS
dofetilide cap (TIKOSYN equiv)	-	3	ANTIARRHYTHMICS
DOJOLVI ORAL LIQUID	-	NC	NUTRIENTS
DOLGIC PLUS TAB	-	NC	ANALGESICS - NONNARCOTIC
DOLOBID TAB	-	NC	ANALGESICS - NONNARCOTIC
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DONNATAL ELXIR	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
DONNATAL TAB	-	NC	ULCER DRUGS
DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	HEMATOPOIETIC AGENTS
DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	HEMATOPOIETIC AGENTS
DORYX MPC TAB	-	NC	TETRACYCLINES
DORYX TAB	-	NC	TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	2	OPHTHALMIC AGENTS
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	2	OPHTHALMIC AGENTS
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
DOVATO TAB	-	3	ANTIVIRALS
DOVONEX CREAM	-	NC	DERMATOLOGICALS
doxazosin tab (CARDURA equiv)	-	2	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	2	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	2	ANTIDEPRESSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	PA	4	DERMATOLOGICALS
DOXEPIN HCL CAP	-	2	ANTIDEPRESSANTS
DOXEPIN HCL CONC	-	2	ANTIDEPRESSANTS
doxepin hcl cream	-	NC	DERMATOLOGICALS
doxepin tab (SILENOR equiv)	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
DOXERCALCIFEROL CAP	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxercalciferol cap (HECTOROL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxycycline (rosacea) cap delayed release (ORACEA equiv)	-	NC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	2	TETRACYCLINES
DOXYCYCLINE HYCLATE CAP	-	NC	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	4	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	2	TETRACYCLINES
doxycycline hyclate tab (TARGADOX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC	TETRACYCLINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
doxycycline monohydrate cap (MONODOX equiv)	-	2	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	2	TETRACYCLINES
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	3	TETRACYCLINES
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC	ANTIEMETICS
D-PENAMINE TAB	-	3	ASSORTED CLASSES
DRISDOL CAP	-	NC	VITAMINS
DRIZALMA DR CAP	-	NC	ANTIDEPRESSANTS
dronabinol cap (MARINOL equiv)	PA	3	ANTIEMETICS
DRONABINOL SOLN, SYNDROS SOLN	-	NC	ANTIEMETICS
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	1	CONTRACEPTIVES
DROXIA CAP	-	3	HEMATOPOIETIC AGENTS
droxidopa cap (NORTHERA equiv)	-	NC	VASOPRESSORS
DRYSOL SOLN	-	2	DERMATOLOGICALS
DSUVIA SL TAB	-	NC	ANALGESICS - OPIOID
DUAC GEL	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DUAKLIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DUETACT TAB	-	NC	ANTIDIABETICS
DUEXIS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DULERA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine cap 40mg (IRENKA equiv)	-	NC	ANTIDEPRESSANTS
DULOXETINE DR CAP	-	NC	ANTIDEPRESSANTS
duloxetine EC cap (CYMBALTA equiv)	-	2	ANTIDEPRESSANTS
DULOXICAINE PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DUOBRII LOTION	-	NC	DERMATOLOGICALS
DUOPA ENTERAL SUSP	-	NC	ANTIPARKINSON AGENTS
DUOVISC KIT	-	NC	OPHTHALMIC AGENTS
DUPIXENT INJ	-	NC	DERMATOLOGICALS
DUPIXENT PEN INJ	-	NC	DERMATOLOGICALS
DUREZOL OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
dutasteride cap (AVODART equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
dutasteride/tamsulosin cap (JALYN equiv)	-	3	GENITOURINARY AGENTS - MISCELLANEOUS
DUTOPROL TAB	-	NC	ANTIHYPERTENSIVES
DUVYZAT ORAL SUSP	-	NC	NEUROMUSCULAR AGENTS
DUZALLO TAB	-	NC	GOUT AGENTS
DXEVO 11-DAY PAK	-	NC	CORTICOSTEROIDS
DYANAVEL XR CHEW	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
DYMISTA SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
DYNACIN TAB	-	NC	TETRACYCLINES
DYRENIUM CAP	-	NC	DIURETICS
E.E.S. TAB	-	4	MACROLIDES
EBGLYSS INJ	-	NC	DERMATOLOGICALS
EBGLYSS PEN INJ	-	NC	DERMATOLOGICALS
EB-N3 DR CAP	-	NC	MULTIVITAMINS
ECONASIL KIT	-	NC	DERMATOLOGICALS
econazole cream (SPECTAZOLE equiv)	-	2	DERMATOLOGICALS
ECONAZOLE NITRATE FOAM, ECOZA FOAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ECOZA FOAM	-	NC	DERMATOLOGICALS
EDARBI TAB	-	NC	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	NC	ANTIHYPERTENSIVES
EDECRIN TAB	-	NC	DIURETICS
EDLUAR SL TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
EDURANT PED TAB	-	3	ANTIVIRALS
EDURANT TAB	-	3	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	2	ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	2	ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	3	ANTIVIRALS
EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB	-	3	ANTIVIRALS
EFFER-K TAB	-	2	MINERALS & ELECTROLYTES
EFFEXOR XR CAP	-	NC	ANTIDEPRESSANTS
EFFIENT TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
EFUDEX CREAM	-	NC	DERMATOLOGICALS
EGATEN TAB	-	NC	ANTHELMINTICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
EGRIFTA INJ	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
EGRIFTA WR KIT	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
EKTERLY TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ELDEPYRL CAP	-	NC	ANTIPARKINSON AGENTS
ELEPSIA XR TAB	-	NC	ANTICONVULSANTS
ELESTAT OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
eletriptan tab (RELPAX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
ELIDEL CREAM	-	NC	DERMATOLOGICALS
ELIGARD INJ, VABRINITY INJ	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ELIGARD INJ, VABRINTY INJ	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ELIGEN B12 TAB	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
ELIMITE CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ELIPHOS TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ELIQUIS SPRINKLE CAP	-	3	ANTICOAGULANTS
ELIQUIS TAB FOR ORAL SUSP	-	3	ANTICOAGULANTS
ELIQUIS TAB, ELIQUIS STARTER PACK	-	3	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	1	CONTRACEPTIVES
ELMIRON CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
ELOCON CREAM	-	NC	DERMATOLOGICALS
ELOCON OINT	-	NC	DERMATOLOGICALS
ELOCTATE INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day)	MSP-PA-QL	2	HEMATOPOIETIC AGENTS
eltrombopag olamine tab 12.5mg, 25mg (PROMACTA equiv) (QL= 1 tab/day)	MSP-PA-QL	2	HEMATOPOIETIC AGENTS
eltrombopag olamine tab 50mg (PROMACTA equiv) (QL= 2 tabs/day)	MSP-PA-QL	2	HEMATOPOIETIC AGENTS
eltrombopag olamine tab 75mg (PROMACTA equiv) (QL= 2 tabs/day)	MSP-PA-QL	2	HEMATOPOIETIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
eluryng vaginal ring (NUVARING equiv)	-	1	CONTRACEPTIVES
ELYXYB SOLN	-	NC	MIGRAINE PRODUCTS
EMBECTA INSULIN SYRINGE	--OTC	2	MEDICAL DEVICES AND SUPPLIES
EMBECTA PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
EMCYT CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EMEND PAK	-	NC	ANTIEMETICS
EMEND SUSP	-	NC	ANTIEMETICS
EMFLAZA SUSP	-	NC	CORTICOSTEROIDS
EMFLAZA TAB	-	NC	CORTICOSTEROIDS
EMGALITY INJ	-	NC	MIGRAINE PRODUCTS
EMGALITY INJ 100MG/ML	-	NC	MIGRAINE PRODUCTS
EMPAVELI INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
EMROSI CAP	-	NC	DERMATOLOGICALS
EMSAM PATCH	-	4	ANTIDEPRESSANTS
emtricitabine cap (EMTRIVA equiv)	-	2	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	1	ANTIVIRALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv)	-	3	ANTIVIRALS
EMTRIVA CAP	-	NC/3P	ANTIVIRALS
EMTRIVA SOLN	-	5	ANTIVIRALS
EMVERM TAB	-	NC	ANTHELMINTICS
ENABLEX TAB	-	NC	URINARY ANTISPASMODICS
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 years and older)	PA	3	ANTIHYPERTENSIVES
enalapril tab (VASOTEC equiv)	-	2	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	NC	ANTIHYPERTENSIVES
ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ENBUMYST SOLN 0.5MG/0.1ML (QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112)	LD-QL	5	DIURETICS
ENDARI POWDER PACKET	-	NC	HEMATOPOIETIC AGENTS
ENDOMETRIN INSERT	PA	3	VAGINAL PRODUCTS
ENDOMETRIN SUPP	PA	3	VAGINAL AND RELATED PRODUCTS
ENFLONSIA INJ	VAC	1	PASSIVE IMMUNIZING AND TREATMENT AGENTS
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	1	VACCINES
enoxaparin inj (LOVENOX equiv)	-	3	ANTICOAGULANTS
enpresse tab (TRI-LEVELEN equiv)	-	1	CONTRACEPTIVES
ENSACOVE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ENSACOVE CAP 100MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ENSPRYNG INJ	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ENSTILAR FOAM	-	NC	DERMATOLOGICALS
entacapone tab (COMTAN equiv)	-	3	ANTIPARKINSON AGENTS
ENTADFI CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	5	ANTIVIRALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ENTEREG CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENTRESTO CAP	-	NC	CARDIOVASCULAR AGENTS - MISC.
ENTRESTO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ENTYVIO SC INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENVARSUS XR TAB	-	NC	ASSORTED CLASSES
EOHILIA SUSP	-	NC	CORTICOSTEROIDS
EPANED SOLN (Prior Authorization required for members age 9 years and older)	PA	4	ANTIHYPERTENSIVES
EPCLUSA PAK	-	NC	ANTIVIRALS
EPCLUSA TAB	-	NC	ANTIVIRALS
EPICERAM EMULSION	-	NC	DERMATOLOGICALS
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	5	ANTICONVULSANTS
EPIDUO FORTE GEL 0.3-2.5%	-	NC	DERMATOLOGICALS
EPIDUO GEL 0.1-2.5%	-	NC	DERMATOLOGICALS
EPIFOAM AEROSOL	-	3	DERMATOLOGICALS
epinastine opthth soln (ELESTAT equiv)	-	4	OPHTHALMIC AGENTS
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	2	VASOPRESSORS
EPIPEN (JR) INJ	-	NC	VASOPRESSORS
EPIVIR SOLN	-	NC/ 3P	ANTIVIRALS
EPIVIR TAB	-	NC/ 3P	ANTIVIRALS
eplerenone tab (INSPRA equiv)	-	2	ANTIHYPERTENSIVES
EPRONTIA SOLN (Prior Authorization required for members age 9 years and older)	PA	4	ANTICONVULSANTS
EPSOLAY CREAM	-	NC	DERMATOLOGICALS
EPZICOM TAB	-	NC/ 3P	ANTIVIRALS
EQUETRO CAP	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERGOCAL CAP	-	NC	VITAMINS
ERGOLOID MESYLATES TAB	-	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOMAR SL TAB (QL= 20 tabs/28 days)	PA-QL	4	MIGRAINE PRODUCTS
ERIVEDGE CAP (QL= 1 cap/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ERLEADA TAB (QL= 4 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB 240MG (QL= 1 tab/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tab/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERMEZA SOLN 150 MCG/5ML	-	NC	THYROID AGENTS
ERTACZO CREAM	-	NC	DERMATOLOGICALS
ERY PAD	-	3	DERMATOLOGICALS
ERYPED SUSP	-	NC	MACROLIDES
ERYTHROMYCIN CAP DR	-	3	MACROLIDES
erythromycin DR cap (ERYC equiv)	-	3	MACROLIDES
ERYTHROMYCIN EC CAP	-	3	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv)	-	3	MACROLIDES
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	4	MACROLIDES
erythromycin gel	-	2	DERMATOLOGICALS
erythromycin ophth oint	-	2	OPHTHALMIC AGENTS
ERYTHROMYCIN OPHTH OINT	-	NC	OPHTHALMIC AGENTS
erythromycin pad	-	2	DERMATOLOGICALS
erythromycin soln	-	2	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
erythromycin tab (ERYTHROMYCIN equiv) (all form except PCE)	-	3	MACROLIDES
erythromycin tab (ERY-TAB equiv)	-	4	MACROLIDES
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	3	DERMATOLOGICALS
ERZOFRI INJ 117MG/0.75ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERZOFRI INJ 156MG/ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERZOFRI INJ 234MG/1.5ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERZOFRI INJ 351MG/2.25ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERZOFRI INJ 39MG/0.25ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ERZOFRI INJ 78MG/0.5ML	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ESBRIET CAP	-	NC	RESPIRATORY AGENTS - MISC.
ESBRIET TAB	-	NC	RESPIRATORY AGENTS - MISC.
ESCAVITE CHEW TAB	-	NC	MULTIVITAMINS
ESCITALOPRAM CAP	-	NC	ANTIDEPRESSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
escitalopram soln (LEXAPRO equiv)	-	3	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	2	ANTIDEPRESSANTS
ESGIC TAB	-	NC	ANALGESICS - NONNARCOTIC
ESKATA SOLN	-	NC	DERMATOLOGICALS
eslicarbazepine acetate tab (APTIOM equiv)	-	NC	ANTICONVULSANTS
esomeprazole cap (NEXIUM equiv)	OTC	2	ULCER DRUGS
esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	4	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ESPEROCT INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
estazolam tab (PROSOM equiv)	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	NC	ESTROGENS
ESTRACE TAB	-	NC	ESTROGENS
ESTRACE VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
estradiol cream (ESTRACE equiv)	-	2	VAGINAL PRODUCTS
estradiol patch (CLIMARA equiv)	-	2	ESTROGENS
estradiol patch (VIVELLE-DOT, MINIVELLE equiv)	-	2	ESTROGENS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
estradiol tab (ESTRACE equiv)	-	2	ESTROGENS
estradiol td gel (DIVIGEL equiv)	-	NC	ESTROGENS
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (18 tabs on first fill))	QL	3	VAGINAL PRODUCTS
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	3	ESTROGENS
estradiol/norethindrone tab (ACTIVELLA equiv)	-	2	ESTROGENS
ESTRATEST TAB	-	NC	ESTROGENS
ESTRING (3 copays per Rx)	-	3	VAGINAL PRODUCTS
estrogens, conjugated tab (PREMARIN equiv)	-	3	ESTROGENS
ESTROPIPATE TAB	-	2	ESTROGENS
estropipate tab (OGEN equiv)	-	2	ESTROGENS
ESTROSTEP FE TAB	-	NC	CONTRACEPTIVES
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ethacrynic tab (EDECRIN equiv)	-	3	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	3	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	3	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	2	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
etodolac cap (LODINE equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	4	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	2	ANALGESICS - ANTI-INFLAMMATORY
ETOPOSIDE CAP	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etravirine tab (INTELENCE equiv)	-	2	ANTIVIRALS
EUCRISA OINT	-	NC	DERMATOLOGICALS
EULEXIN CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EURAX CREAM	-	NC	DERMATOLOGICALS
EVAMIST SPRAY	-	NC	ESTROGENS
EVEKEO ODT	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
EVEKEO TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv)	PA	5	MISCELLANEOUS THERAPEUTIC CLASSES
everolimus tab 5mg (AFINITOR equiv) (QL= 2 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVISTA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
EVIVO LIQUID	-	NC	ANTIDIARRHEALS
EVOCLIN FOAM	-	NC	DERMATOLOGICALS
EVOTAZ TAB	-	3	ANTIVIRALS
EVOXAC CAP	-	NC	MOUTH / THROAT / DENTAL AGENTS
EVRYSDI SOLN	-	NC	NEUROMUSCULAR AGENTS
EVRYSDI TAB	-	NC	NEUROMUSCULAR AGENTS
EVZIO INJ	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
EVZIO INJ	-	NC	ANTIDOTES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC	DERMATOLOGICALS
EXELDERM SOLN	-	4	DERMATOLOGICALS
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC	DERMATOLOGICALS
EXELON PATCH	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
exemestane tab (AROMASIN equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXENATIDE INJ (BYETTA INJ EQUIV)	-	NC	ANTIDIABETICS
EXFORGE TAB	-	NC	ANTIHYPERTENSIVES
EXJADE TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
EXTAVIA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXXUA TAB/EXXUA TITRATION PACK	-	NC	ANTIDEPRESSANTS
EYSUVIS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
EZALLOR SPRINKLE CAP	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe tab (ZETIA equiv)	-	2	ANTIHYPERLIPIDEMICS
EZETIMIBE/ATORVASTATIN TAB	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv)	-	NC	ANTIHYPERLIPIDEMICS
FABHALTA CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
FABIOR AEROSOL FOAM	-	NC	DERMATOLOGICALS
FABRAZYME INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	NC	FLUOROQUINOLONES
FALESSA KIT	-	NC	CONTRACEPTIVES
FALESSA TAB	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	3	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	3	ULCER DRUGS
famotidine tab (PEPCID equiv)	OTC	NC	ULCER DRUGS
FANAPT TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FANAPT TITRATION PACK	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FARESTON TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FARXIGA TAB (QL= 1 tab/day)	QL	3	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FASENRA PEN INJ	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FAZACLO ODT 12.5MG, 25MG, 100MG	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST	2	GOUT AGENTS
FEIBA INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
felbamate susp (FELBATOL equiv)	-	3	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	3	ANTICONVULSANTS
FELBATOL SUSP	-	NC	ANTICONVULSANTS
FELBATOL TAB	-	NC	ANTICONVULSANTS
FELDENE CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
felodipine ER tab (PLENDIL equiv)	-	2	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	4	VAGINAL PRODUCTS
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	1	MEDICAL DEVICES AND SUPPLIES
FEMARA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FEMCON FE CHEW TAB	-	NC	CONTRACEPTIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FEMHRT TAB	-	NC	ESTROGENS
FEMLYV TAB	-	1	CONTRACEPTIVES
FEMRING (3 copays per Rx)	-	4	VAGINAL PRODUCTS
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	2	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP	-	NC	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	2	ANTIHYPERLIPIDEMICS
fenofibric acid DR cap (TRILIPIX equiv)	-	2	ANTIHYPERLIPIDEMICS
FENOFIBRIC TAB	-	4	ANTIHYPERLIPIDEMICS
FENOFIBRIC TAB, FIBRICOR TAB	-	4	ANTIHYPERLIPIDEMICS
FENOGLIDE TAB	-	NC	ANTIHYPERLIPIDEMICS
fenoprofen calcium cap (NALFON equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN CAP, NAFLON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN TAB	-	4	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FENOPRON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENTANYL BUCCAL TAB	-	NC	ANALGESICS - OPIOID
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	3	ANALGESICS - OPIOID
FENTANYL CITRATE LOLLIPOP	-	NC	ANALGESICS - OPIOID
fentanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	3	ANALGESICS - OPIOID
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC	ANALGESICS - OPIOID
FENTORA TAB	-	NC	ANALGESICS - OPIOID
FEONYX TAB	-	NC	HEMATOPOIETIC AGENTS
FERIVA 21/7 TAB	-	NC	HEMATOPOIETIC AGENTS
FEROTRINSIC CAP	-	2	HEMATOPOIETIC AGENTS
ferrex 150 forte cap	-	2	HEMATOPOIETIC AGENTS
FERREX 28 TAB	-	4	HEMATOPOIETIC AGENTS
ferric citrate tab	-	4	GASTROINTESTINAL AGENTS - MISC.
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	5	ANTIDOTES
FERRIPROX TAB 1000MG (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	5	ANTIDOTES AND SPECIFIC ANTAGONISTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FERRIPROX TAB 500MG	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
FERRO-PLEX TAB	-	NC	HEMATOPOIETIC AGENTS
ferrous sulfate elixir	OTC	NC	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID	OTC	NC	HEMATOPOIETIC AGENTS
ferrous sulfate soln	OTC	NC	HEMATOPOIETIC AGENTS
FESILTY INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	2	URINARY ANTISPASMODICS
FETZIMA CAP	-	NC	ANTIDEPRESSANTS
FETZIMA TITRATION PACK	-	NC	ANTIDEPRESSANTS
FIASP FLEXTOUCH INJ	-	NC	ANTIDIABETICS
FIASP INJ	-	NC	ANTIDIABETICS
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC	ANTIDIABETICS
FIBRIK CAP	-	NC	MULTIVITAMINS
FIBRYGA INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3	MACROLIDES
FILKRI INJ	-	NC	HEMATOPOIETIC AGENTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	5	GENITOURINARY AGENTS - MISCELLANEOUS
FILSUVEZ GEL	-	NC	DERMATOLOGICALS
FINACEA FOAM	-	NC	DERMATOLOGICALS
FINACEA GEL	-	NC	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
fingolimod hcl cap 0.5mg (GILENYA equiv)	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FINTEPLA SOLN	-	NC	ANTICONVULSANTS
FIORICET CAP	-	NC	ANALGESICS - NONNARCOTIC
FIORICET/CODEINE CAP	-	NC	ANALGESICS - OPIOID
FIORINAL CAP	-	NC	ANALGESICS - NONNARCOTIC
FIORINAL/CODEINE CAP	-	NC	ANALGESICS - OPIOID
FIRAZYR INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	5	ANTIMYASTHENIC / CHOLINERGIC AGENTS
FIRST METRONIDAZOLE SUSP	-	4	ANTI-INFECTIVE AGENTS - MISC.
FIRST MOUTHWASH BLM	-	4	MOUTH / THROAT / DENTAL AGENTS
FIRST OMEPRAZOLE SUSP	-	NC	ULCER DRUGS
FIRST PANTOPRAZOLE SUSP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
FIRVANQ SOLN 25MG/ML	-	2	ANTI-INFECTIVE AGENTS - MISC.
FIRVANQ SOLN 50MG/ML	-	2	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
FLAREX OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
flavoxate tab (URISPAS equiv)	-	4	URINARY ANTISPASMODICS
flecainide tab (TAMBOCOR equiv)	-	2	ANTIARRHYTHMICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FLEQSUVY SUSP (Prior Authorization required for members age 9 years and older)	PA	4	MUSCULOSKELETAL THERAPY AGENTS
FLOLIPID SUSP (Prior Authorization required for members age 9 years and older)	PA	4	ANTIHYPERLIPIDEMICS
FLOMAX CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
FLONASE SENSIMIST NASAL SPRAY	OTC	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLO-PRED SUSP	-	NC	CORTICOSTEROIDS
FLORIVA CHEW TAB	-	NC	MULTIVITAMINS
FLORIVA PLUS DROPS	-	NC	MULTIVITAMINS
FLOVENT DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES
FLUBLOK INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES
FLUCELVAX INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES
fluconazole susp (DIFLUCAN equiv)	-	2	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	2	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	3	ANTIFUNGALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fludarabine inj	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fludrocortisone tab (FLORINEF equiv)	-	2	CORTICOSTEROIDS
FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES
FLUMADINE TAB	-	NC	ANTIVIRALS
FLUMIST NASAL (QL= 1 dose/28 days)	QL-VAC	1	VACCINES
flunisolide nasal soln (QL= 2 bottles/fill)	QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	2	DERMATOLOGICALS
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	3	DERMATOLOGICALS
fluocinolone acetonide oint	-	2	DERMATOLOGICALS
fluocinolone acetonide soln	-	2	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	3	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	2	DERMATOLOGICALS
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	2	DERMATOLOGICALS
fluocinonide emollient cream	-	2	DERMATOLOGICALS
fluocinonide gel	-	2	DERMATOLOGICALS
fluocinonide oint	-	2	DERMATOLOGICALS
fluocinonide soln	-	2	DERMATOLOGICALS
FLUOPAR KIT	-	NC	DERMATOLOGICALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FLUORABON SOLN ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	1	MINERALS & ELECTROLYTES
FLUORAC CREAM	-	NC	DERMATOLOGICALS
FLUORIDE CHW 0.25MG ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1	MINERALS & ELECTROLYTES
FLUORIDEX SENSITIVITY PASTE	-	2	MOUTH / THROAT / DENTAL AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	2	OPHTHALMIC AGENTS
fluorouracil cream (EFUDEX CREAM equiv)	-	2	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	4	DERMATOLOGICALS
FLUOROURACIL SOLN	-	3	DERMATOLOGICALS
fluorouracil soln (FLUOROURACIL equiv)	-	3	DERMATOLOGICALS
FLUOVIX PAK	-	NC	DERMATOLOGICALS
fluoxetine cap (PROZAC equiv)	-	2	ANTIDEPRESSANTS
fluoxetine cap (SARAFEM equiv)	-	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FLUOXETINE CAP (PMDD)	-	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fluoxetine soln (PROZAC equiv)	-	2	ANTIDEPRESSANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fluoxetine tab (PROZAC equiv)	-	2	ANTIDEPRESSANTS
FLUOXETINE TAB	-	4	ANTIDEPRESSANTS
fluoxetine weekly cap (PROZAC equiv)	-	NC	ANTIDEPRESSANTS
fluphenazine decanoate inj	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
fluphenazine tab (PROLIXIN equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
FLURANDRENOL LOTION	-	NC	DERMATOLOGICALS
flurandrenolide cream (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide oint (CORDRAN equiv)	-	NC	DERMATOLOGICALS
FLURAZEPAM CAP	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
FLURBIPROFEN OPHTH SOLN	-	3	OPHTHALMIC AGENTS
FLURBIPROFEN TAB	-	2	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
FLUTAMIDE CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
flutamide cap (EULEXIN equiv)	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FLUTICASONE DISKUS INHALER	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE LOTION	-	NC	DERMATOLOGICALS
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	2	DERMATOLOGICALS
fluticasone propionate hfa inhal aero (FLUTICASONE equiv)	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone propionate lotion (CUTIVATE equiv)	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fluticasone propionate oint (CUTIVATE equiv)	-	2	DERMATOLOGICALS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv)	-	3	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	-	4	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	2	ANTIDEPRESSANTS
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	1	VACCINES
FML FORTE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
FML LIQUIFLIM OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
FOCALIN TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
FOCALIN XR CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
FOLBEE PLUS CZ TAB	-	2	MULTIVITAMINS
folbee tab (FOLGARD RX equiv)	-	NC	HEMATOPOIETIC AGENTS
FOLGARD RX TAB	-	NC	HEMATOPOIETIC AGENTS
folic acid tab 1mg ($0 copay for female members only; All other members covered at generic copay)	-	1	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for female members only)	OTC	1	HEMATOPOIETIC AGENTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
folic acid tab 800mcg (Covered for female members only)	OTC	1	HEMATOPOIETIC AGENTS
FOLIKA-V TAB	-	NC	MULTIVITAMINS
FOLITE TAB	-	NC	HEMATOPOIETIC AGENTS
FOLLISTIM AQ INJ	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOLTANX TAB	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
FOLVITE-FE TAB	-	NC	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	-	3	ANTICOAGULANTS
formoterol fumarate neb soln (PERFOROMIST equiv)	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTAMET TAB	-	NC	ANTIDIABETICS
FORTEO INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORTESTA GEL 2%	-	NC	ANDROGENS-ANABOLIC
FORZINITY INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FOSAMAX TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	2	ANTIVIRALS
fosfomycin tromethamine powder pack (MONUROL equiv)	-	4	ANTI-INFECTIVE AGENTS - MISC.
fosinopril tab (MONOPRIL equiv)	-	2	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	NC	ANTIHYPERTENSIVES
FOSRENOL CHEW TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
FOSRENOL POWDER PACK	-	3	GASTROINTESTINAL AGENTS - MISC.
FOTIVDA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FOUNDAYO TAB	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
FRAGMIN INJ	-	NC	ANTICOAGULANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FRAICHE 5000 SENSITIVE GEL	-	NC	MOUTH / THROAT / DENTAL AGENTS
FREESTYLE FREEDOM LITE METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
FROVA TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
frovatriptan tab (FROVA equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
FRUZAQLA CAP 1MG (QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FRUZAQLA CAP 5MG (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FULPHILA INJ	MSP	5	HEMATOPOIETIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FULVICIN P/G TAB	-	NC	ANTIFUNGALS
FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB	-	NC	ANTIFUNGALS
FUROSCIX KIT (QL= 8 inj/fill; Only available throug Onco360 or CareMed 877-662-6633)	LD-QL	5	DIURETICS
FUROSCIX READYFLOW INJ	-	NC	DIURETICS
FUROSEMIDE SOLN	-	2	DIURETICS
furosemide soln (LASIX equiv)	-	2	DIURETICS
furosemide tab (LASIX equiv)	-	2	DIURETICS
FUZEON INJ	-	NC/ 3P	ANTIVIRALS
FYCOMPA SUSP	-	NC	ANTICONVULSANTS
FYCOMPA TAB	-	NC	ANTICONVULSANTS
FYLNETRA INJ	-	NC	HEMATOPOIETIC AGENTS
gabapentin (once-daily) tab (GRALISE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day)	QL	2	ANTICONVULSANTS
gabapentin cap 200mg (RELGAABI equiv)	-	NC	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	3	ANTICONVULSANTS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	2	ANTICONVULSANTS
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	2	ANTICONVULSANTS
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
GABARONE TAB	-	NC	ANTICONVULSANTS
GABITRIL TAB	-	NC	ANTICONVULSANTS
GALAFOLD CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
galantamine ER cap (RAZADYNE ER equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	NC	MINERALS & ELECTROLYTES
GARDASIL 9 INJ	VAC	1	VACCINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GASTROCROM CONC	-	NC	GASTROINTESTINAL AGENTS - MISC.
gatifloxacin ophth soln (ZYMAXID equiv)	-	4	OPHTHALMIC AGENTS
GATTEX KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
GAVILYTE-C SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	1	LAXATIVES
GAVRETO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GEAMETDRAY GEL	-	NC	DERMATOLOGICALS
gefitinib tab (IRESSA equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	NC	MOUTH / THROAT / DENTAL AGENTS
GELNIQUE	-	NC	URINARY ANTISPASMODICS
gemfibrozil tab (LOPID equiv)	-	2	ANTIHYPERLIPIDEMICS
GEMTESA TAB	-	NC	URINARY ANTISPASMODICS
GEN7T LOTION	-	NC	DERMATOLOGICALS
GEN7T PAD 3.5%	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GEN7T PLUS LOTION	-	NC	DERMATOLOGICALS
GEN7T PLUS PAD	-	NC	DERMATOLOGICALS
GENOTROPIN INJ	MSP-PA	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENOTROPIN INJ 5MG	MSP-PA	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	2	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	2	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	2	DERMATOLOGICALS
gentamicin sulfate oint	-	2	DERMATOLOGICALS
GENVOYA TAB	-	NC/ 3P	ANTIVIRALS
GEODON CAP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
GIALAX KIT	-	NC	LAXATIVES
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1	CONTRACEPTIVES
GILENYA CAP 0.25MG	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GILENYA CAP 0.5MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GIMOTI NASAL SPRAY	-	NC	GASTROINTESTINAL AGENTS - MISC.
glatiramer inj (COPAXONE equiv)	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEEVEC TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GLEOSTINE CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	2	ANTIDIABETICS
GLIMEPIRIDE TAB	-	NC	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	2	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	2	ANTIDIABETICS
GLIPIZIDE TAB	-	NC	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	2	ANTIDIABETICS
GLOPERBA SOLN	-	NC	GOUT AGENTS
glucagon (rdna) for inj kit (QL= 2 inj/fill)	QL	3	ANTIDIABETICS
GLUCAGON DIAGNOSTIC INJ	-	NC	DIAGNOSTIC PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	3	ANTIDIABETICS
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	3	ANTIDIABETICS
GLUCOCARD 01 BLOOD GLUCOSE W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD 01-MINI GLUCOSE W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD EXPRESSION MONITOR W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD EXPRESSION TEST STRIPS	-	3	DIAGNOSTIC PRODUCTS
GLUCOCARD SHINE CONNEX W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD SHINE EXPRESS W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD SHINE TEST STRIPS	-	3	DIAGNOSTIC PRODUCTS
GLUCOCARD SHINE W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD VITAL MONITOR W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOCARD VITAL TEST STRIPS	-	3	DIAGNOSTIC PRODUCTS
GLUCOCARD X-METER W/DEVICE KIT	-	3	MEDICAL DEVICES AND SUPPLIES
GLUCOPHAGE TAB	-	NC	ANTIDIABETICS
GLUCOPHAGE XR TAB	-	NC	ANTIDIABETICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GLUCOTROL TAB	-	NC	ANTIDIABETICS
GLUCOTROL XL TAB	-	NC	ANTIDIABETICS
GLUMETZA TAB 1000MG	-	NC	ANTIDIABETICS
GLUMETZA TAB 500MG	-	NC	ANTIDIABETICS
GLYBURID MCR TAB	-	2	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	2	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	2	ANTIDIABETICS
GLYCATE TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC	ULCER DRUGS
glycerol phenylbutyrate liquid (RAVICTI equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
glycopyrrolate oral soln (CUVPOSA equiv)	-	4	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
glycopyrrolate tab (ROBINUL equiv)	-	3	ULCER DRUGS
GLYGEST PAK	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
GLYNASE TAB	-	NC	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GLYXAMBI TAB (QL= 1 tab/day)	QL	3	ANTIDIABETICS
GOCOVRI CAP	-	NC	ANTIPARKINSON AGENTS
GOLYTELY SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	1	LAXATIVES
GOMEKLI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GOMEKLI CAP 1MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GOMEKLI TAB FOR ORAL SUSP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GONAL-F RFF INJ	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
GONAL-F RFF INJ, GONAL-F INJ	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
GONITRO POWDER	-	NC	ANTIANGINAL AGENTS
GORDON'S UREA OINT 40%	-	NC	DERMATOLOGICALS
GRALISE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill)	QL	2	ANTIEMETICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GRANISOL ORAL SOLN	-	NC	ANTIEMETICS
GRANIX INJ	-	NC	HEMATOPOIETIC AGENTS
GRASTEK SL TAB	-	NC	BIOLOGICALS MISC
griseofulvin micro tab (GRIFULVIN V equiv)	-	3	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	3	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	3	ANTIFUNGALS
GRIS-PEG TAB	-	NC	ANTIFUNGALS
GUAIFENESEN SYRUP	-	NC	COUGH / COLD / ALLERGY
guaifenesin tab (ALLFEN JR equiv)	-	NC	COUGH / COLD / ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	2	COUGH / COLD / ALLERGY
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC	COUGH / COLD / ALLERGY
guanfacine ER tab (INTUNIV equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
guanfacine IR tab (TENEX equiv)	-	2	ANTIHYPERTENSIVES
GUANIDINE TAB	-	4	ANTIMYASTHENIC / CHOLINERGIC AGENTS
GVOKE INJ (QL= 2 inj/fill)	QL	3	ANTIDIABETICS
GVOKE INJ KIT (QL= 2 inj/fill)	QL	3	ANTIDIABETICS
GVOKE PFS INJ (QL= 2 inj/fill)	QL	3	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GWYN LO PATCH	-	NC	CONTRACEPTIVES
GYNAZOLE CREAM	-	4	VAGINAL PRODUCTS
HADLIMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HAEGARDA INJ (Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, OptionCare 972-536-7355, Optum 877-445-6874, Orsini 800-410-8575, or Walgreens 888-347-3416)	LD-PA	5	HEMATOLOGICAL AGENTS - MISC.
halcinonide cream (HALOG equiv)	-	NC	DERMATOLOGICALS
HALCINONIDE SOLN	-	NC	DERMATOLOGICALS
halcinonide soln (HALOG equiv)	-	NC	DERMATOLOGICALS
HALCION TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
HALOBETASOL AER	-	NC	DERMATOLOGICALS
HALOBETASOL AERO	-	NC	DERMATOLOGICALS
halobetasol propionate cream (ULTRAVATE equiv)	-	3	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
halobetasol propionate oint (ULTRAVATE equiv)	-	3	DERMATOLOGICALS
HALOG CREAM	-	NC	DERMATOLOGICALS
HALOG OINT	-	NC	DERMATOLOGICALS
HALOG SOLN	-	NC	DERMATOLOGICALS
halonate pac kit (ULTRAVATE KIT equiv)	-	NC	DERMATOLOGICALS
haloperidol decanoate inj (HALDOL equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
haloperidol lactate conc (HALDOL equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
haloperidol lactate inj (HALDOL equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
HARLIKU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HARVONI PELLET PAK	-	NC	ANTIVIRALS
HARVONI TAB	-	NC	ANTIVIRALS
HAVRIX INJ, VAQTA INJ	VAC	1	VACCINES
HC BUTYRATE CREAM	-	NC	DERMATOLOGICALS
HC BUTYRATE SOLN	-	NC	DERMATOLOGICALS
HC PRAMOXINE CREAM 1-2.5%	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HC/IODOQUIN CREAM	-	NC	DERMATOLOGICALS
HC/PRAMOXINE CREAM 1-2.35%	-	NC	DERMATOLOGICALS
HC-LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
HECTOROL CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HELIDAC PACK	-	NC	ULCER DRUGS
HEMADY TAB	-	2	CORTICOSTEROIDS
HEMANGEOL ORAL SOLN	-	NC	BETA BLOCKERS
HEMANGEOL SOLN	-	NC	BETA BLOCKERS
HEMLIBRA INJ	MSP-PA	5	HEMATOLOGICAL AGENTS - MISC.
HEMOFIL M, KOATE INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
heparin porcine inj	-	NC	ANTICOAGULANTS
HEPCLUDEX INJ	-	NC	ANTIVIRALS
HEPLISAV-B INJ	VAC	1	VACCINES
HERNEXEOS TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HETLIOZ CAP	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HETLIOZ SUSP	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
HIPREX TAB	-	NC	ANTI-INFECTIVE AGENTS MISC.
HIXDEFRIMA SOLN	-	NC	DERMATOLOGICALS
HIZENTRA INJ	MSP-PA	5	PASSIVE IMMUNIZING AND TREATMENT AGENTS
HOMATROPINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
HORIZANT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HULIO INJ (adalimumab-fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HULIO KIT (adalimumab-fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMALOG JR KWIKPEN INJ	-	3	ANTIDIABETICS
HUMALOG KWIKPEN INJ	-	3	ANTIDIABETICS
HUMALOG MIX INJ	-	3	ANTIDIABETICS
HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN	-	3	ANTIDIABETICS
HUMALOG PEN INJ	-	3	ANTIDIABETICS
HUMALOG TEMPO PEN	-	3	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HUMATIN CAP	-	NC	AMINOGLYCOSIDES
HUMATROPE INJ, ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 80MG (QL= 2 syringes/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX INJ	OTC	3	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HUMULIN MIX PEN INJ	OTC	3	ANTIDIABETICS
HUMULIN N INJ	OTC	3	ANTIDIABETICS
HUMULIN N PEN INJ	OTC	3	ANTIDIABETICS
HUMULIN R INJ	OTC	3	ANTIDIABETICS
HUMULIN R INJ U-500	-	3	ANTIDIABETICS
HUMULIN R U-500 KWIKPEN INJ	-	3	ANTIDIABETICS
HURRISEAL MIS SNAP	-	NC	MEDICAL DEVICES AND SUPPLIES
HYCAMTIN CAP	MSP-PA	5	ANTINEOPLASTICS
HYCLODEX SOLN	-	NC	DERMATOLOGICALS
HYCODAN SYRUP	-	NC	COUGH / COLD / ALLERGY
HYCOFENIX SOLN	-	NC	COUGH / COLD / ALLERGY
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	4	COUGH / COLD / ALLERGY
hydralazine tab (APRESOLINE equiv)	-	2	ANTIHYPERTENSIVES
HYDREA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydrochlorothiazide cap (MICROZIDE equiv)	-	2	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	2	DIURETICS
HYDROCODONE BITARTRATE ER CAP	-	NC	ANALGESICS - OPIOID

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3	ANALGESICS - OPIOID
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	2	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	4	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	2	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	4	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	4	COUGH / COLD / ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	2	COUGH / COLD / ALLERGY
HYDROCODONE/IBUPROFEN TAB	-	4	ANALGESICS - OPIOID

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	4	ANALGESICS - OPIOID
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	4	ANALGESICS - OPIOID
HYDROCORTISONE ACETATE CREAM, MICORT-HC CREAM	-	NC	DERMATOLOGICALS
hydrocortisone butyrate cream (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC	DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE BUTYRATE OINT	-	NC	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE CREAM	-	2	ANORECTAL AND RELATED PRODUCTS
hydrocortisone cream (PROCTOCORT equiv)	-	2	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	3	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	2	DERMATOLOGICALS
hydrocortisone lotion (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE LOTION 2.5%	-	2	DERMATOLOGICALS
hydrocortisone oint	-	2	DERMATOLOGICALS
HYDROCORTISONE PAK	-	NC	DERMATOLOGICALS
hydrocortisone succinate inj 1000mg (SOLU-CORTEF equiv) (QL= 2 vials/fill)	QL	3	CORTICOSTEROIDS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
hydrocortisone supp (ANUSOL HC equiv)	-	NC	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	2	CORTICOSTEROIDS
hydrocortisone valerate cream	-	NC	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydrocortisone/pramoxine cream 2.5-1% (PRAMOSONE equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE/PRAMOXINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
hydromorphone ER tab (EXALGO equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	4	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	NC	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	2	ANALGESICS - OPIOID
HYDROXYCHLOROQUINE TAB	-	2	ANTIMALARIALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	2	ANTIMALARIALS
HYDROXYM GEL	-	NC	DERMATOLOGICALS
HYDROXYPROGESTERONE CAPROATE INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyprogesterone inj (MAKENA equiv)	MSP-PA	4	PROGESTINS
hydroxyurea cap (HYDREA equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyzine pamoate cap (VISTARIL equiv)	-	2	ANTIANXIETY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HYDROXYZINE PAMOATE CAP 100MG	-	2	ANTIANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	2	ANTIANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	2	ANTIANXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	5	DERMATOLOGICALS
HYLAMEND GEL FIRST AID	-	NC	ANTISEPTICS & DISINFECTANTS
HYLINATE LOTION	-	NC	DERMATOLOGICALS
HYMPAVZI INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
HYOPHEN TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
HYOSCYAMINE ELXIR	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
HYOSCYAMINE INJ	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	2	ULCER DRUGS
HYOSCYAMINE SULFATE ER TAB	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	2	ULCER DRUGS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HYOSCYAMINE SULFATE SL TAB	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	2	ULCER DRUGS
HYOSCYAMINE TAB	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
hyoscyamine tab (LEVSIN equiv)	-	2	ULCER DRUGS
HYPER-SAL NEB SOLN 7%	-	NC	COUGH / COLD / ALLERGY
HYQVIA INJ	-	NC	PASSIVE IMMUNIZING AGENTS
HYRIMOZ INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HYRIMOZ PFS INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HYRNUO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HYZAAR TAB	-	NC	ANTIHYPERTENSIVES
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
IBRANCE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBSRELA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
IBTROZI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBU 600-EZS KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	2	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab (Rx covered Only)	-	2	ANALGESICS - ANTI-INFLAMMATORY
IBUPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen-famotidine tab	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ICAR-C PLUS TAB 100-250-0.025-1 MG	-	4	HEMATOPOIETIC AGENTS
icatibant inj (FIRAZYR equiv)	MSP-PA	5	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (Only available through AcariaHealth 800-511-5144)	LD-PA-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day)	QL	3	ANTIHYPERLIPIDEMICS
ICOTYDE TAB	-	NC	DERMATOLOGICALS
IDACIO INJ (adalimumab-aacf)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
IDELVION INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IDVYNSO TAB	-	NC/3P	ANTIVIRALS
IHEEZO GEL	-	NC	OPHTHALMIC AGENTS
ILEVRO OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA SUSP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 140MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
IMBRUVICA TAB 280MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMCIVREE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
imipramine pamoate cap (TOFRANIL PM equiv)	-	4	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	2	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	2	DERMATOLOGICALS
IMIQUIMOD CREAM 3.75%	-	NC	DERMATOLOGICALS
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC	DERMATOLOGICALS
IMITREX 4MG INJ, ZEMBRACE INJ	-	NC	MIGRAINE PRODUCTS
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
IMITREX INJ	-	NC	MIGRAINE PRODUCTS
IMITREX TAB	-	NC	MIGRAINE PRODUCTS
IMKELDI SOLUTION	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMOVAX INJ	VAC	EXC	VACCINES
IMPAVIDO CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
IMPEKLO LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
IMPOYZ CREAM	-	NC	DERMATOLOGICALS
IMULDOSA SYRINGE	-	NC	DERMATOLOGICALS
IMURAN TAB	-	NC	ASSORTED CLASSES
IMVEXXY SUPP	-	NC	VAGINAL PRODUCTS
INBRIJA INH POWDER	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	2	DIURETICS
INDERAL LA CAP	-	NC	BETA BLOCKERS
INDERAL XL CAP, INNOPRAN XL CAP	-	NC	BETA BLOCKERS
INDOCIN SUPP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
INDOMETHACIN CAP, TIVORBEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
indomethacin suppository (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin susp (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INFLAMMA-K KIT	-	NC	DERMATOLOGICALS
INFLATHERM PAK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INGREZZA CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA PACK 40-80MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
INLURIYO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INLYTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INLYTA TAB 1MG (QL= 8 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INPEFA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
INPEN INSULIN INJECTION DEVICE	-	NC	MEDICAL DEVICES
INQOVI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INREBIC CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INSPRA TAB	-	NC	ANTIHYPERTENSIVES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN GLARGINE INJ	-	3	ANTIDIABETICS
INSULIN GLARGINE SOLN PEN-INJ	-	3	ANTIDIABETICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC	ANTIDIABETICS
INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML	-	NC	ANTIDIABETICS
INSULIN LISPRO INJ (HUMALOG equiv)	-	2	ANTIDIABETICS
INSULIN LISPRO JR KWIKPEN INJ	-	3	ANTIDIABETICS
INSULIN LISPRO KWIKPEN INJ	-	3	ANTIDIABETICS
INSULIN SYRINGE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	5	ANTIVIRALS
INTENSE COUGH LIQUID	-	NC	COUGH / COLD / ALLERGY
INTERMEZZO SL TAB	-	NC	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
INTRAROSA SUPP	-	NC	VAGINAL PRODUCTS
INTUNIV TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
INVEGA SUSTENNA INJ	-	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
INVEGA TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
INVEGA TRINZA INJ	-	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
INVELTYS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
INVOKAMET TAB	-	NC	ANTIDIABETICS
INVOKAMET XR TAB	-	NC	ANTIDIABETICS
INVOKANA TAB	-	NC	ANTIDIABETICS
INZIRQO SUSP (Prior Authorization required for members age 9 years and older)	PA	4	DIURETICS
IODOFLEX PAD	-	NC	ANTISEPTICS & DISINFECTANTS
IODOQUINOL/HC ALOE GEL	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	NC	DERMATOLOGICALS
IODOQUINOL-HYDROCORTISONE CREAM	-	NC	DERMATOLOGICALS
iohexol inj (OMNIPAQUE equiv)	-	NC	DIAGNOSTIC PRODUCTS
IOPIDINE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
IOPIDINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
IPOL INJ	VAC	1	VACCINES
ipratropium bromide hfa inhaler aerosol (ATROVENT equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	2	NASAL AGENTS - SYSTEMIC AND TOPICAL

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ipratropium neb soln (ATROVENT equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
IQIRVO TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
irbesartan tab (AVAPRO equiv)	-	2	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	NC	ANTIHYPERTENSIVES
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	2	HEMATOPOIETIC AGENTS
ISENTRESS (HD) TAB	-	3	ANTIVIRALS
ISENTRESS CHEW TAB	-	4	ANTIVIRALS
ISENTRESS POWDER PACK	-	4	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1	CONTRACEPTIVES
isoniazid syrup (ISONIAZID equiv)	-	4	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	2	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARPINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ISORDIL TITRADOSE TAB	-	NC	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	2	ANTIANGINAL AGENTS
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	4	ANTIANGINAL AGENTS
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
isosorbide mononitrate ER tab (IMDUR equiv)	-	2	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	2	ANTIANGINAL AGENTS
isotretinoin cap 25mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS
isotretinoin cap 35mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS
isradipine cap (DYNACIRC equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	3	OPHTHALMIC AGENTS
ISTURISA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ITOVEBI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
itraconazole cap (SPORANOX equiv)	-	3	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	PA	4	ANTIFUNGALS
ivabradine hcl tab (CORLANOR equiv)	-	2	CARDIOVASCULAR AGENTS - MISC.
ivermectin cream (SOOLANTRA equiv) (QL= 45 grams/30 days)	QL	3	DERMATOLOGICALS
IVERMECTIN CREAM	-	NC	DERMATOLOGICALS
IVERMECTIN LOTION	-	NC	DERMATOLOGICALS
ivermectin tab (STROMECTOL equiv)	-	3	ANTHELMINTICS
IVERMECTIN TAB	-	NC	ANTHELMINTICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
IWILFIN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IXCHIQ INJ	VAC	EXC	VACCINES
IXIARO INJ	VAC	EXC	VACCINES
IXINITY INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
IYUZEH OPHTH DROPS	-	NC	OPHTHALMIC AGENTS
JADENU SPRINKLE	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
JADENU TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
JAKAFI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JAKAFI XR TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JALYN CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
JANUMET TAB	-	NC	ANTIDIABETICS
JANUMET XR TAB (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL-¢	3	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	3	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
JASCAYD TAB	-	NC	RESPIRATORY AGENTS - MISC.
JAVADIN SOLN	-	NC	ANTIHYPERTENSIVES
JAYPIRCA TAB (QL= 2 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JENLIVA CAP	-	NC	MULTIVITAMINS
JENTADUETO TAB (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
JIDEYTRO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
jinteli tab (FEMHRT equiv)	-	2	ESTROGENS
JIVI INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
JOENJA TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
jolessa tab, amethia tab (SEASONALE, SEASONIQUE equiv)	-	1	CONTRACEPTIVES
JOURNAVX TAB	-	NC	ANALGESICS - NONNARCOTIC
JUBLIA SOLN	-	NC	DERMATOLOGICALS
JULUCA TAB	-	NC/3P	ANTIVIRALS
JUXTAPID CAP	-	NC	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
JYLAMVO SOLN, XATMEP SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JYNARQUE PAK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNNEOS INJ	VAC	1	VACCINES
K CITRATE SOLN CITR ACD	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
K/NA CITRATE SOL CITR ACD	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
KADIAN CAP	-	NC	ANALGESICS - OPIOID
KALETRA SOLN	-	NC/ 3P	ANTIVIRALS
KALETRA TAB	-	5	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5	RESPIRATORY AGENTS - MISC.
KAPSPARGO CAP	-	NC	BETA BLOCKERS
KAPVAY TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KARBINAL ER SUSP	-	NC	ANTIHISTAMINES
KATERZIA SUSP	-	NC	CALCIUM CHANNEL BLOCKERS
KEFLEX CAP	-	NC	CEPHALOSPORINS
KEFLEX CAP 750MG	-	NC	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	1	CONTRACEPTIVES
KENALOG INJ	-	4	CORTICOSTEROIDS
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	4	CORTICOSTEROIDS
KENALOG SPRAY	-	NC	DERMATOLOGICALS
KEPPRA SOLN	-	NC	ANTICONVULSANTS
KEPPRA TAB	-	NC	ANTICONVULSANTS
KEPPRA XR TAB	-	NC	ANTICONVULSANTS
KERAFOAM	-	NC	DERMATOLOGICALS
KERALAC CREAM	-	NC	DERMATOLOGICALS
KERAMATRIX	-	NC	DERMATOLOGICALS
KERASTAT CREAM	-	NC	DERMATOLOGICALS
KERASTAT GEL	-	NC	DERMATOLOGICALS
KERENDIA TAB (QL= 1 tab/day)	PA-QL	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
KERLONE TAB	-	NC	BETA BLOCKERS
KERYDIN SOLN	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KESIMPTA INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
KETAMINE HCL TROCHES	-	NC	GENERAL ANESTHETICS
ketoconazole cream (NIZORAL CREAM equiv)	-	2	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	2	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	2	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	2	DIAGNOSTIC PRODUCTS
KETOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	4	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj (TORADOL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ketorolac ophth soln (ACULAR (LS) equiv)	-	2	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	2	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC TROMETHAMINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
KETOSTIX	OTC	2	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	2	OPHTHALMIC AGENTS
KEVEYIS TAB	-	NC	DIURETICS
KEVZARA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	5	CORTICOSTEROIDS
KINERET INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	1	TOXOIDS
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	1	TOXOIDS
KIRSTY INJ	-	NC	ANTIDIABETICS
KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KITABIS PAK NEB SOLN	-	NC	AMINOGLYCOSIDES
KLARITY-B DROPS	-	NC	OPHTHALMIC AGENTS
KLARITY-L DROPS	-	NC	OPHTHALMIC AGENTS
KLARON LOTION	-	NC	DERMATOLOGICALS
KLISYRI OINT	-	NC	DERMATOLOGICALS
KLONOPIN TAB	-	NC	ANTICONVULSANTS
KLOXXADO NASAL SPRAY	-	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
KOGENATE FS INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
KOMBIGLYZE XR TAB	-	NC	ANTIDIABETICS
KOMZIFTI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KONVOMEP SUSP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
KORLYM TAB	-	NC	ANTIDIABETICS
KOSELUGO CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO SPRINKLE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
K-PHOS NEUTRAL TAB 155-852-130MG	-	NC	MINERALS & ELECTROLYTES
K-PHOS TAB	-	3	MINERALS & ELECTROLYTES
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KRINTAFEL TAB	-	NC	ANTIMALARIALS
K-TAB	-	2	MINERALS & ELECTROLYTES
KUVAN POWDER PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KUVAN TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYBELLA INJ	-	NC	DERMATOLOGICALS
KYGEVVI POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYLEENA IUD	-	1	CONTRACEPTIVES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KYNAMRO INJ	-	NC	ANTIHYPERLIPIDEMICS
KYNMOBI FILM	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYNMOBI TITRATION KIT	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYTRIL TAB	-	NC	ANTIEMETICS
KYZATREX CAP	-	NC	ANDROGENS-ANABOLIC
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC	ANDROGENS-ANABOLIC
L.E.T. GEL	-	NC	DERMATOLOGICALS
labetalol hcl tab 400mg	-	NC	BETA BLOCKERS
labetalol tab (NORMODYNE equiv)	-	2	BETA BLOCKERS
lacosamide oral solution (VIMPAT equiv)	-	2	ANTICONVULSANTS
lacosamide tab (VIMPAT equiv)	-	2	ANTICONVULSANTS
LACRISERT OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
lactulose oral crystal packet	-	NC	LAXATIVES
lactulose soln	-	2	GASTROINTESTINAL AGENTS - MISC.
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	3	ANTIVIRALS
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	3	ANTIVIRALS
LAMICTAL CHEW TAB	-	NC	ANTICONVULSANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LAMICTAL ODT	-	NC	ANTICONVULSANTS
LAMICTAL ODT KIT	-	NC	ANTICONVULSANTS
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	4	ANTICONVULSANTS
LAMICTAL STARTER KIT	-	NC	ANTICONVULSANTS
LAMICTAL TAB	-	NC	ANTICONVULSANTS
LAMICTAL XR TAB	-	NC	ANTICONVULSANTS
LAMISIL TAB	-	NC	ANTIFUNGALS
lamivudine soln (EPIVIR equiv)	-	2	ANTIVIRALS
lamivudine tab (EPIVIR equiv)	-	2	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	2	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	2	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	4	ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	NC	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL equiv)	-	NC	ANTICONVULSANTS
lamotrigine starter kit (LAMICTAL STARTER KIT equiv)	-	4	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	2	ANTICONVULSANTS
LAMPIT TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
LANCET DEVICE	OTC	2	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LANCET KIT	OTC	2	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	2	MEDICAL DEVICES AND SUPPLIES
LANOXIN TAB	-	NC	CARDIOTONICS
LANOXIN TAB 62.5MCG	-	NC	CARDIOTONICS
lansoprazole cap (PREVACID equiv)	OTC	2	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv) (Prior Authorization required for members age 9 years and older)	PA	4	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
LANSOPRAZOLE SUSP	-	NC	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
LANSOPRAZOLE/AMOXICILLIN/CLARITHTHROMYCIN KIT	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ	-	3	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	3	ANTIDIABETICS
lapatinib ditosylate tab (TYKERB equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LASIX ONYU INJ 80MG/2.67ML (QL= 6 cartridges/fill)	QL	3	DIURETICS
LASIX ONYU REUSABLE UNIT (QL= 1 device/year)	QL	3	MEDICAL DEVICES AND SUPPLIES
LASIX TAB	-	NC	DIURETICS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	2	OPHTHALMIC AGENTS
LATUDA TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LAZANDA NASAL SPRAY	-	NC	ANALGESICS - OPIOID
LAZCLUZE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	3	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	2	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LENVIMA CAP (QL= 3 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEQEMBI IQLIK INJ 250MG/1.25ML (QL= 8 inj/28 days; Only available through Caremed 877-227-340 or Walgreens 888-347-3416)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LEQSELVI TAB	-	NC	DERMATOLOGICALS
LEROCHOL SOLN	-	NC	ANTIHYPERLIPIDEMICS
LESCOL XL TAB	-	NC	ANTIHYPERLIPIDEMICS
LETAIRIS TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
letrozole tab (FEMARA equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUCOVOR CA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LEUKERAN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	-	NC	HEMATOPOIETIC AGENTS
leuprolide inj (LUPRON equiv)	INF-MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days)	QL	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVAQUIN TAB	-	NC	FLUOROQUINOLONES
LEVBID ER TAB 0.375MG	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
LEVEMIR FLEXTOUCH INJ	-	3	ANTIDIABETICS
LEVEMIR INJ	-	3	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	2	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	2	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	2	ANTICONVULSANTS
LEVETIRACETAM TAB FOR ORAL SUSP, SPRITAM TAB FOR ORAL SUSP	-	NC	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LEVITRA TAB	-	EXC	CARDIOVASCULAR AGENTS - MISC.
LEVOBUNOLOL OPHTH SOLN	-	2	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	2	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocarnitine tab (CARNITOR equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine soln (XYZAL equiv)	-	4	ANTIHISTAMINES
levocetirizine tab (XYZAL equiv)	-	4	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	2	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN 0.5%	-	2	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	2	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	2	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	1	CONTRACEPTIVES
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	1	CONTRACEPTIVES
levorphanol tab (LEVORPHANOL equiv)	-	NC	ANALGESICS - OPIOID
LEVOTHYROXINE INJ	-	NC	THYROID AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LEVOTHYROXINE INJ 100MCG/ML	-	NC	THYROID AGENTS
levothyroxine tab (SYNTHROID equiv)	-	2	THYROID AGENTS
LEVSIN INJ	-	NC	ULCER DRUGS
LEVSIN SL TAB 0.125MG	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
LEVSIN TAB 0.125MG	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
LEXAPRO TAB	-	NC	ANTIDEPRESSANTS
LEXIVA TAB	-	NC/3P	ANTIVIRALS
LEXTOL PAK	-	NC	DERMATOLOGICALS
l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day)	MSP-PA-QL	2	HEMATOPOIETIC AGENTS
LIALDA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIBERVANT FILM	-	NC	ANTICONVULSANTS
LIBRAX CAP	-	NC	ULCER DRUGS
LICART PATCH	-	NC	DERMATOLOGICALS
LIDAMANTLE LOTION	-	NC	DERMATOLOGICALS
LIDO/MENTHOL SPRAY	-	NC	DERMATOLOGICALS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LIDO/RAC/TET GEL	-	NC	DERMATOLOGICALS
LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
lidocaine cream 3% (LIDAMANTLE equiv)	-	2	DERMATOLOGICALS
lidocaine cream 3.88% (LIDOTRAL equiv)	-	NC	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	2	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	NC	DERMATOLOGICALS
lidocaine hcl cream 4.12%	-	NC	DERMATOLOGICALS
lidocaine oint (QL= 107gm/30 days)	QL	2	DERMATOLOGICALS
lidocaine oint/transparent dressing kit (LIDOPAC equiv)	-	NC	DERMATOLOGICALS
LIDOCAINE ORAL SOLN	-	NC	MOUTH / THROAT / DENTAL AGENTS
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	4	DERMATOLOGICALS
lidocaine patch 3.5% (GEN7T equiv)	OTC	NC	DERMATOLOGICALS
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	3	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	2	DERMATOLOGICALS
LIDOCAINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
lidocaine viscous soln (LIDOCAINE HCL (MOUTH-THROAT) equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LIDOCAINE/HC CREAM	-	3	ANORECTAL AND RELATED PRODUCTS
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	NC	DERMATOLOGICALS
LIDOCAINE/TETRACAINE CREAM	-	NC	DERMATOLOGICALS
LIDOCIN GEL	-	NC	DERMATOLOGICALS
LIDODERM PATCH	-	NC	DERMATOLOGICALS
LIDO-EP-TETR SOLN	-	NC	DERMATOLOGICALS
LIDOLOG KIT	-	NC	CORTICOSTEROIDS
LIDOSTREAM KIT	-	NC	DERMATOLOGICALS
LIDOTIN PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LIDOTRAL CREAM	-	NC	DERMATOLOGICALS
LIDOTREX GEL	-	NC	DERMATOLOGICALS
LIDOVEX CREAM	-	NC	DERMATOLOGICALS
LIFYORLI CAP DOSE PACK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LIKMEZ SUSP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
LINDANE SHAMPOO	-	4	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	3	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP (QL= 1 cap/day)	PA-QL	4	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	2	THYROID AGENTS
LIPFENDRA TAB	-	NC	ANTIHYPERLIPIDEMICS
LIPITOR TAB	-	NC	ANTIHYPERLIPIDEMICS
LIQREV SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv)	-	EXC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days)	PA-QL	3/3P	ANTIDIABETICS
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	2	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	2	ANTIHYPERTENSIVES
LITFULO CAP	-	NC	DERMATOLOGICALS
LITHIUM CARBONATE CAP	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate cap (ESKALITH ER equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium carbonate tab	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lithium oral solution (LITHIUM equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LITHOBID TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LITHOSTAT TAB	-	4	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB	-	4	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LIVDELZI CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI SOLN (QL= 90ml/30 days; Only availabl through Eversana 866-849-4481)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI SOLN 19MG/ML	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI TAB 30MG	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	ANTIVIRALS
L-METHYLFOLATE TAB	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
LMR PLUS KIT	-	NC	DERMATOLOGICALS
LO LOESTRIN TAB	-	1	CONTRACEPTIVES
LOARGYS INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
LOCOID CREAM	-	NC	DERMATOLOGICALS
LOCOID LIPOCREAM	-	NC	DERMATOLOGICALS
LOCOID LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LOCOID OINT	-	NC	DERMATOLOGICALS
LOCOID SOLN	-	NC	DERMATOLOGICALS
LODOCO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
LODOSYN TAB	-	NC	ANTIPARKINSON AGENTS
lofexidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days)	PA-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
lohist liquid (DECON-A equiv)	OTC	NC	COUGH / COLD / ALLERGY
LOKELMA PAK (QL= 1 packet/day)	PA-QL	3	MISCELLANEOUS THERAPEUTIC CLASSES
LOKELMA PAK 10GM	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
LOKELMA PAK 5GM	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
LOMOTIL TAB	-	NC	ANTIDIARRHEALS
lomustine cap (GLEOSTINE equiv)	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LONSURF TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap	-	NC	ANTIDIARRHEALS
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC	ANTIDIARRHEAL / PROBIOTIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LOPID TAB	-	NC	ANTIHYPERLIPIDEMICS
lopinavir/ritonavir soln (KALETRA equiv)	-	5	ANTIVIRALS
lopinavir/ritonavir tab (KALETRA equiv)	-	2	ANTIVIRALS
LOPRESSOR SOLN	-	NC	BETA BLOCKERS
LOPRESSOR TAB	-	NC	BETA BLOCKERS
LOPROX CREAM	-	NC	DERMATOLOGICALS
LOPROX SHAMPOO	-	NC	DERMATOLOGICALS
loratadine cap (CLARITIN equiv)	OTC	EXC	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	2	ANTIANXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	2	ANTIANXIETY AGENTS
LORBRENA TAB 100MG (QL= 1 tab/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LOREEV XR CAP	-	NC	ANTIANXIETY AGENTS
LORTAB	-	NC	ANALGESICS - OPIOID
LORTAB ELIXIR	-	4	ANALGESICS - OPIOID
LORVATUS PHARMAPAK KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
losartan tab (COZAAR equiv)	-	2	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	NC	ANTIHYPERTENSIVES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LOTEMAX GEL	-	4	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	3	OPHTHALMIC AGENTS
LOTEMAX OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
LOTEMAX SM GEL 0.38%	-	NC	OPHTHALMIC AGENTS
LOTENSIN HCT TAB	-	NC	ANTIHYPERTENSIVES
LOTENSIN TAB	-	NC	ANTIHYPERTENSIVES
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	3	OPHTHALMIC AGENTS
loteprednol etabonate-tobramycin ophth susp (ZYLET equiv)	-	NC	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX, ALREX equiv)	-	3	OPHTHALMIC AGENTS
LOTREL CAP	-	NC	ANTIHYPERTENSIVES
LOTRIMIN AF CREAM	-	NC	DERMATOLOGICALS
LOTRISONE CREAM	-	NC	DERMATOLOGICALS
LOTRONEX TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
lovastatin tab (MEVACOR equiv)	-	1	ANTIHYPERLIPIDEMICS
LOVAZA CAP	-	NC	ANTIHYPERLIPIDEMICS
LOVENOX INJ	-	NC	ANTICOAGULANTS
loxapine cap (LOXITANE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	QL	2	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LULICONAZOLE CREAM, LUZU CREAM	-	NC	DERMATOLOGICALS
LUMAKRAS TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 240MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 320MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	3	OPHTHALMIC AGENTS
LUMRYZ PACK (QL= 1 pack/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUMRYZ STARTER PACK (QL= 1 packet/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUNESTA TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
LUPANETA PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
LUPRON DEPOT INJ	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUPRON DEPOT PED INJ	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
lurasidone hcl tab (LATUDA equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
LURBIRO TAB 100MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
LUVIRA CAP	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
LUXIQ FOAM	-	NC	DERMATOLOGICALS
LYBALVI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LYNAVOY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LYNKUET CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
LYNPARZA TAB (QL= 4 tabs/day; Only available through Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, or Optum 877-445-6874)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	-	NC	ANTICONVULSANTS
LYRICA CAP 225MG	-	NC	ANTICONVULSANTS
LYRICA CAP 300MG	-	NC	ANTICONVULSANTS
LYRICA CR TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LYRICA SOLN	-	NC	ANTICONVULSANTS
LYSODREN TAB (Only available through Walgreen 888-347-3416)	LD	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYSTEDA TAB	-	NC	HEMOSTATICS
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYUMJEV INJ	-	3	ANTIDIABETICS
LYUMJEV KWIKPEN INJ	-	3	ANTIDIABETICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LYUMJEV TEMPO PEN	-	3	ANTIDIABETICS
LYUMJEV TEMPO PEN	-	NC	ANTIDIABETICS
LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older)	PA	4	MUSCULOSKELETAL THERAPY AGENTS
macitentan tab (OPSUMIT equiv) (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2	CARDIOVASCULAR AGENTS - MISC.
MACRILEN PACK	-	NC	DIAGNOSTIC PRODUCTS
MACROBID CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
MACRODANTIN CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
MACRODANTIN CAP 25MG	-	NC	ANTI-INFECTIVE AGENTS - MISC.
MAFENIDE ACETATE SOLN PACK	-	NC	DERMATOLOGICALS
MAGNESIUM SULF INJ	-	NC	MINERALS & ELECTROLYTES
magnesium sulfate inj	-	NC	MINERALS & ELECTROLYTES
MAKENA INJ	-	NC	PROGESTINS
MALARONE TAB	-	NC	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	4	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	1	MEDICAL DEVICES AND SUPPLIES
MANNITOL INJ	-	NC	DIURETICS
maraviroc tab (SELZENTRY equiv)	-	2	ANTIVIRALS
MARINOL CAP	-	NC	ANTIEMETICS
MARPLAN TAB	-	NC	ANTIDEPRESSANTS
MATERVIA CAP	-	NC	MULTIVITAMINS
MATRONEX TAB	-	NC	MULTIVITAMINS
MATULANE CAP	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAVIK TAB	-	NC	ANTIHYPERTENSIVES
MAVYRET PAK	-	NC	ANTIVIRALS
MAVYRET TAB	-	NC	ANTIVIRALS
MAXALT MLT TAB	-	NC	MIGRAINE PRODUCTS
MAXALT TAB	-	NC	MIGRAINE PRODUCTS
MAXIDEX OPHTH SOLN	-	3	OPHTHALMIC AGENTS
MAXITROL OPHTH OINT	-	NC	OPHTHALMIC AGENTS
MAXITROL OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
MAXZIDE TAB	-	NC	DIURETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MAYZENT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAYZENT TAB STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
mebendazole chew tab	-	2	ANTHELMINTICS
meclizine chew tab (BONINE equiv)	OTC	2	ANTIEMETICS
MECLIZINE CHEW TAB	-	NC	ANTIEMETICS
meclizine hcl tab (ANTIVERT equiv)	-	NC	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	OTC	2	ANTIEMETICS
MECLOFENAMATE CAP	-	4	ANALGESICS - ANTI-INFLAMMATORY
MEDI-PATCH W/LIDOCAINE PATCH	-	NC	DERMATOLOGICALS
MEDROL DOSE PACK	-	NC	CORTICOSTEROIDS
MEDROL TAB	-	3	CORTICOSTEROIDS
MEDROL TAB	-	NC	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	1	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	2	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
mefloquine tab (LARIAM equiv)	-	3	ANTIMALARIALS
megestrol ES susp (MEGACE ES equiv)	-	4	PROGESTINS
megestrol susp (MEGACE equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEGESTROL SUSP	-	4	PROGESTINS
megestrol tab (MEGACE equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST SOLN	MSP-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKTOVI TAB (QL= 6 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam cap (VIVLODEX equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM COMFORT KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MELOXICAM SUSP, ZYBIC SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
melphalan inj (ALKERAN equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
memantine ER cap (NAMENDA XR equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine sol (NAMENDA equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab (NAMENDA equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MEMANTINE TITRATION PAK	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENACTRA INJ	VAC	1	VACCINES
MENEST TAB	-	4	ESTROGENS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MENOPUR INJ	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MENOSTAR PATCH	-	NC	ESTROGENS
MENQUADFI INJ	VAC	1	VACCINES
MENTAX CREAM	-	4	DERMATOLOGICALS
MENTHOREAL10 THERAPY PACK	-	NC	DERMATOLOGICALS
MENVEO INJ	VAC	1	VACCINES
meperidine tab (DEMEROL equiv)	-	NC	ANALGESICS - OPIOID
MEPHYTON TAB	-	NC	VITAMINS
meprobamate tab (MILTOWN equiv)	-	4	ANTIANXIETY AGENTS
MEPRON SUSP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
mercaptopurine susp (PURIXAN equiv) (Prior Authorization required for members age 9 years and older)	PA	4	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mercaptopurine tab (PURINETHOL equiv)	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MERILOG INJ	-	NC	ANTIDIABETICS
MERILOG SOLOSTAR INJ	-	NC	ANTIDIABETICS
meropenem inj (MERREM equiv)	-	4	ANTI-INFECTIVE AGENTS - MISC.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MESALAMINE DR CAP	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR cap (DELZICOL equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR tab (LIALDA equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (APRISO equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (PENTASA CR equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
mesalamine tab (ASACOL equiv)	-	4	GASTROINTESTINAL AGENTS - MISC.
mesna tab (MESNEX equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESNEX TAB	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESTINON TAB	-	NC	ANTIMYASTHENIC / CHOLINERGIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MESTINON TIMESPAN TAB	-	NC	ANTIMYASTHENIC / CHOLINERGIC AGENTS
METANX CAP	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
METAXALONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
metaxalone tab (SKELAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METDRAY GEL	-	NC	DERMATOLOGICALS
metformin ER osmotic tab (FORTAMET equiv)	-	NC	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	2	ANTIDIABETICS
metformin hcl tab 625MG	-	NC	ANTIDIABETICS
metformin hcl tab 750MG	-	NC	ANTIDIABETICS
metformin soln (RIOMET equiv)	-	4	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	2	ANTIDIABETICS
METFORMIN TAB	-	NC	ANTIDIABETICS
methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2	ANALGESICS - OPIOID

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
METHADOSE CONC	-	NC	ANALGESICS - OPIOID
methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2	ANALGESICS - OPIOID
methamphetamine hcl tab (METHAMPHETAMINE equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	3	DIURETICS
METHENAM MAN TAB	-	2	ANTI-INFECTIVE AGENTS - MISC.
methenamine hippurate tab (HIPREX equiv)	-	3	ANTI-INFECTIVE AGENTS - MISC.
METHENAMINE ORAL SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
methimazole tab (TAPAZOLE equiv)	-	2	THYROID AGENTS
METHITEST TAB	-	NC	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
methocarbamol tab 1000mg (ROBAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METHOTREXATE INJ	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
methotrexate tab (TREXALL equiv)	-	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
METHOXSALEN CAP	-	3	DERMATOLOGICALS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	3	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	4	ULCER DRUGS
methsuximide cap (CELONTIN equiv)	-	3	ANTICONVULSANTS
methyldopa tab (ALDOMET equiv)	-	2	ANTIHYPERTENSIVES
METHYLDOPA TAB	-	4	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	3	OXYTOCICS
METHYLIN SOLN	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate CD cap (METADATE CD equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate chew tab (METHYLIN equiv)	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
methylphenidate ER cap (RITALIN LA equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER cap (APTENSIO XR equiv)	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab (CONCERTA equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB	-	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB 27MG	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
METHYLPHENIDATE ER TAB 36MG	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB 54MG	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate ER tab 72mg	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
METHYLPHENIDATE ER TAB, RELEXXII TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
methylphenidate tab (RITALIN equiv)	-	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylphenidate td patch (DAYTRANA equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	2	CORTICOSTEROIDS
methylprednisolone dose pack (MEDROL equiv)	-	2	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	2	CORTICOSTEROIDS
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	2	CORTICOSTEROIDS
methyltestosterone cap	PA	4	ANDROGENS-ANABOLIC
metoclopramide soln (REGLAN equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	2	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	2	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	2	BETA BLOCKERS
METOPROLOL TARTRATE TAB	-	NC	BETA BLOCKERS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	NC	ANTIHYPERTENSIVES
METOZOLV ODT	-	NC	GASTROINTESTINAL AGENTS - MISC.
METROCREAM	-	NC	DERMATOLOGICALS
METROGEL 1%	-	NC	DERMATOLOGICALS
METROGEL VAGINAL GEL	-	NC	VAGINAL PRODUCTS
METROLOTION	-	NC	DERMATOLOGICALS
metronidazole cap (FLAGYL equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	2	DERMATOLOGICALS
metronidazole gel (METROGEL equiv)	-	3	DERMATOLOGICALS
metronidazole gel 0.75% (METROGEL equiv)	-	2	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	3	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
METRONIDAZOLE TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	2	VAGINAL PRODUCTS
metyrosine cap (DEMSER equiv)	-	NC	ANTIHYPERTENSIVES
mexiletine hcl cap	-	3	ANTIARRHYTHMICS
MEXPAROX HC CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MFLUSIVA INJ (QL= 1 inj/28; Covered for members age 50 years and older)	QL-VAC	1	VACCINES
MIACALCIN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
micafungin inj (MYCAMINE equiv)	M	6	ANTIFUNGALS
MICARDIS HCT TAB	-	NC	ANTIHYPERTENSIVES
MICARDIS TAB	-	NC	ANTIHYPERTENSIVES
MICLARA LIQUID	OTC	NC	ANTIHISTAMINES
MICONAZOLE 3 SUPP 200MG	-	4	VAGINAL PRODUCTS
MICROVIX LP PAK	-	NC	DERMATOLOGICALS
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
MIDAZOLAM INJ	-	NC	ANTICONVULSANTS
midodrine tab (PROAMATINE equiv)	-	2	VASOPRESSORS
MIDUELLA, PARAGARD IUD	-	1	CONTRACEPTIVES
MIEBO OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
MIFEPREX TAB	-	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day)	MSP-PA-QL	5	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
mifepristone tab 200mg (MIFIPREX equiv)	-	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIGERGOT SUPP	-	NC	MIGRAINE PRODUCTS
MIGLITOL TAB	-	4	ANTIDIABETICS
miglitol tab (MIGLITOL equiv)	-	4	ANTIDIABETICS
miglustat cap (ZAVESCA equiv)	-	NC	HEMATOPOIETIC AGENTS
MIGRANAL SPRAY	-	NC	MIGRAINE PRODUCTS
MILLIPRED DP PAK	-	NC	CORTICOSTEROIDS
MILLIPRED TAB	-	NC	CORTICOSTEROIDS
milnacipran hcl tab (SAVELLA equiv) (QL= 2 tabs/day)	QL	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
milnacipran hcl tab pak (SAVELLA equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MINASTRIN CHEW TAB	-	NC	CONTRACEPTIVES
MINIPRESS CAP	-	NC	ANTIHYPERTENSIVES
MINOCIN CAP	-	NC	TETRACYCLINES
minocycline cap (MINOCIN equiv)	-	2	TETRACYCLINES
MINOCYCLINE ER CAP	-	NC	TETRACYCLINES
minocycline ER tab (SOLODYN equiv)	-	NC	TETRACYCLINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
minocycline tab (DYNACIN equiv)	-	3	TETRACYCLINES
MINOLIRA TAB	-	NC	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	2	ANTIHYPERTENSIVES
MIPLYFFA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
mirabegron granules for oral extended release susp (MYRBETRIQ equiv)	-	NC	URINARY ANTISPASMODICS
mirabegron tab er (MYRBETRIQ equiv)	-	NC	URINARY ANTISPASMODICS
MIRALAX	OTC	NC	LAXATIVES
MIRALAX PACKET	OTC	NC	LAXATIVES
MIRAPEX ER TAB	-	NC	ANTIPARKINSON AGENTS
MIRAPEX TAB	-	NC	ANTIPARKINSON AGENTS
MIRCERA INJ	-	NC	HEMATOPOIETIC AGENTS
MIRCETTE TAB	-	NC	CONTRACEPTIVES
MIRENA IUD	-	1	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	2	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	2	ANTIDEPRESSANTS
MIRVASO GEL	-	EXC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	2	ULCER DRUGS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
M-M-R II INJ	VAC	1	VACCINES
MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days)	QL-VAC	1	VACCINES
MOBIC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	2	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
MODEYSO CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
moexipril tab (UNIVASC equiv)	-	NC	ANTIHYPERTENSIVES
MOLINDONE TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
mometasone cream (ELOCON equiv)	-	2	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv) (QL= 2 bottles/fill)	QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	2	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	2	DERMATOLOGICALS
MONODOX CAP	-	NC	TETRACYCLINES
montelukast chew tab (SINGULAIR equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
montelukast granule pack (SINGULAIR equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MONUROL GRANULE PACK	-	NC	ANTI-INFECTIVE AGENTS - MISC.
MORPHABOND TAB	-	NC	ANALGESICS - OPIOID
MORPHINE SULFATE ER BEAD CAP (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	4	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2	ANALGESICS - OPIOID
MORPHINE SULFATE ORAL SOLN 10 MG/5ML	-	2	ANALGESICS - OPIOID
MORPHINE SULFATE ORAL SOLN 100MG/5ML	-	2	ANALGESICS - OPIOID
morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv)	-	2	ANALGESICS - OPIOID
morphine sulfate soln	-	2	ANALGESICS - OPIOID
MORPHINE SULFATE SOLN 20MG/5ML	-	2	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	3	ANALGESICS - OPIOID
morphine sulfate tab	-	2	ANALGESICS - OPIOID

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MOTEGRITY TAB (QL= 1 tab/day)	QL	4	GASTROINTESTINAL AGENTS - MISC.
MOTOFEN TAB	-	4	ANTIDIARRHEALS
MOTPOLY XR CAP	-	NC	ANTICONVULSANTS
MOTRIN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MOUNJARO INJ (QL= 4 inj/28 days)	PA-QL	3/3 P	ANTIDIABETICS
MOVANTIK TAB (QL= 1 tab/day)	PA-QL	3	GASTROINTESTINAL AGENTS - MISC.
MOVIPREP SOLN	-	NC	LAXATIVES
MOXATAG TAB	-	NC	PENICILLINS
MOXATAG TAB 775MG	-	NC	PENICILLINS
MOXEZA OPHTH SOLN 0.5%	-	NC	OPHTHALMIC AGENTS
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	2	OPHTHALMIC AGENTS
MOXIFLOXACIN SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	3	FLUOROQUINOLONES
MOZOBIL INJ	-	NC	HEMATOPOIETIC AGENTS
MPM PAK	-	NC	OXYTOCICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MRESVIA INJ (QL= 1 dose/lifetime)	QL-VAC	1	VACCINES
MS CONTIN TAB	-	NC	ANALGESICS - OPIOID
MUCINEX LIQUID	-	NC	COUGH / COLD / ALLERGY
MULPLETA TAB	-	NC	HEMATOPOIETIC AGENTS
MULTAQ TAB	-	3	ANTIARRHYTHMICS
MULTIGEN FOLIC TAB	-	2	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	2	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	2	HEMATOPOIETIC AGENTS
MULTI-MAC TAB	-	NC	MULTIVITAMINS
MULTIPLE-VITAMIN/FL-FE DROPS	-	NC	MULTIVITAMINS
MULTIVITAMIN CHEW TAB	-	NC	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	NC	MULTIVITAMINS
mupirocin cream (BACTROBAN equiv)	-	NC	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	2	DERMATOLOGICALS
MYALEPT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MYAMBUTOL TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
MYCAMINE INJ	M	6	ANTIFUNGALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MYCAPSSA CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MYCOBUTIN CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
mycophenolate DR tab (MYFORTIC equiv)	-	5	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	5	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	5	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	5	ASSORTED CLASSES
MYDAYIS CAP 12.5MG	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
MYDAYIS CAP 25MG	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
MYDAYIS CAP 37.5MG	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MYDAYIS CAP 50MG	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
MYDCOMBI OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
MYDRIACYL OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
MYFEMBREE TAB	-	NC	ESTROGENS
MYFORTIC TAB	-	NC	ASSORTED CLASSES
MYHIBBIN SUSP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
MYLERAN TAB	MSP	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYNATAL-Z TAB	-	4	MULTIVITAMINS
MYNEPHRON CAP	-	NC	MULTIVITAMINS
MYQORZO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
MYRBETRIQ SUSP	-	NC	URINARY ANTISPASMODICS
MYRBETRIQ TAB	-	3	URINARY ANTISPASMODICS
MYSOLINE TAB	-	NC	ANTICONVULSANTS
MYTESI TAB	-	NC	ANTIDIARRHEALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
nabumetone tab (RELAFEN equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	3	BETA BLOCKERS
NAFLON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naftifine cream (NAFTIN equiv)	-	4	DERMATOLOGICALS
NAFTIFINE CREAM	-	NC	DERMATOLOGICALS
naftifine hcl gel 2% (NAFTIN equiv)	-	NC	DERMATOLOGICALS
NAFTIN GEL 2%	-	NC	DERMATOLOGICALS
nalbuphine inj	-	NC	ANALGESICS - OPIOID
naloxone hcl nasal spray (NARCAN equiv)	OTC	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone inj	-	2	ANTIDOTES
naloxone prefilled inj	-	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	2	ANTIDOTES
NAMENDA TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NAMENDA XR CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA XR TITRATION PACK	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAPRELAN CR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB 500MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
naproxen EC tab (NAPROSYN EC equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SOD ER TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen susp (NAPROSYN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	OTC	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
NARDIL TAB 15MG	-	4	ANTIDEPRESSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	4	NASAL AGENTS - SYSTEMIC AND TOPICAL
NASCOBAL SPRAY	-	4	HEMATOPOIETIC AGENTS
NATACYN OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
NATAZIA TAB	-	1	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	NC	ANTIDIABETICS
NATESTO GEL	-	NC	ANDROGENS-ANABOLIC
NATESTO NASAL GEL	-	NC	ANDROGENS-ANABOLIC
NATROBA SUSP (QL= 1 bottle/fill)	QL	4	DERMATOLOGICALS
NATROBA SUSP 0.90% (QL= 1 bottle/fill)	QL	4	DERMATOLOGICALS
NAYZILAM SPRAY	-	NC	ANTICONVULSANTS
nebivolol hcl tab (BYSTOLIC equiv)	-	2	BETA BLOCKERS
NEBUPENT NEB SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NEBUSAL NEB SOLN	-	NC	COUGH / COLD / ALLERGY
NEFAZODONE TAB	-	4	ANTIDEPRESSANTS
NEFFY SPRAY (QL= 2 doses/fill)	QL	3	VASOPRESSORS
NEMLUVIO INJ	-	NC	DERMATOLOGICALS
NENDRUX GEL	-	NC	DERMATOLOGICALS
NEO/BAC/POLY OPHTH OINT	-	2	OPHTHALMIC AGENTS
NEO/POLY/BAC/HC OPHTH OINT	-	2	OPHTHALMIC AGENTS
neomycin tab	-	2	AMINOGLYCOSIDES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	2	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocoritisone otic soln (CORTISPORIN equiv)	-	2	OTIC AGENTS
neomycin/polymixin/hydrocoritisone otic susp (CORTISPORIN equiv)	-	2	OTIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	2	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	2	OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	3	OPHTHALMIC AGENTS
NEONATAL 19 TAB	-	4	MULTIVITAMINS
NEONATAL FE TAB	-	4	MULTIVITAMINS
NEORAL CAP	-	NC	ASSORTED CLASSES
NEORAL SOLN	-	NC	ASSORTED CLASSES
NEOSALUS FOAM	-	NC	DERMATOLOGICALS
NEOSALUS LOTION	-	NC	DERMATOLOGICALS
NEOSPORIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
NEO-SYNALAR CREAM	-	NC	DERMATOLOGICALS
NEPHRON FA TAB	-	3	HEMATOPOIETIC AGENTS
NEPTAZANE TAB	-	NC	DIURETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NEREUS CAP	-	NC	ANTIEMETICS
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEULASTA INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPRO PATCH	-	4	ANTIPARKINSON AGENTS
NEURONTIN CAP	-	NC	ANTICONVULSANTS
NEURONTIN SOLN	-	NC	ANTICONVULSANTS
NEURONTIN TAB 600MG	-	NC	ANTICONVULSANTS
NEURONTIN TAB 800MG	-	NC	ANTICONVULSANTS
NEVANAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
NEVIRAPINE ER TAB	-	NC/ 3P	ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv)	-	NC/ 3P	ANTIVIRALS
NEVIRAPINE SUSP	-	NC/ 3P	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	NC/ 3P	ANTIVIRALS
NEXAVAR TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NEXICLON XR TAB	-	NC	ANTIHYPERTENSIVES

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NEXIUM 24HR TAB	OTC	4	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
NEXIUM GRANULE PACK	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3	ANTIHYPERLIPIDEMICS
NEXLIZET TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3	ANTIHYPERLIPIDEMICS
NEXPLANON IMPLANT	-	1	CONTRACEPTIVES
NEXTSTELLIS TAB	-	1	CONTRACEPTIVES
NGENLA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
niacin ER tab (NIASPAN equiv)	-	2	ANTIHYPERLIPIDEMICS
NIACOR TAB	-	NC	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	NC	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	4	CALCIUM CHANNEL BLOCKERS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NICODERM PATCH (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	2	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	2	CALCIUM CHANNEL BLOCKERS
NILOTINB TAR CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NILOTINIB D-TAR CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nilotinib hcl cap (TASIGNA equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NILUTAMIDE TAB	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nilutamide tab (NILANDRON equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	NC	CALCIUM CHANNEL BLOCKERS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nintedanib esylate cap (OFEV equiv)	-	NC	RESPIRATORY AGENTS - MISC.
NIRAVAM ODT	-	NC	ANTIANXIETY AGENTS
nisoldipine ER tab (SULAR equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	NC	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 25.5MG	-	NC	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER, SULAR ER TAB	-	NC	CALCIUM CHANNEL BLOCKERS
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	3	ANTI-INFECTIVE AGENTS - MISC.
nitisinone cap (ORFADIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NITRO-DUR PATCH	-	NC	ANTIANGINAL AGENTS
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	4	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin monohydrate cap (MACROBID equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin susp (FURADANTIN equiv) (Prior Authorization required for members age 9 years and older)	PA	4	ANTI-INFECTIVE AGENTS - MISC.
NITROFURANTOIN SUSP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NITROGLYCERIN ER CAP	-	2	ANTIANGINAL AGENTS
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	4	ANTIANGINAL AGENTS
nitroglycerin oint	-	3	ANTIANGINAL AGENTS
nitroglycerin oint (RECTIV equiv)	-	4	ANORECTAL AND RELATED PRODUCTS
nitroglycerin patch (NITRO-DUR equiv)	-	2	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	2	ANTIANGINAL AGENTS
NITROLINGUAL PUMP SPRAY	-	NC	ANTIANGINAL AGENTS
NITROSTAT SL TAB	-	NC	ANTIANGINAL AGENTS
NITYR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NIVESTYM INJ	MSP	5	HEMATOPOIETIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NIZATIDINE CAP	-	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
nizatidine cap (AXID equiv)	-	2	ULCER DRUGS
NIZORAL SHAMPOO	-	NC	DERMATOLOGICALS
NOCDURNA SL TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NOCTIVA EMULSION SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	1	CONTRACEPTIVES
norethindrone acetate/ethinyl estradial FE chew tab (MINASTRIN equiv)	-	1	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	1	CONTRACEPTIVES
norethindrone tab (NORA-QD equiv)	-	1	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	2	PROGESTINS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	1	CONTRACEPTIVES
NORGESIC TAB FORTE	-	NC	MUSCULOSKELETAL THERAPY AGENTS
NORGESIC TAB, ORPHENADRINE/ASPIRIN/CAFFEINE TAB 25-385-30MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
NORITATE CREAM	-	NC	DERMATOLOGICALS
NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older)	PA	4	CALCIUM CHANNEL BLOCKERS
NORPACE CAP	-	NC	ANTIARRHYTHMICS
NORPACE CR CAP	-	3	ANTIARRHYTHMICS
NORPRAMIN TAB	-	NC	ANTIDEPRESSANTS
NOR-QD TAB	-	NC	CONTRACEPTIVES
NORTHERA CAP	-	NC	VASOPRESSORS
nortrel tab (OVCON 35 equiv)	-	1	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	2	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	2	ANTIDEPRESSANTS
NORVASC TAB	-	NC	CALCIUM CHANNEL BLOCKERS
NORVIR POWDER PACK	-	4	ANTIVIRALS
NORVIR TAB	-	NC/ 3P	ANTIVIRALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NOURIANZ TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
NOVACORT GEL	-	NC	DERMATOLOGICALS
NOVAVAX INJ (QL= 1 dose/24 days)	QL-VAC	1	VACCINES
NOVOEIGHT INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
NOVOFINE PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N RELION 100UNIT/ML	OTC	NC	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG FLEXPEN RELION INJ	-	NC	ANTIDIABETICS
NOVOLOG INJ	-	NC	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NOVOLOG MIX FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG MIX INJ	-	NC	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	NC	ANTIDIABETICS
NOVOSEVEN RT INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
NOVOTWIST PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	2	MEDICAL DEVICES AND SUPPLIES
NOXAFIL PAK	-	4	ANTIFUNGALS
NOXAFIL SUSP	-	NC	ANTIFUNGALS
NOXAFIL TAB	-	NC	ANTIFUNGALS
NUBEQA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NUCALA INJ	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUCARACLINPA KIT	-	NC	DERMATOLOGICALS
NUCARARXPAK KIT	-	NC	DERMATOLOGICALS
NUCORT LOTION	-	4	DERMATOLOGICALS
NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3	ANALGESICS - OPIOID

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NUCYNTA TAB	-	4	ANALGESICS - OPIOID
NUDERMRXPAK PAK	-	NC	DERMATOLOGICALS
NUEDEXTA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nulido pad (NULIDO equiv)	-	NC	DERMATOLOGICALS
NUPLAZID CAP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
NUPLAZID TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
NUVAKAAN II KIT	-	NC	DERMATOLOGICALS
NUVARING	-	NC	CONTRACEPTIVES
NUVESSA VAGINAL GEL	-	NC	VAGINAL AND RELATED PRODUCTS
NUVIGIL TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
NUWIQ INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
NUWIQ KIT	-	EXC	HEMATOLOGICAL AGENTS - MISC.
NUZYRA TAB	-	NC	TETRACYCLINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NYATA KIT	-	NC	DERMATOLOGICALS
NYMALIZE SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
NYPOZI INJ	-	NC	HEMATOPOIETIC AGENTS
nystatin cream (MYCOSTATIN CREAM equiv)	-	2	DERMATOLOGICALS
nystatin oint	-	2	DERMATOLOGICALS
nystatin susp	-	2	MOUTH / THROAT / DENTAL AGENTS
NYSTATIN SUSP	-	NC	MOUTH / THROAT / DENTAL AGENTS
nystatin tab	-	2	ANTIFUNGALS
nystatin topical powder	-	2	DERMATOLOGICALS
nystatin/triamcinolone cream	-	2	DERMATOLOGICALS
nystatin/triamcinolone oint	-	2	DERMATOLOGICALS
NYVEPRIA INJ	-	NC	HEMATOPOIETIC AGENTS
OBIZUR INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
OCALIVA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OCTREOTIDE INJ 100MCG	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCUFLOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ODACTRA SL TAB	PA	4	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
ODEFSEY TAB	-	NC/ 3P	ANTIVIRALS
ODOMZO CAP (QL= 1 cap/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP	-	NC	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	2	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	2	OTIC AGENTS
OFLOXACIN TAB	-	2	FLUOROQUINOLONES
OGSIVEO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OGSIVEO TAB 50MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OHTUVAYRE SUSP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OJEMDA SUSP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OJEMDA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
olanzapine ODT (ZYPREXA equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLLIZAC POWDER	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
olmesartan tab (BENICAR equiv)	-	2	ANTIHYPERTENSIVES
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	2	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	NC	ANTIHYPERTENSIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
olopatadine nasal spray (PATANASE equiv)	-	3	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln (PATADAY equiv)	OTC	2	OPHTHALMIC AGENTS
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	2	OPHTHALMIC AGENTS
OLPRUVA PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OLUMIANT TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
OLUX E FOAM	-	NC	DERMATOLOGICALS
OLUX FOAM	-	NC	DERMATOLOGICALS
OMEGA-3 RX PAK COMPLETE	-	NC	ANTIHYPERLIPIDEMICS
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	2	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	2	ULCER DRUGS
omeprazole magnesium DR tab 20mg (PRILOSEC equiv)	OTC	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
omeprazole tab	OTC	2	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC	ULCER DRUGS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC	ULCER DRUGS
OMLONTI OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
OMLYCLO SYRINGE	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMLYCLO SYRINGE 150MG/ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMLYCLO SYRINGE 300MG/2ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMNARIS NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
OMNICEF SUSP	-	NC	CEPHALOSPORINS
OMNIPAQUE INJ	-	NC	DIAGNOSTIC PRODUCTS
OMNIPAQUE SOLN	-	NC	DIAGNOSTIC PRODUCTS
OMNIPOD 5 DEX G7G6 INTRO KIT (QL= 1 kit/year)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 DEX G7G6 PODS (QL= 10 pods/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	3	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT (QL= 1 kit/year)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 LIBRE2 PLUS G6 PODS (QL= 10 pods/30 days)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PDM KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT (QL= 10 pods/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	3	MEDICAL DEVICES AND SUPPLIES
OMNITROPE INJ	MSP-PA	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
OMVOH INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ONAPGO INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
ondansetron ODT (ZOFRAN equiv)	-	2	ANTIEMETICS
ondansetron soln (ZOFRAN equiv)	-	2	ANTIEMETICS
ondansetron tab (ZOFRAN equiv)	-	2	ANTIEMETICS
ONDANSETRON TAB	-	NC	ANTIEMETICS
ONDANSETRON TAB ODT	-	NC	ANTIEMETICS
ONEXTON GEL1.2-3.75%	-	NC	DERMATOLOGICALS
ONFI SUSP	-	NC	ANTICONVULSANTS
ONFI TAB	-	NC	ANTICONVULSANTS
ONGLYZA TAB	-	NC	ANTIDIABETICS
ONTRALFY ORAL SOLN	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ONUREG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ONYCHO-MED KIT	-	NC	DERMATOLOGICALS
ONYDA XR SUSP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ONZETRA XSAIL	-	NC	MIGRAINE PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OPANA TAB	-	NC	ANALGESICS - OPIOID
OPFOLDA CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OPILL TAB	OTC	NC	CONTRACEPTIVES
OPIPZA FILM	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
OPIUM TINCTURE	-	4	ANTIDIARRHEAL / PROBIOTIC AGENTS
OPSUMIT TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
OPSYNVI TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
OPVEE NASAL SPRAY	-	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
OPZELURA CREAM (QL= 12 tubes/year)	PA-QL	4	DERMATOLOGICALS
ORACEA CAP	-	NC	DERMATOLOGICALS
ORACIT SOLN	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
ORALAIR SL TAB	-	NC	BIOLOGICALS MISC
ORAP TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ORAPRED ODT TAB, PREDNISOLONE ODT TAB	-	4	CORTICOSTEROIDS
ORAPRED SOLN	-	NC	CORTICOSTEROIDS
ORAVIG TAB	-	NC	MOUTH / THROAT / DENTAL AGENTS
ORENCIA CLICK INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 50MG/0.4ML	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ORENITRAM TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORENITRAM TAB MONTH PAK	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORFADIN CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORFADIN SUSP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ORGOVYX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORIAHNN CAP	-	NC	ESTROGENS
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5	RESPIRATORY AGENTS - MISC.
ORLADEYO CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
ORLADEYO PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
ORLYNVAH TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ORSERDU TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORSERDU TAB 345MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORTHO TRI-CYCLEN (LO) TAB	-	NC	CONTRACEPTIVES
ORTHO-CYCLEN TAB	-	NC	CONTRACEPTIVES
ORTIKOS ER CAP	-	NC	CORTICOSTEROIDS
ORUDIS CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	2	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	2	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	3	ANTIVIRALS
OSMOLEX ER TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
OSMOPREP TAB	-	NC	LAXATIVES
OSPHENA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OTEZLA STARTER PACK (QL= 1 pack/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OTEZLA TAB (QL= 2 tabs/day)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA XR TAB (QL= 1 tab/day)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
otomax-HC otic soln (CORTANE-B equiv)	-	NC	OTIC AGENTS
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC	OTIC AGENTS
OTULFI INJ	-	NC	DERMATOLOGICALS
OTULFI, USTEKINUMAB-AAUZ SYRINGE	-	NC	DERMATOLOGICALS
OVACE PLUS CREAM	-	NC	DERMATOLOGICALS
OVACE PLUS GEL WASH	-	NC	DERMATOLOGICALS
OVACE PLUS LIQ WASH 10%	-	NC	DERMATOLOGICALS
OVACE PLUS LOTION	-	NC	DERMATOLOGICALS
OVACE PLUS SHAMPOO	-	NC	DERMATOLOGICALS
OVACE PLUS FOAM	-	NC	DERMATOLOGICALS
OVCON 35 TAB	-	NC	CONTRACEPTIVES
OVEEZA CAP	-	NC	HEMATOPOIETIC AGENTS
OVIDE LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OVIDREL INJ	INF	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
oxaprozin tab (DAYPRO equiv)	-	3	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	NC	ANTIANXIETY AGENTS
OXBRYTA TAB	-	NC	HEMATOPOIETIC AGENTS
OXBRYTA TAB FOR ORAL SUSP	-	NC	HEMATOPOIETIC AGENTS
oxcarbazepine er tab (OXTELLAR equiv)	-	NC	ANTICONVULSANTS
oxcarbazepine susp (TRILEPTAL equiv)	-	2	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	2	ANTICONVULSANTS
OXERVATE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
OXIANUJO CREAM	-	NC	DERMATOLOGICALS
oxiconazole nitrate cream (OXISTAT equiv)	-	4	DERMATOLOGICALS
OXISTAT CREAM	-	NC	DERMATOLOGICALS
OXISTAT LOTION	-	NC	DERMATOLOGICALS
OXSORALEN ULTRA CAP	-	NC	DERMATOLOGICALS
OXTELLAR XR TAB	-	NC	ANTICONVULSANTS
oxybutynin ER tab (DITROPAN XL equiv)	-	2	URINARY ANTISPASMODICS
oxybutynin syrup	-	2	URINARY ANTISPASMODICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
oxybutynin tab (DITROPAN equiv)	-	2	URINARY ANTISPASMODICS
oxybutynin tab 2.5mg	-	NC	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	2	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	3	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	3	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	2	ANALGESICS - OPIOID
OXYCODONE TAB	-	NC	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	3	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	2	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC	ANALGESICS - OPIOID
OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
OXYIR CAP	-	3	ANALGESICS - OPIOID
oxymetazoline hcl cream (RHOFADE equiv)	-	EXC	DERMATOLOGICALS
oxymorphone tab	-	NC	ANALGESICS - OPIOID
OZEMPIC INJ (QL= 1 pack/28 days)	PA-QL	3/3P	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OZEMPIC TAB, RYBELSUS TAB (QL=1 tab/day)	PA-QL	3/3 P	ANTIDIABETICS
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	5	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	5	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
paliperidone ER tab (INVEGA equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PALSONIFY TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PALYNZIQ INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PAMELOR CAP	-	NC	ANTIDEPRESSANTS
pamidronate inj	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PANCREAZE CAP, PERTZYE CAP	-	NC	DIGESTIVE AIDS
PANDEL CREAM	-	NC	DERMATOLOGICALS
PANRETIN GEL	-	NC	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	2	ULCER DRUGS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
pantoprazole sodium packet (PROTONIX PAK equiv)	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
paramox hc gel (NOVACORT GEL equiv)	-	NC	DERMATOLOGICALS
PAREGORIC TINCTURE	-	NC	ANTIDIARRHEALS
paricalcitol cap (ZEMPLAR equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PARLODEL CAP	-	NC	ANTIPARKINSON AGENTS
PARLODEL TAB	-	NC	ANTIPARKINSON AGENTS
PARNATE TAB	-	NC	ANTIDEPRESSANTS
paroxetine cap (BRISDELLE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	3	ANTIDEPRESSANTS
PAROXETINE SUSP	-	4	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	2	ANTIDEPRESSANTS
PASER GRANULE	-	NC	ANTIMYCOBACTERIAL AGENTS
PATANASE NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
PAXIL CR TAB	-	NC	ANTIDEPRESSANTS
PAXIL ORAL SUSP	-	4	ANTIDEPRESSANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PAXIL TAB	-	NC	ANTIDEPRESSANTS
PAXLOVID PAK (QL= 11 tabs/90 days)	QL	3	ANTIVIRALS
PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days)	QL	3	ANTIVIRALS
PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days)	QL	3	ANTIVIRALS
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PAZOPANIB TAB 400MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEAK FLOW METER	OTC	2	MEDICAL DEVICES AND SUPPLIES
PEDIARIX INJ	VAC	1	TOXOIDS
pediatric multiple vitamins/fluoride soln	-	NC	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	NC	MULTIVITAMINS
PEDIZOLPAK THERAPY PACK	-	NC	DERMATOLOGICALS
PEDVAXHIB INJ	VAC	1	VACCINES
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	1	LAXATIVES

NC =Not Covered		**generic =**small letters		**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	1	LAXATIVES
peg 3350/electrolytes soln (NULYTELY equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	1	LAXATIVES
PEGASYS INJ	MSP	5	ANTIVIRALS
PEG-PREP KIT	-	NC	LAXATIVES
PELLIX SOLN	-	NC	DERMATOLOGICALS
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEN NEEDLE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
PENBRAYA INJ	VAC	1	VACCINES
penciclovir cream (DENAVIR equiv)	-	NC	DERMATOLOGICALS
penicillamine tab (DEPEN TITRATAB equiv)	-	3	MISCELLANEOUS THERAPEUTIC CLASSES
penicilliamine cap (CUPRIMINE equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin vk tab (VEETIDS equiv)	-	2	PENICILLINS
PENICILLN VK SOLN	-	2	PENICILLINS
PENICILLN VK SOLN 125MG/5ML	-	NC	PENICILLINS
PENICILLN VK SOLN 250MG/5ML	-	NC	PENICILLINS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PENLAC SOLN	-	NC	DERMATOLOGICALS
PENMENVY INJ	VAC	1	VACCINES
PENNSAID SOLN	-	NC	DERMATOLOGICALS
PENTACEL INJ	VAC	1	TOXOIDS
pentamidine neb soln (NEBUPENT equiv)	-	3	ANTI-INFECTIVE AGENTS - MISC.
PENTASA CR CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
PENTAZOCINE/NALOXONE TAB	-	4	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv)	-	4	ANALGESICS - OPIOID
PENTOSAN CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pentoxifylline ER tab (TRENTAL equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
PEPCID SUSP	-	NC	ULCER DRUGS
PEPCID TAB	OTC	NC	ULCER DRUGS
perampanel susp (FYCOMPA equiv)	-	NC	ANTICONVULSANTS
perampanel tab (FYCOMPA equiv)	-	NC	ANTICONVULSANTS
PERCOCET TAB	-	NC	ANALGESICS - OPIOID
PERFOROMIST NEB SOLN	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PERIDEX SOLN	-	NC	MOUTH / THROAT / DENTAL AGENTS
PERINDOPRIL TAB	-	2	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	2	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	2	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PEXEVA TAB	-	NC	ANTIDEPRESSANTS
PHEBURANE ORAL PELLETS	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PHENAZOPYRIDINE TAB	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab (PYRIDIUM equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
PHENDIMETRAZINE ER TAB	-	EXC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
phendimetrazine tab (BONTRIL PDM equiv)	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
PHENELZINE SULFATE TAB	-	2	ANTIDEPRESSANTS
phenelzine tab (NARDIL equiv)	-	2	ANTIDEPRESSANTS
phenobarbital elixir	-	2	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
PHENOBARBITAL ELXIR	-	2	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
PHENOBARBITAL TAB	-	2	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	-	3	ANTIHYPERTENSIVES
phentermine tab 8mg, lomaira tab 8mg	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
phenylephrine ophth soln (MYDFRIN equiv)	-	2	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	2	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	3	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
phenytoin susp (DILANTIN equiv)	-	2	ANTICONVULSANTS
PHEXXI GEL (QL= 1 box/fill)	QL	1	VAGINAL AND RELATED PRODUCTS
PHOSLO CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
PHOSPHA 250 NEUTRAL TAB	-	2	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PHOSPHO-TRIN K500 TAB	-	3	MINERALS & ELECTROLYTES
PHOTREXA OP KIT	-	NC	OPHTHALMIC AGENTS
PHOTREXA VISCOUS OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PHYRAGO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
phytonadione tab (MEPHYTON equiv)	-	3	VITAMINS
PIFELTRO TAB	-	NC	ANTIVIRALS
pilocarpine hcl ophth soln 1.25% (VUITY equiv)	-	NC	OPHTHALMIC AGENTS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	2	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older)	-	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
pimozide tab (ORAP equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	NC	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	2	ANTIDIABETICS
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC	ANTIDIABETICS
PIQRAY TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	MSP-PA-QL	2	RESPIRATORY AGENTS - MISC.
PIRFENIDONE TAB	-	NC	RESPIRATORY AGENTS - MISC.
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	MSP-PA-QL	2	RESPIRATORY AGENTS - MISC.
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	MSP-PA-QL	2	RESPIRATORY AGENTS - MISC.
piroxicam cap (FELDENE equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
pitavastatin calcium tab (LIVALO equiv)	-	3	ANTIHYPERLIPIDEMICS
PIVOT INSULIN PUMP STARTER KIT	-	NC	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PIVOT SUPPLY KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
PIVYA TAB	-	NC	PENICILLINS
PLAN B TAB	OTC	1	CONTRACEPTIVES
PLAQUENIL TAB	-	NC	ANTIMALARIALS
PLAVIX TAB 300MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
PLAVIX TAB 75MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
PLEGRIDY INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLENITY CAP	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
PLENVU SOLN	-	NC	LAXATIVES
plerixafor subcutaneous inj (MOZOBIL equiv)	-	NC	HEMATOPOIETIC AGENTS
PLEXION CREAM 9.8-4.8%	-	NC	DERMATOLOGICALS
PLIAGLIS CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PLIAGLIS KIT	-	NC	DERMATOLOGICALS
PNEUMOVAX INJ	VAC	1	VACCINES
PODIAPN CAP	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
PODOCON SOLN	-	3	DERMATOLOGICALS
podofilox gel (CONDYLOX equiv)	-	NC	DERMATOLOGICALS
PODOFILOX SOLN	-	3	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	3	DERMATOLOGICALS
POKONZA ORAL SOLN	-	NC	MINERALS & ELECTROLYTES
POKONZA POWDER	-	NC	MINERALS & ELECTROLYTES
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	NC	LAXATIVES
POLYETHYLENE GLYCOL 8000 GRANULES	-	3	PHARMACEUTICAL ADJUVANTS
polyethylene glycol packet (MIRALAX equiv)	OTC	NC	LAXATIVES
POLY-IRON CAP 150 FORTE	-	2	HEMATOPOIETIC AGENTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	2	OPHTHALMIC AGENTS
POLYTRIM OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
POLY-TUSSIN DM SYRUP	-	NC	COUGH / COLD / ALLERGY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
POLY-VI-FLOR SUSP	-	NC	MULTIVITAMINS
pomalidomide cap (POMALYST equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
POMALYST CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PONSTEL CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
PONVORY TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PONVORY TAB STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
posaconazole DR tab (NOXAFIL equiv)	-	4	ANTIFUNGALS
posaconazole susp (NOXAFIL equiv)	-	4	ANTIFUNGALS
POTABA CAP	-	4	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	2	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	2	MINERALS & ELECTROLYTES
potassium chloride ER tab (K-TAB equiv)	-	2	MINERALS & ELECTROLYTES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
potassium chloride micro tab (K-DUR equiv)	-	2	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	3	MINERALS & ELECTROLYTES
potassium chloride soln	-	3	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE TAB ER	-	2	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROCIT-K equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
POTASSIUM IODIDE ORAL SOLN	-	3	COUGH / COLD / ALLERGY
PRADAXA CAP	-	4	ANTICOAGULANTS
PRADAXA PELLET PACK	-	NC	ANTICOAGULANTS
pramipexole ER tab (MIRAPEX ER equiv)	-	4	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	2	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1%	-	NC	DERMATOLOGICALS
PRAMOSONE CREAM 2.5-1%	-	NC	DERMATOLOGICALS
PRAMOSONE LOTION	-	NC	DERMATOLOGICALS
PRAMOSONE OINT	-	NC	DERMATOLOGICALS
PRANDIMET TAB	-	NC	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
prasugrel tab (EFFIENT equiv)	-	2	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	1	ANTIHYPERLIPIDEMICS
praziquantel tab (BILTRICIDE equiv)	-	3	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	2	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
PRECISION XTRA METER	OTC	1	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	OTC	3	DIAGNOSTIC PRODUCTS
PRECOSE TAB	-	NC	ANTIDIABETICS
PRED FORTE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	3	OPHTHALMIC AGENTS
prednisolone acetate ophth susp (PRED FORTE equiv)	-	2	OPHTHALMIC AGENTS
prednisolone ODT (ORAPRED equiv)	-	3	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	2	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
prednisolone soln	-	2	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	2	CORTICOSTEROIDS
PREDNISOLONE SOLN	-	4	CORTICOSTEROIDS
prednisolone tab (MILLIPRED equiv)	-	NC	CORTICOSTEROIDS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISONE DR TAB	-	NC	CORTICOSTEROIDS
PREDNISONE DR TAB, RAYOS DR TAB	-	NC	CORTICOSTEROIDS
prednisone pack	-	NC	CORTICOSTEROIDS
PREDNISONE SOLN	-	3	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	2	CORTICOSTEROIDS
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC	CORTICOSTEROIDS
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	2	ANTICONVULSANTS
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	2	ANTICONVULSANTS
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	2	ANTICONVULSANTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
pregabalin ER tab (LYRICA CR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	3	ANTICONVULSANTS
PREGEN DHA CAP	-	NC	MULTIVITAMINS
PREGENNA TAB	-	NC	MULTIVITAMINS
PREGNYL INJ, NOVAREL INJ	INF-M	6	ENDOCRINE AND METABOLIC AGENTS - MISC.
PREHEVBRIO SUSP	VAC	1	VACCINES
PREMARIN TAB	-	3	ESTROGENS
PREMARIN VAGINAL CREAM	-	3	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	3	ESTROGENS
PRENARA CAP	-	NC	MULTIVITAMINS
PRENATABS RX TAB	-	2	MULTIVITAMINS
PRENATAL 19 CHEW TAB	-	2	MULTIVITAMINS
PRENATAL 19 TAB	-	2	MULTIVITAMINS
PRENATAL VITAMINS (NON-PREFERRED)	-	4	MULTIVITAMINS
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	-	2	MULTIVITAMINS
PRENATE MAX TAB	-	NC	MULTIVITAMINS
PRENATOL-M TAB 27-1.2MG	-	NC	MULTIVITAMINS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PRENATRIX TAB	-	NC	MULTIVITAMINS
PRENATRYL TAB	-	NC	MULTIVITAMINS
PRESTALIA TAB	-	NC	ANTIHYPERTENSIVES
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	3	ANTIMYCOBACTERIAL AGENTS
PREVACID CAP (RX Only)	-	4	ULCER DRUGS
PREVACID OTC CAP	OTC	4	ULCER DRUGS
PREVACID SOLUTAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
PREVIDENT 5000 PASTE 1.1%	-	3	MOUTH / THROAT / DENTAL AGENTS
PREVIDENT GEL	-	3	MOUTH / THROAT / DENTAL AGENTS
PREVIDENT SOLN 0.2%	-	3	MOUTH / THROAT / DENTAL AGENTS
PREVNAR 20 INJ	VAC	1	VACCINES
PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days)	MSP-PA-QL	5	ANTIVIRALS
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	MSP-PA-QL	5	ANTIVIRALS
PREZCOBIX TAB	-	3	ANTIVIRALS
PREZISTA SUSP	-	5	ANTIVIRALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PREZISTA TAB	-	3	ANTIVIRALS
PREZISTA TAB	-	NC/3P	ANTIVIRALS
PRIFTIN TAB	-	3	ANTIMYCOBACTERIAL AGENTS
PRILOSEC CAP	-	NC	ULCER DRUGS
primaquine tab (PRIMAQUINE equiv)	-	2	ANTIMALARIALS
PRIMAQUINE TAB	-	NC	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	2	ANTICONVULSANTS
PRIMIDONE TAB	-	NC	ANTICONVULSANTS
PRIMLEV TAB 10-300MG	-	NC	ANALGESICS - OPIOID
PRIMLEV TAB 5-300MG	-	NC	ANALGESICS - OPIOID
PRINIVIL TAB, ZESTRIL TAB	-	NC	ANTIHYPERTENSIVES
PRIORIX INJ	VAC	1	VACCINES
PRISTIQ TAB	-	NC	ANTIDEPRESSANTS
PROAIR RESPICLICK INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
probenecid tab (BENEMID equiv)	-	2	GOUT AGENTS
procainamide inj	-	NC	ANTIARRHYTHMICS
prochlorperazine supp (COMPAZINE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
prochlorperazine tab (COMPAZINE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
PROCORT CREAM	-	NC	ANORECTAL AGENTS
PROCRIT INJ	-	3	HEMATOPOIETIC AGENTS
PROCTOCORT CREAM	-	NC	DERMATOLOGICALS
PROCTOFOAM HC FOAM	-	3	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	2	ANORECTAL AGENTS
PROCYSBI GRANULES PACKET	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PRODRIN TAB	-	NC	MIGRAINE PRODUCTS
PROFILNINE INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
PROFINAC PAK	-	NC	DERMATOLOGICALS
progesterone cap (PROMETRIUM equiv)	-	2	PROGESTINS
progesterone oil inj	-	2	PROGESTINS
PROGESTERONE SUPP	PA	4	VAGINAL PRODUCTS
progesterone vaginal insert (ENDOMETRIN equiv)	PA	3	VAGINAL AND RELATED PRODUCTS
PROGLYCEM SUSP	-	NC	ANTIDIABETICS
PROGRAF CAP	-	NC	ASSORTED CLASSES
PROGRAF PACKET	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PROLATE TAB 7.5-300MG	-	NC	ANALGESICS - OPIOID
PROLENSA OPHTH SOLN	-	3	OPHTHALMIC AGENTS
PROLIA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
PROMACTA POWDER	-	NC	HEMATOPOIETIC AGENTS
PROMACTA TAB	-	NC	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	2	COUGH / COLD / ALLERGY
promethazine supp (PHENERGAN equiv)	-	3	ANTIHISTAMINES
promethazine syrup	-	2	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	2	ANTIHISTAMINES
PROMETHAZINE VC SYRUP	-	2	COUGH / COLD / ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	2	COUGH / COLD / ALLERGY
PROMETHAZINE VC/CODEINE SYRUP	-	2	COUGH / COLD / ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	2	COUGH / COLD / ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	2	COUGH / COLD / ALLERGY
PROMETHEGAN SUPP	-	3	ANTIHISTAMINES
PROMETRIUM CAP	-	NC	PROGESTINS
PROMISEB CREAM	-	NC	DERMATOLOGICALS
propafenone ER cap (RYTHMOL SR equiv)	-	3	ANTIARRHYTHMICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
propafenone tab (RYTHMOL equiv)	-	2	ANTIARRHYTHMICS
proparacaine ophth soln (ALCAINE equiv)	-	2	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	2	BETA BLOCKERS
propranolol hcl oral soln 20mg/5ml	-	2	BETA BLOCKERS
PROPRANOLOL SOLN	-	2	BETA BLOCKERS
PROPRANOLOL SOLN 20MG/5ML	-	2	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	2	BETA BLOCKERS
propylthiouracil tab	-	2	THYROID AGENTS
PROQUAD INJ	VAC	1	VACCINES
PROQUIN XR TAB	-	NC	FLUOROQUINOLONES
PROSCAR TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PROSED DS TAB	-	NC	URINARY ANTI-INFECTIVES
PROTHELIAL PASTE	-	NC	MOUTH / THROAT / DENTAL AGENTS
PROTONIX EC TAB	-	NC	ULCER DRUGS
PROTOPIC OINT	-	NC	DERMATOLOGICALS
protriptyline tab (VIVACTIL equiv)	-	4	ANTIDEPRESSANTS
PROVERA TAB	-	NC	PROGESTINS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PROVIGIL TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
PROZAC CAP	-	NC	ANTIDEPRESSANTS
PROZAC WEEKLY CAP	-	NC	ANTIDEPRESSANTS
prucalopride succinate tab (MOTEGRITY equiv) (QL= 1 tab/day)	QL	2	GASTROINTESTINAL AGENTS - MISC.
PULMICORT FLEXHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMICORT INH SUSP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	-	NC	RESPIRATORY AGENTS - MISC.
PUREFOLIX TAB	-	NC	HEMATOPOIETIC AGENTS
PYLERA CAP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
pyrazinamide tab	-	2	ANTIMYCOBACTERIAL AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PYRIDIUM TAB 100MG	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PYRIDIUM TAB 200MG	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pyridostigmine CR tab (MESTINON equiv)	-	3	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	2	ANTIMYASTHENIC / CHOLINERGIC AGENTS
PYRIDOSTIGMINE TAB 30MG	-	NC	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyridstigmine soln (MESTINON equiv)	-	4	ANTIMYASTHENIC / CHOLINERGIC AGENTS
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	ANTIMALARIALS
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC	ANTIMALARIALS
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	HEMATOLOGICAL AGENTS - MISC.
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	HEMATOLOGICAL AGENTS - MISC.
PYZCHIVA INJ	-	NC	DERMATOLOGICALS
QBRELIS SOLN (Prior Authorization required for members age 9 years and older)	PA	4	ANTIHYPERTENSIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
QBREXZA PAD	-	NC	DERMATOLOGICALS
QDOLO SOLN, TRAMADOL SOLN	-	NC	ANALGESICS - OPIOID
QELBREE ER CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
QFITLIA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
QLOSI OPHTH SOLN, VUITY OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
QMIIZ ODT TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
QNASL NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
QTERN TAB	-	NC	ANTIDIABETICS
QUALAQUIN CAP	-	NC	ANTIMALARIALS
QUAZEPAM TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
QUDEXY XR CAP	-	NC	ANTICONVULSANTS
QUESTRAN LITE POWDER	-	NC	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
QUESTRAN POWDER	-	NC	ANTIHYPERLIPIDEMICS
QUESTRAN POWDER PACK	-	NC	ANTIHYPERLIPIDEMICS
quetiapine tab (SEROQUEL equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
QUETIAPINE TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
QUILLIVANT XR SUSP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
quinapril tab (ACCUPRIL equiv)	-	2	ANTIHYPERTENSIVES
QUINAPRIL/HCTZ TAB	-	NC	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	NC	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	3	ANTIARRHYTHMICS
quinidine sulfate tab	-	2	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB	-	NC	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	NC	ANTIMALARIALS
QUINIXIL PAK	-	NC	DERMATOLOGICALS
QUINOSONE KIT	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
QUIOFIC SOLN	-	NC	HEMATOPOIETIC AGENTS
QULIPTA TAB	-	NC	MIGRAINE PRODUCTS
QUVIVIQ TAB	-	NC	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
QVAR AERO	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
QVAR REDIHALER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
rabeprazole EC tab (ACIPHEX equiv)	-	2	ULCER DRUGS
RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5	NEUROMUSCULAR AGENTS
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5	NEUROMUSCULAR AGENTS
RAGWITEK SL TAB	-	NC	BIOLOGICALS MISC
RALDESY SOLN	-	NC	ANTIDEPRESSANTS
raloxifene tab (EVISTA equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	QL	3	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS
ramipril cap (ALTACE equiv)	-	2	ANTIHYPERTENSIVES
RANEXA TAB	-	NC	ANTIANGINAL AGENTS
RANITIDINE TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
ranolazine tab (RANEXA equiv)	-	2	ANTIANGINAL AGENTS
RAPAFLO CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RAPAMUNE SOLN	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
RAPAMUNE TAB	-	NC	ASSORTED CLASSES
rasagiline tab (AZILECT equiv)	-	3	ANTIPARKINSON AGENTS
RAVICTI LIQUID	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYALDEE CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RAZADYNE SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RAZADYNE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBIF INJ	MSP	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBINYN INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
REBLOZYL INJ	-	NC	HEMATOPOIETIC AGENTS
RECOMBINATE INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
RECORLEV TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RECTIV OINT	-	4	ANORECTAL AND RELATED PRODUCTS
REDEMPLO PFS INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
REDITREX INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
REGLAN TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELAFEN DS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
RELENZA DISKHALER	-	NC	ANTIVIRALS
RELEUKO INJ	-	NC	HEMATOPOIETIC AGENTS
RELEUKO PREFILLED SYRINGE INJ	-	NC	HEMATOPOIETIC AGENTS
RELEVIA TAB 27-1MG	-	NC	MULTIVITAMINS
RELEXXI ER TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
RELISTOR INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELPAX TAB	-	NC	MIGRAINE PRODUCTS
RELTONE CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
REMERON SOLUTAB	-	NC	ANTIDEPRESSANTS
REMERON TAB	-	NC	ANTIDEPRESSANTS
RENACIDIN SOLN	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RENAGEL TAB 800MG	-	NC	GASTROINTESTINAL AGENTS - MISC.
renaphro cap (NEPHROCAP equiv)	-	NC	MULTIVITAMINS
RENOVA CREAM	-	EXC	DERMATOLOGICALS
RENVELA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
repaglinide tab (PRANDIN equiv)	-	2	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3	ANTIHYPERLIPIDEMICS
REQUIP TAB	-	NC	ANTIPARKINSON AGENTS
REQUIP XL TAB	-	NC	ANTIPARKINSON AGENTS
RESERVAPAK SYRUP	-	NC	ALTERNATIVE MEDICINES
RESTASIS OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
RESTORIL CAP 15MG	-	NC	HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RESTORIL CAP 22.5MG	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
RESTORIL CAP 30MG	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
RESTORIL CAP 7.5MG	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
RETACRIT INJ	-	3	HEMATOPOIETIC AGENTS
RETEVMO CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO CAP 40MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO TAB 40MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETIN-A CREAM (Acne Only - Prior Authorization required for members age 35 years and older)	PA	2	DERMATOLOGICALS
RETIN-A GEL (Acne Only - Prior Authorization required for members age 35 years and older)	PA	2	DERMATOLOGICALS
RETIN-A MICRO GEL/GEL PUMP	-	NC	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RETIN-A MICRO GEL/GEL PUMP, TRETINOIN MICROSPHERE GEL/GEL PUMP	-	NC	DERMATOLOGICALS
RETROVIR CAP	-	NC/ 3P	ANTIVIRALS
RETROVIR SYRUP	-	NC/ 3P	ANTIVIRALS
RETROVIR TAB	-	NC/ 3P	ANTIVIRALS
REVATIO SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVATIO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVLIMID CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
REVUFORJ TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REVUFORJ TAB 110MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REVUFORJ TAB 25MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REXAPHENAC CREAM	-	NC	DERMATOLOGICALS
REXASIL KIT	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
REXULTI TAB (QL= 1 tab/day)	PA-QL	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
REYATAZ CAP	-	NC/ 3P	ANTIVIRALS
REYATAZ POWDER PACK	-	5	ANTIVIRALS
REYVOW TAB	-	NC	MIGRAINE PRODUCTS
REZDIFFRA TAB	-	NC/ 3P	GASTROINTESTINAL AGENTS - MISC.
REZENOPY SPRAY 10MG/0.11ML	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REZUROCK TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
REZVOGLAR INJ	-	NC	ANTIDIABETICS
REZYST CHEW TAB	-	NC	ANTIDIARRHEALS
RHAPSIDO TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
RHOFADE CREAM	-	EXC	DERMATOLOGICALS
RHOPRESSA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RIASTAP INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
RIBAVIRIN CAP	MSP	2	ANTIVIRALS
ribavirin cap (REBETOL equiv)	MSP	2	ANTIVIRALS
RIBAVIRIN INH	-	NC	ANTIVIRALS
ribavirin inh soln (VIRAZOLE equiv)	-	NC	ANTIVIRALS
RIBAVIRIN TAB	MSP	2	ANTIVIRALS
rifabutin cap (MYCOBUTIN equiv)	-	3	ANTIMYCOBACTERIAL AGENTS
RIFADIN CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	3	ANTIMYCOBACTERIAL AGENTS
rifapentine tab (PRIFTIN equiv)	-	3	ANTIMYCOBACTERIAL AGENTS
RIFATER TAB	-	4	ANTIMYCOBACTERIAL AGENTS
rilpivirine hcl tab (EDURANT equiv)	-	3	ANTIVIRALS
RILUTEK TAB	-	NC	NEUROMUSCULAR AGENTS
riluzole tab (RILUTEK equiv)	-	3	NEUROMUSCULAR AGENTS
RIMANTADINE TAB	-	4	ANTIVIRALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RINVOQ ER TAB (QL= 1 tab/day)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
RINVOQ ORAL SOLN (QL= 12ml/day)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
RIOMET SOLN	-	NC	ANTIDIABETICS
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab (ACTONEL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERDAL INJ	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RISPERDAL M ODT	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RISPERDAL SOLN	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RISPERDAL TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
risperidone microspheres inj (RISPERDAL equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RISPERIDONE ODT	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
risperidone ODT (RISPERDAL M equiv)	-	3	ANTIPSYCHOTICS / ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
RITALIN LA CAP, APTENSIO XR CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
RITALIN TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ritonavir tab (NORVIR equiv)	-	2	ANTIVIRALS
RITUXAN INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rivaroxaban for susp (XARELTO equiv)	-	2	ANTICOAGULANTS
rivaroxaban tab 2.5mg (XARELTO equiv)	-	2	ANTICOAGULANTS
rivastigmine cap (EXELON equiv)	-	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
rivastigmine patch (EXELON equiv)	-	3	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RIVFLOZA INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RIVFLOZA INJ 160MG	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RIVFLOZA VIAL	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RIVIVE, REXTOVY SPRAY	OTC	2	ANTIDOTES AND SPECIFIC ANTAGONISTS
RIXUBIS INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
RIZAFILM MIS	-	NC	MIGRAINE PRODUCTS
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	2	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	2	MIGRAINE PRODUCTS
ROAOXIA GEL	-	NC	DERMATOLOGICALS
ROBAXIN TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ROBINUL TAB	-	NC	ULCER DRUGS

NC =Not Covered		**generic** =small letters		**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ROCALTROL CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ROCALTROL SOLN	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ROCKLATAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
roflumilast tab (DALIRESP equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ROMVIMZA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ropinirole ER tab (REQUIP XL equiv)	-	3	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	2	ANTIPARKINSON AGENTS
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC	LOCAL ANESTHETICS-PARENTER AL
ROSADAN KIT	-	NC	DERMATOLOGICALS
ROSULA EMULSION	-	NC	DERMATOLOGICALS
rosuvastatin tab (CRESTOR equiv)	-	1	ANTIHYPERLIPIDEMICS
ROSZET TAB	-	NC	ANTIHYPERLIPIDEMICS
ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB	-	NC	ANTIHYPERLIPIDEMICS
ROTARIX SUSP	VAC	1	VACCINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ROTATEQ INJ	VAC	1	VACCINES
ROWASA KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
ROXICODONE TAB	-	NC	ANALGESICS - OPIOID
ROXYBOND TAB	-	NC	ANALGESICS - OPIOID
ROZEREM TAB	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ROZLYTREK PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	5	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv) (Prior Authorization required for members age 9 years and older)	PA	3	ANTICONVULSANTS
rufinamide tab (BANZEL equiv)	-	3	ANTICONVULSANTS
RUKOBIA ER TAB	-	NC/ 3P	ANTIVIRALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RYALTRIS SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
RYBIX ODT	-	NC	ANALGESICS - OPIOID
RYDAPT CAP (QL= 56 caps/28 days)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYTHMOL SR CAP	-	NC	ANTIARRHYTHMICS
SABRIL POWDER PACK	-	NC	ANTICONVULSANTS
SABRIL TAB	-	NC	ANTICONVULSANTS
sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day)	QL	2	CARDIOVASCULAR AGENTS - MISC.
SAFYRAL TAB	-	1	CONTRACEPTIVES
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SALAGEN TAB	-	NC	MOUTH / THROAT / DENTAL AGENTS
SALEX LOTION KIT	-	NC	DERMATOLOGICALS
SALEX SHAMPOO	-	4	DERMATOLOGICALS
SALICATE LIQUID	-	NC	DERMATOLOGICALS
SALICYLIC AC SOLN ER, XALIX SOLN	-	NC	DERMATOLOGICALS
SALIMEZ FORTE CREAM	-	NC	DERMATOLOGICALS
SALSALATE TAB	-	3	ANALGESICS - NONNARCOTIC

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
salsalate tab (DISALCID equiv)	-	3	ANALGESICS - NONNARCOTIC
SAMSCA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SAMSCA TAB 15MG	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANCUSO PATCH (QL= 4 patches/fill)	QL	4	ANTIEMETICS
SANDIMMUNE CAP	-	NC	ASSORTED CLASSES
SANDIMMUNE SOLN 100MG/ML	-	5	ASSORTED CLASSES
SANDOSTATIN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANTYL OINT (QL= 90gm/30 days)	QL	3	DERMATOLOGICALS
SAPHNELO INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
SAPHNELO PEN INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
SAPHRIS SL TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sapropterin dihydrochloride powder packet (KUVAN equiv)	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
sapropterin dihydrochloride soluble tab (KUVAN equiv)	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
SARAFEM TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVAYSA TAB	-	NC	ANTICOAGULANTS
SAVELLA PAK	-	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
saxagliptin hcl tab (ONGLYZA equiv)	-	NC	ANTIDIABETICS
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC	ANTIDIABETICS
SAXENDA INJ	-	EXC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SCARCIN GEL	-	NC	DERMATOLOGICALS
SCARCIN LIQUID ROLL-ON	-	NC	DERMATOLOGICALS
SCEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SCEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
scopolamine patch (TRANSDERM-SCOP equiv)	-	3	ANTIEMETICS
SDAMLO SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
SEASONIQUE TAB	-	NC	CONTRACEPTIVES
SECUADO PATCH	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
SEGLENTIS TAB	-	NC	ANALGESICS - OPIOID
SEGLUROMET TAB	-	NC	ANTIDIABETICS
SELARSDI INJ	-	NC	DERMATOLOGICALS
selegiline cap (ELDEPRYL equiv)	-	2	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	2	ANTIPARKINSON AGENTS
SELENIUM SUL SHA	-	3	DERMATOLOGICALS
SELENIUM SUL SHA 2%	-	NC	DERMATOLOGICALS
SELENIUM SULFIDE LOTION	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
selenium sulfide lotion 2.5% (SELSUN equiv)	-	NC	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	3	DERMATOLOGICALS
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC	DERMATOLOGICALS
SELRX SHAMPOO 2.3%	-	NC	DERMATOLOGICALS
SELZENTRY SOLN	-	5	ANTIVIRALS
SELZENTRY TAB	-	5	ANTIVIRALS
SEMGLEE INJ	-	NC	ANTIDIABETICS
SEMGLEE INJ (SINGLE PEN)	-	NC	ANTIDIABETICS
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	NC	ANTIDIABETICS
SEMGLEE PEN INJ	-	NC	ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	NC	ANTIDIABETICS
SEMGLEE SOLN	-	NC	ANTIDIABETICS
SEMPREX-D CAP	-	EXC	COUGH / COLD / ALLERGY
SENSIPAR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEPHIENCE POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SEREVENT DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SERNIVO SPRAY	-	NC	DERMATOLOGICALS
SEROQUEL TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
SEROQUEL XR TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
SERTRALINE CAP	-	NC	ANTIDEPRESSANTS
sertraline conc (ZOLOFT equiv)	-	2	ANTIDEPRESSANTS
sertraline hcl cap	-	NC	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	2	ANTIDEPRESSANTS
SEVELAMER CARBONATE TAB	-	3	GASTROINTESTINAL AGENTS - MISC.
sevelamer hydrochloride tab (RENAGEL equiv)	-	4	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (RENVELA equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	3	GASTROINTESTINAL AGENTS - MISC.
SEVENFACT INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
SEYSARA TAB	-	NC	TETRACYCLINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SFROWASA ENEMA	-	4	GASTROINTESTINAL AGENTS - MISC.
SHINGRIX INJ (Covered for members age 19 years and older)	VAC	1	VACCINES
SIGNIFOR INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SIKLOS TAB	-	NC	HEMATOPOIETIC AGENTS
SILALITE PAK MIS	-	NC	DERMATOLOGICALS
SILATRIX GEL	-	NC	MOUTH / THROAT / DENTAL AGENTS
sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older)	PA	3	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab (VIAGRA equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv)	PA	2	CARDIOVASCULAR AGENTS - MISC.
SILIPAC KIT	-	NC	DERMATOLOGICALS
SILIQ INJ	-	NC	DERMATOLOGICALS
silodosin cap (RAPAFLO equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
SILVADENE CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	2	DERMATOLOGICALS
SILVERA PAD	-	NC	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
SIMCOR TAB	-	NC	ANTIHYPERLIPIDEMICS
SIMLANDI INJ (adalimumab-ryvk) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
SIMLANDI KIT (adalimumab-ryvk) (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI ARIA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 100MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 100MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1	ANTIHYPERLIPIDEMICS
simvastatin tab 80mg (ZOCOR equiv) (80 mg simvastatin is not covered)	-	NC	ANTIHYPERLIPIDEMICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SINEMET CR TAB	-	NC	ANTIPARKINSON AGENTS
SINEMET TAB	-	NC	ANTIPARKINSON AGENTS
SINGULAIR CHEW TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR GRANULE PACK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SINGULAIR TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
sirolimus soln (RAPAMUNE equiv)	-	5	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	5	ASSORTED CLASSES
SIRTURO TAB (QL= 4 tabs/day; Restricted to Infectious Disease Specialist)	MSP-QL-RS	5	ANTIMYCOBACTERIAL AGENTS
sitagliptin phosphate tab (JANUVIA equiv) (QL= 1 tab/day)	QL-¢	3	ANTIDIABETICS
sitagliptin phosphate-metformin hcl er tab (JANUMET equiv) (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
sitagliptin phosphate-metformin hcl tab (JANUMET equiv) (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
SITAGLIPTIN/METFORMIN TAB	-	NC	ANTIDIABETICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SITAVIG TAB	-	NC	ANTIVIRALS
SITZMARKS CAP	-	NC	DIAGNOSTIC PRODUCTS
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	3	ANTI-INFECTIVE AGENTS - MISC.
SIVEXTRO TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
SKELAXIN TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SKLICE LOTION	-	NC	DERMATOLOGICALS
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	NEUROMUSCULAR AGENTS
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	MSP-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	MSP-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 55MG/0.37ML (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
SKYTROFA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SLYND TAB	-	1	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
SOAANZ TAB	-	NC	DIURETICS
SOD CHLORIDE INJ	M	6	MINERALS & ELECTROLYTES
SOD SUL/SULF LIQ 9-4.5%	-	3	DERMATOLOGICALS
SOD SUL/SULF SUSP 10-5%	-	NC	DERMATOLOGICALS
SOD SUL/SULF SUSP 8-4%	-	NC	DERMATOLOGICALS
sodium chloride 0.9% irr soln	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
sodium chloride inj	-	NC	MINERALS & ELECTROLYTES
sodium citrate/citric acid soln (BICITRA equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride cream (PREVIDENT equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1	MOUTH / THROAT / DENTAL AGENTS
SODIUM FLUORIDE GEL	-	2	MOUTH / THROAT / DENTAL AGENTS
SODIUM FLUORIDE PASTE	-	2	MOUTH / THROAT / DENTAL AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sodium fluoride soln (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1	MINERALS & ELECTROLYTES
SODIUM FLUORIDE SOLN	-	2	MOUTH / THROAT / DENTAL AGENTS
SODIUM FLUORIDE TAB ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1	MINERALS & ELECTROLYTES
sodium fluoride tab (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1	MINERALS & ELECTROLYTES
SODIUM IODIDE I-131 SOLN	-	NC	THYROID AGENTS
sodium oxybate oral soln (XYREM equiv) (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	5	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
sodium phenylbutyrate powder (BUPHENYL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sodium phenylbutyrate tab (BUPHENYL equiv)	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	3	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	2	ASSORTED CLASSES
SODIUM SULFA LIQ WASH	-	NC	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	3	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	3	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR CREAM 10-2%	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR LOTION	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR WASH	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN equiv	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC	DERMATOLOGICALS
sodium/magnesium/potassium soln (SUPREP equiv) ($0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1	LAXATIVES
SOFDRA GEL	-	NC	DERMATOLOGICALS
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	3	ANTIVIRALS
SOGROYA INJ	MSP-PA	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOHONOS CAP 1.5MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 10MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 1MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SOHONOS CAP 2.5MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 5MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOLAICE PATCH	-	NC	DERMATOLOGICALS
SOLARAVIX PAK	-	NC	DERMATOLOGICALS
solifenacin tab (VESICARE equiv)	-	2	URINARY ANTISPASMODICS
SOLIQUA INJ (QL= 15ml/25 days)	PA-QL	3	ANTIDIABETICS
SOLODYN TAB	-	NC	TETRACYCLINES
SOLOSEC GRANULES PACKET	-	NC	AMEBICIDES
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	3	CORTICOSTEROIDS
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	3	CORTICOSTEROIDS
SOLU-MEDROL INJ	-	NC	CORTICOSTEROIDS
SOLU-MEDROL INJ 2GM	-	3	CORTICOSTEROIDS
SOLU-MEDROL PF INJ	-	NC	CORTICOSTEROIDS
SOMA TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMA TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMAVERT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SOOLANTRA CREAM	-	NC	DERMATOLOGICALS
sorafenib tosylate tab (NEXAVAR equiv)	MSP-PA	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SORIATANE CAP	-	NC	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	2	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	2	BETA BLOCKERS
SOTYKTU TAB	-	NC	DERMATOLOGICALS
SOTYLIZE SOLN	-	NC	BETA BLOCKERS
SOTYLIZE SOLN 5MG/ML	-	NC	BETA BLOCKERS
SOVALDI PELLET PAK	-	NC	ANTIVIRALS
SOVALDI TAB	-	NC	ANTIVIRALS
SOVUNA TAB 200MG	-	NC	ANTIMALARIALS
SOVUNA TAB 300MG	-	NC	ANTIMALARIALS
SPEVIGO INJ	-	NC	DERMATOLOGICALS
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	1	VACCINES
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	1	VACCINES
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	3	DERMATOLOGICALS
SPIRIVA HANDIHALER (For use with Handihaler device)	PA	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial o ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), or BUDESONIDE/FORMOTEROL)	QL-ST	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	PA	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone susp (CAROSPIR equiv)	-	NC	DIURETICS
spironolactone tab (ALDACTONE equiv)	-	2	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	2	DIURETICS
SPORANOX CAP	-	NC	ANTIFUNGALS
SPORANOX SOLN	-	NC	ANTIFUNGALS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1	CONTRACEPTIVES
SPRIX NASAL SPRAY	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SPRYCEL TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SPS	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
STALEVO TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
STARJEMZA INJ	-	NC	DERMATOLOGICALS
STARJEMZA PFS INJ	-	NC	DERMATOLOGICALS
STAVZOR CAP	-	NC	ANTICONVULSANTS
STEGLATRO TAB	-	NC	ANTIDIABETICS
STEGLUJAN TAB	-	NC	ANTIDIABETICS
STELARA INJ (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
STENDRA TAB	-	EXC	CARDIOVASCULAR AGENTS - MISC.
STEQEYMA INJ (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
STEQEYMA INJ 90MG (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
STEQEYMA VIAL	-	NC	DERMATOLOGICALS
STIMUFEND INJ	-	NC	HEMATOPOIETIC AGENTS
STIOLTO INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
STRATTERA CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
STRENSIQ INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIANT FILM	-	NC	ANDROGENS-ANABOLIC
STRIBILD TAB	-	NC/ 3P	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STROMECTOL TAB	-	NC	ANTHELMINTICS
STROVITE TAB	-	NC	MULTIVITAMINS
SUBLOCADE SOLN, BRIXADI SOLN	-	NC	ANALGESICS - OPIOID
SUBOXONE SL FILM	-	NC	ANALGESICS - OPIOID
SUBSYS SPRAY	-	NC	ANALGESICS - OPIOID
SUBVENITE SUSP (Prior Authorization required for members age 9 years and older)	PA	4	ANTICONVULSANTS
SUCRAID SOLN	-	NC	DIGESTIVE AIDS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sucralfate susp (CARAFATE equiv)	-	3	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
sucralfate tab (CARAFATE equiv)	-	2	ULCER DRUGS
SUFLAVE SOLN (QL= 2 fills/365 days)	QL	3	LAXATIVES
SULFACETAMIDE SOD OPHTH SOLN	-	2	OPHTHALMIC AGENTS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	2	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	2	OPHTHALMIC AGENTS
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC	DERMATOLOGICALS
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC	DERMATOLOGICALS
SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-4.8%	-	NC	DERMATOLOGICALS
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
sulfadiazine tab	-	4	SULFONAMIDES
SULFAMYLON CREAM	-	3	DERMATOLOGICALS
SULFAMYLON PACK	-	NC	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sulfasalazine tab (AZULFIDINE equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	2	ANALGESICS - ANTI-INFLAMMATORY
SUMADAN WASH 9-4.5%	-	NC	DERMATOLOGICALS
SUMADEN XLT KIT	-	NC	DERMATOLOGICALS
SUMANSETRON PAK	-	NC	MIGRAINE PRODUCTS
SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3	MIGRAINE PRODUCTS
sumatriptan inj (IMITREX equiv) (QL= 6 inj/fill, 3 fills/30 days)	QL	3	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 3 fills/30 days)	QL	3	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 10 vials/fi 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC	MIGRAINE PRODUCTS
SUMAVEL DOSEPRO INJ	-	NC	MIGRAINE PRODUCTS
SUMAXIN WASH	-	NC	DERMATOLOGICALS
sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day)	MSP-PA-QL	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUNLENCA INJ	-	NC/ 3P	ANTIVIRALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SUNLENCA TAB	-	NC/ 3P	ANTIVIRALS
SUNLENCA TAB 300MG	-	NC/ 3P	ANTIVIRALS
SUNOSI TAB (QL= 1 tab/day)	PA-QL	3	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
SUPRAX CAP	-	4	CEPHALOSPORINS
SUPRAX CAP	-	NC	CEPHALOSPORINS
SUPRAX SUSP	-	NC	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	4	CEPHALOSPORINS
SUPREP BOWEL PREP PACK	-	NC	LAXATIVES
SURMONTIL CAP	-	NC	ANTIDEPRESSANTS
SUSTIVA TAB	-	NC/ 3P	ANTIVIRALS
SUSTOL INJ	-	NC	ANTIEMETICS
SUTAB TAB	-	NC	LAXATIVES
SUTENT CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYLATRON INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SYMBICORT INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SYMBRAVO TAB	-	NC	MIGRAINE PRODUCTS
SYMBYAX CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	3	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	NC/ 3P	ANTIVIRALS
SYMLINPEN INJ	-	NC	ANTIDIABETICS
SYMPAZAN ORAL FILM	-	NC	ANTICONVULSANTS
SYMPROIC TAB (QL= 1 tab/day)	PA-QL	3	GASTROINTESTINAL AGENTS - MISC.
SYMTUZA TAB	-	NC/ 3P	ANTIVIRALS
SYNAGIS INJ	-	NC	PASSIVE IMMUNIZING AGENTS
SYNAREL NASAL SOLN	-	3	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNERA PATCH	-	4	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SYNJARDY TAB (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	3	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
SYNTHROID TAB	-	4	THYROID AGENTS
SYPRINE CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
TABLOID TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TABRECTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX OINT	-	NC	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	2	ASSORTED CLASSES
tacrolimus cap er (ASTAGRAF XL equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	2	DERMATOLOGICALS
tadalafil tab (CIALIS equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab (PAH) (ADCIRCA equiv)	PA	2	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; Step Therapy requires trial of doxazosin tab prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap)	QL-ST	2	CARDIOVASCULAR AGENTS - MISC.
TADLIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	4	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAFINLAR TAB	MSP-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv) (QL= 1 vial/day)	PA-QL	3	OPHTHALMIC AGENTS
TAGRISSO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAKHZYRO INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; On available through Accredo 800-803-2523)	LD-PA-QL	5	HEMATOLOGICAL AGENTS - MISC.
TALICIA CAP	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
TALTZ INJ (QL= 1 inj/28 days)	MSP-PA-QL	5	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days)	MSP-PA-QL	5	DERMATOLOGICALS
TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days)	MSP-PA-QL	5	DERMATOLOGICALS
TALZENNA CAP 0.1MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.25MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.35MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.5MG, 0.75MG, 1MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAMIFLU CAP	-	NC	ANTIVIRALS
TAMIFLU CAP 30MG	-	NC	ANTIVIRALS
tamoxifen tab (NOLVADEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	2	GENITOURINARY AGENTS - MISCELLANEOUS
TANZEUM INJ	-	NC	ANTIDIABETICS
TAPAZOLE TAB	-	NC	THYROID AGENTS
TAPENTADOL ER TAB 100MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 150MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 200MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 250MG	-	NC	ANALGESICS - OPIOID

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TAPENTADOL ER TAB 50MG	-	NC	ANALGESICS - OPIOID
tapentadol hcl tab (NUCYNTA equiv)	-	4	ANALGESICS - OPIOID
TAPENTADOL SOLN	-	NC	ANALGESICS - OPIOID
TARCEVA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	-	NC	DERMATOLOGICALS
TARKA TAB	-	NC	ANTIHYPERTENSIVES
TARPEYO CAP	-	NC	CORTICOSTEROIDS
TASCENSO ODT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TASIGNA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tasimelteon cap (HETLIOZ equiv)	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
TASMAR TAB	-	NC	ANTIPARKINSON AGENTS
TASOPROL CREAM KIT	-	NC	DERMATOLOGICALS
tavaborole soln (KERYDIN equiv) (QL= 10ml/30 days; Step Therapy requires trial of both ciclopirox nail soln and terbinafine tab)	QL-ST	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TAVALISSE TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	5	HEMATOLOGICAL AGENTS - MISC.
TAYTULLA CAP	-	4	CONTRACEPTIVES
tazarotene cream 0.05% (TAZORAC equiv)	-	4	DERMATOLOGICALS
tazarotene cream 0.1% (TAZORAC equiv)	-	NC	DERMATOLOGICALS
tazarotene gel (TAZORAC equiv)	-	NC	DERMATOLOGICALS
TAZORAC CREAM	-	NC	DERMATOLOGICALS
TAZORAC GEL	-	NC	DERMATOLOGICALS
TECFIDERA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEGRETOL SUSP	-	NC	ANTICONVULSANTS
TEGRETOL TAB	-	NC	ANTICONVULSANTS
TEGRETOL XR TAB	-	NC	ANTICONVULSANTS
TEKTURNA TAB	-	NC	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	2	ANTIHYPERTENSIVES
telmisartan/amlodipine tab (TWYNSTA equiv)	-	3	ANTIHYPERTENSIVES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TELMISARTAN/AMLODIPINE TAB	-	NC	ANTIHYPERTENSIVES
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	2	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temazepam cap 22.5mg (RESTORIL equiv)	-	4	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	4	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
TEMODAR CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TEMOVATE CREAM	-	NC	DERMATOLOGICALS
TEMOVATE OINT	-	NC	DERMATOLOGICALS
temozolomide cap (TEMODAR equiv)	MSP	2	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TEMPO SMART BUTTON (QL= 1 button/8 months)	QL	3	MEDICAL DEVICES AND SUPPLIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2	ANTIVIRALS
TENORETIC TAB	-	NC	ANTIHYPERTENSIVES
TENORMIN TAB	-	NC	BETA BLOCKERS
TEPMETKO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TERAVAX CAP	-	NC	MULTIVITAMINS
TERAZOL CREAM	-	NC	VAGINAL PRODUCTS
terazosin cap (HYTRIN equiv)	-	2	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	2	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	2	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	2	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	2	VAGINAL PRODUCTS
teriflunomide tab (AUBAGIO TAB equiv)	MSP	2	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
teriparatide (recombinant) soln pen-inj (FORTEO equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TESSALON CAP	-	NC	COUGH / COLD / ALLERGY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TEST STRIP (all other test strips)	OTC	NC	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	2	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	3	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	3	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	3	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	3	ANDROGENS-ANABOLIC
testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	4	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	4	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 10MG/ACT	-	NC	ANDROGENS-ANABOLIC
testosterone gel 2% (FORTESTA equiv)	-	NC	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 20.25MG/1.25GM (QL= 1 packet/day)	PA-QL	4	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
TESTOSTERONE GEL, VOGELXO GEL	-	NC	ANDROGENS-ANABOLIC
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	3	ANDROGENS-ANABOLIC
TETANUS/DIPHTHERIA TOXOID INJ	VAC	1	TOXOIDS
tetrabenazine tab (XENAZINE equiv)	MSP-PA	4	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracaine hcl ophth soln	-	2	OPHTHALMIC AGENTS
TETRACAINE OPHTH SOLN	-	2	OPHTHALMIC AGENTS
TETRACAINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
tetracycline cap	-	4	TETRACYCLINES
TETRACYCLINE TAB	-	NC	TETRACYCLINES
TEXACORT SOLN	-	NC	DERMATOLOGICALS
TEZRULY SOLN	-	NC	ANTIHYPERTENSIVES
TEZSPIRE INJ (QL= 1 pen/28 days)	MSP-PA-QL	5	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THALITONE TAB	-	NC	DIURETICS
THALOMID CAP	MSP-PA	5	ASSORTED CLASSES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
THEO-24 CAP	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	2	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THEOPHYLLINE TAB ER	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline tab er (THEOPHYLLINE ER equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA EC TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
THIOLA TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine hcl tab (THIORIDAZINE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
THYQUIDITY SOLN	-	NC	THYROID AGENTS
TIAGABINE TAB	-	3	ANTICONVULSANTS
tiagabine tab (GABITRIL equiv)	-	3	ANTICONVULSANTS
TIAZAC CAP	-	NC	CALCIUM CHANNEL BLOCKERS
TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ticagrelor tab (BRILINTA equiv)	-	3	HEMATOLOGICAL AGENTS - MISC.
TICANASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
TICOVAC INJ	VAC	EXC	VACCINES
TIGAN CAP	-	NC	ANTIEMETICS
TIGAN INJ	-	NC	ANTIEMETICS
TIGLUTIK SUSP	-	NC	NEUROMUSCULAR AGENTS
TIKOSYN CAP	-	NC	ANTIARRHYTHMICS
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	4	OPHTHALMIC AGENTS
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	3	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	2	OPHTHALMIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	3	OPHTHALMIC AGENTS
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	4	OPHTHALMIC AGENTS
TIMOLOL MALEATE TAB	-	2	BETA BLOCKERS
timolol maleate tab (BLOCADREN equiv)	-	2	BETA BLOCKERS
timolol ophth soln (BETIMOL equiv)	-	3	OPHTHALMIC AGENTS
TIMOPTIC OCUDOSE OPHTH SOLN 0.25%	-	NC	OPHTHALMIC AGENTS
TIMOPTIC OCUDOSE OPHTH SOLN 0.5%	-	NC	OPHTHALMIC AGENTS
TIMOPTIC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
TIMOPTIC-XE OPHTH GEL	-	NC	OPHTHALMIC AGENTS
TINDAMAX TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
tinidazole tab (TINDAMAX equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
tiopronin tab (THIOLA equiv)	MSP-PA	5	GENITOURINARY AGENTS - MISCELLANEOUS
tiopronin tab delayed release (THIOLA EC equiv)	MSP-PA	5	GENITOURINARY AGENTS - MISCELLANEOUS
tiotropium bromide cap inhaler (SPIRIVA equiv) (For use with Handihaler device)	PA	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TIROSINT CAP	-	NC	THYROID AGENTS
TIROSINT-SOL	-	NC	THYROID AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TIVICAY PD TAB	-	3	ANTIVIRALS
TIVICAY TAB	-	3	ANTIVIRALS
tizanidine cap (ZANAFLEX equiv)	-	3	MUSCULOSKELETAL THERAPY AGENTS
TIZANIDINE COMFORT KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	2	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	5	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	3	OPHTHALMIC AGENTS
TOBRADEX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
TOBRADEX ST OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	2	AMINOGLYCOSIDES
tobramycin neb soln (BETHKIS equiv)	-	NC	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX equiv)	-	2	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	2	OPHTHALMIC AGENTS
TOBREX OPHTH OINT	-	4	OPHTHALMIC AGENTS
TOBREX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	1	VAGINAL PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tofacitinib citrate ER tab (XELJANZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
tofacitinib citrate oral soln (XELJANZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
tofacitinib citrate tab (XELJANZ equiv) (QL= 2 tabs/day)	LMSP-PA-QL	2	ANALGESICS - ANTI-INFLAMMATORY
TOFRANIL TAB	-	NC	ANTIDEPRESSANTS
tolcapone tab (TASMAR equiv)	-	NC	ANTIPARKINSON AGENTS
TOLECTIN DS CAP, TOLMETIN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLECTIN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB, TOLECTIN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLSURA CAP	-	NC	ANTIFUNGALS
tolterodine SR cap (DETROL LA equiv)	-	2	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	2	URINARY ANTISPASMODICS
tolvaptan tab (JYNARQUE equiv)	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tolvaptan tab (SAMSCA equiv)	MSP	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
tolvaptan tab therapy pack (JYNARQUE equiv) (QL: 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2	ENDOCRINE AND METABOLIC AGENTS - MISC.
TONMYA SL TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TOPAMAX SPRINKLE CAP	-	NC	ANTICONVULSANTS
TOPAMAX TAB	-	NC	ANTICONVULSANTS
TOPICORT CREAM	-	NC	DERMATOLOGICALS
TOPICORT CREAM 0.05%	-	NC	DERMATOLOGICALS
TOPICORT GEL	-	NC	DERMATOLOGICALS
TOPICORT OINT	-	NC	DERMATOLOGICALS
TOPICORT OINT 0.05%	-	NC	DERMATOLOGICALS
topiramate ER cap (QUDEXY equiv)	-	NC	ANTICONVULSANTS
topiramate er cap (TROKENDI XR equiv)	-	NC	ANTICONVULSANTS
topiramate oral soln (EPRONTIA equiv) (Prior Authorization required for members age 9 years and older)	PA	4	ANTICONVULSANTS
topiramate sprinkle cap (TOPAMAX equiv)	-	2	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
topiramate tab (TOPAMAX equiv)	-	2	ANTICONVULSANTS
TOPROL XL TAB	-	NC	BETA BLOCKERS
toremifene tab (FARESTON equiv)	-	3	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torsemide tab (DEMADEX equiv)	-	2	DIURETICS
torsemide tab 20mg (SOAANZ equiv)	-	2	DIURETICS
TOSYMRA SOLN	-	NC	MIGRAINE PRODUCTS
TOUJEO MAX SOLOSTAR INJ	-	3	ANTIDIABETICS
TOUJEO SOLOSTAR INJ	-	3	ANTIDIABETICS
TOVET KIT	-	NC	DERMATOLOGICALS
TOVIAZ TAB	-	4	URINARY ANTISPASMODICS
TRACLEER TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
TRACLEER TAB 62.5MG, 125MG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	QL	3	ANTIDIABETICS
TRAMADOL COMPOUND KIT	-	NC	DERMATOLOGICALS
TRAMADOL ER CAP	-	NC	ANALGESICS - OPIOID
tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	4	ANALGESICS - OPIOID

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	4	ANALGESICS - OPIOID
TRAMADOL HCL TAB	-	NC	ANALGESICS - OPIOID
tramadol hcl tab 100mg	-	NC	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	2	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	2	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	NC	ANTIHYPERTENSIVES
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC	ANTIHYPERTENSIVES
tranexamic acid inj (CYKLOKAPRON equiv)	-	NC	HEMOSTATICS
tranexamic acid tab (LYSTEDA equiv)	-	2	HEMOSTATICS
TRANSDERM-SCOP PATCH	-	NC	ANTIEMETICS
TRANXENE-T TAB	-	NC	ANTIANXIETY AGENTS
tranylcypromine tab (PARNATE equiv)	-	3	ANTIDEPRESSANTS
TRAVATAN Z DROPS	-	NC	OPHTHALMIC AGENTS
travoprost ophth soln (TRAVATAN Z equiv) (QL= 2.5ml/30 days)	QL	3	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	2	ANTIDEPRESSANTS
trazodone tab 300mg (DESYREL equiv)	-	NC	ANTIDEPRESSANTS
TREANDA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRECATOR TAB (Restricted to Infectious Disease Specialist)	RS	4	ANTIMYCOBACTERIAL AGENTS
TRELEGY ELLIPTA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TREMFYA INDUCTION INJ 200MG/ML	-	NC	GASTROINTESTINAL AGENTS - MISC.
TREMFYA INJ	-	NC	DERMATOLOGICALS
TREMFYA INJ 200MG/2ML	-	NC	GASTROINTESTINAL AGENTS - MISC.
TRESIBA FLEXTOUCH INJ	-	3	ANTIDIABETICS
TRESIBA INJ	-	3	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	MSP	2	ANTINEOPLASTICS
tretinoin cream (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (Acne Only - Prio Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
tretinoin gel 0.05% (ATRALIN equiv)	-	NC	DERMATOLOGICALS
tretinoin microsphere gel (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRETINOIN MICROSPHERE GEL 0.04% (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
TRETINOIN MICROSPHERE GEL 0.1% (Acne Onl - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
TRETINOIN MICROSPHERE GEL PUMP 0.04% (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
TRETINOIN MICROSPHERE GEL PUMP 0.1% (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3	DERMATOLOGICALS
TRETINOIN MICROSPHERE GEL/GEL PUMP	-	NC	DERMATOLOGICALS
TRETTEN INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
TREXALL TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TREXIMET TAB	-	NC	MIGRAINE PRODUCTS
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC	ANALGESICS - OPIOID
triamcinolone acetate inj (KENALOG equiv)	-	2	CORTICOSTEROIDS
triamcinolone acetonide oint (TRIANEX equiv)	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
triamcinolone cream	-	2	DERMATOLOGICALS
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	2	MOUTH / THROAT / DENTAL AGENTS
TRIAMCINOLONE LOTION	-	2	DERMATOLOGICALS
triamcinolone oint	-	2	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	2	NASAL AGENTS - SYSTEMIC AND TOPICAL
TRIAMCINOLONE SPRAY	-	NC	DERMATOLOGICALS
triamcinolone spray (KENALOG equiv)	-	NC	DERMATOLOGICALS
triamterene cap (DYRENIUM equiv)	-	3	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	2	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	2	DIURETICS
TRIAMVEX KIT	-	NC	DERMATOLOGICALS
TRIANEX OINT	-	NC	DERMATOLOGICALS
triazolam tab (HALCION equiv)	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
TRIBENZOR TAB	-	NC	ANTIHYPERTENSIVES
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC	DIAGNOSTIC PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC	ALLERGENIC EXTRACTS / BIOLOGICALS MISC
TRICHOSOL SOLN	-	NC	PHARMACEUTICAL ADJUVANTS
TRICOR TAB	-	NC	ANTIHYPERLIPIDEMICS
trientine cap (SYPRINE equiv)	MSP-PA	5	MISCELLANEOUS THERAPEUTIC CLASSES
TRIENTINE CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
trifluoperazine tab (STELAZINE equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
TRIGLIDE TAB	-	NC	ANTIHYPERLIPIDEMICS
trihexyphenidyl elixir (ARTANE equiv)	-	2	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	2	ANTIPARKINSON AGENTS
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	3	ANTIDIABETICS
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
TRIKAFTA TAB	-	NC	RESPIRATORY AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	5	RESPIRATORY AGENTS - MISC.
tri-legest tab (ESTROSTEP FE equiv)	-	1	CONTRACEPTIVES
TRILEPTAL SUSP	-	NC	ANTICONVULSANTS
TRILEPTAL TAB	-	NC	ANTICONVULSANTS
TRILIPIX CAP	-	NC	ANTIHYPERLIPIDEMICS
TRILOCICLO KIT	-	NC	DERMATOLOGICALS
TRI-LUMA CREAM	-	EXC	DERMATOLOGICALS
trimethobenzamide cap (TIGAN equiv)	-	2	ANTIEMETICS
trimethobenzamide hcl inj (TIGAN equiv)	-	NC	ANTIEMETICS
TRIMETHOPRIM TAB	-	2	ANTI-INFECTIVE AGENTS - MISC.
trimethoprim tab (PROLOPRIM equiv)	-	2	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	4	ANTIDEPRESSANTS
TRI-NORINYL TAB	-	NC	CONTRACEPTIVES
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL-¢	4	ANTIDEPRESSANTS
TRIONEX PAK	-	NC	DERMATOLOGICALS
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1	CONTRACEPTIVES
TRIUMEQ PD TAB	-	NC/3P	ANTIVIRALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRIUMEQ TAB	-	NC/3P	ANTIVIRALS
TRI-VITAMIN FLUORIDE DROPS	-	NC	MULTIVITAMINS
TROKENDI XR CAP	-	NC	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	2	OPHTHALMIC AGENTS
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
trospium chloride SR cap (SANCTURA XR equiv)	-	3	URINARY ANTISPASMODICS
trospium tab (SANCTURA equiv)	-	2	URINARY ANTISPASMODICS
TRUDHESA NASAL SPRAY	-	NC	MIGRAINE PRODUCTS
TRULANCE TAB (QL= 1 tab/day)	PA-QL	3	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ (QL= 4 pens/28 days)	PA-QL	3/3P	ANTIDIABETICS
TRUMENBA INJ	VAC	1	VACCINES
TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TRUSOPT OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
TRUTAKNA INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
TRYNGOLZA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TRYNGOLZA INJ 50MG/0.8ML	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TRYPTYR SOLN	-	NC	OPHTHALMIC AGENTS
TRYVIO TAB	-	NC	ANTIHYPERTENSIVES
TUDORZA PRESSAIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TUKYSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TUSSICAPS	-	NC	COUGH / COLD / ALLERGY
tussigon tab (HYCODAN equiv)	-	2	COUGH / COLD / ALLERGY
TUXARIN ER TAB	-	NC	COUGH / COLD / ALLERGY
TUZISTRA XR SUSP	-	NC	COUGH / COLD / ALLERGY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TWIIST REFILL KIT (QL= 1 kit/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
TWIIST STARTER KIT (QL= 1 kit/month)	QL	3	MEDICAL DEVICES AND SUPPLIES
TWINRIX INJ	VAC	1	VACCINES
TWIRLA PATCH	-	1	CONTRACEPTIVES
TWYNEO CREAM	-	NC	DERMATOLOGICALS
TWYNSTA TAB	-	NC	ANTIHYPERTENSIVES
TYBLUME TAB	-	1	CONTRACEPTIVES
TYBOST TAB	-	NC/3P	ANTIVIRALS
TYENNE INJ (QL= 2 inj/28 days)	MSP-PA-QL	5	ANALGESICS - ANTI-INFLAMMATORY
TYKERB TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYLENOL/CODEINE TAB	-	NC	ANALGESICS - OPIOID
TYMLOS INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYPHIM VI INJ	VAC	EXC	VACCINES
TYRVAYA NASAL SPRAY	-	NC	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TYSABRI INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TYVASO DPI POWDER	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER 48-80MCG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	-	NC	CARDIOVASCULAR AGENTS - MISC.
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.
UBRELVY TAB	-	NC	MIGRAINE PRODUCTS
UCERIS RECTAL FOAM	PA	4	ANORECTAL AND RELATED PRODUCTS
UCERIS TAB	-	NC	CORTICOSTEROIDS
UDENYCA INJ	-	NC	HEMATOPOIETIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ULORIC TAB	-	NC	GOUT AGENTS
ULTRACET TAB	-	NC	ANALGESICS - OPIOID
ULTRAM TAB	-	NC	ANALGESICS - OPIOID
ULTRAVATE CREAM	-	NC	DERMATOLOGICALS
ULTRAVATE LOTION	-	NC	DERMATOLOGICALS
ULTRAVATE OINT	-	NC	DERMATOLOGICALS
ULTRAVATE PAC KIT	-	NC	DERMATOLOGICALS
UMECLIDINIUM ELLIPTA INHALER 62.5MCG/INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UMECTA EMULSION	-	NC	DERMATOLOGICALS
UMECTA SUSP	-	NC	DERMATOLOGICALS
UPNEEQ SOLN	-	EXC	OPHTHALMIC AGENTS
UPTRAVI INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI THERAPY PACK (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
URAMAXIN CREAM	-	NC	DERMATOLOGICALS
URAMAXIN GEL	-	NC	DERMATOLOGICALS
URANOVIA CREAM	-	EXC	DERMATOLOGICALS
urea cream	-	NC	DERMATOLOGICALS
urea emulsion	-	NC	DERMATOLOGICALS
urea gel (URAMAXIN equiv)	-	NC	DERMATOLOGICALS
UREA LOT	-	NC	DERMATOLOGICALS
UREA NAIL KIT	-	NC	DERMATOLOGICALS
UREA SUSP	-	NC	DERMATOLOGICALS
urea susp 40% (UMECTA equiv)	-	NC	DERMATOLOGICALS
URECHOLINE TAB	-	NC	URINARY ANTISPASMODICS
URELIEF PLUS TAB	-	NC	URINARY ANTISPASMODICS
UROCIT-K TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
UROXATRAL TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
URSO FORTE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ursodiol cap (ACTIGALL equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
URSODIOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	2	GASTROINTESTINAL AGENTS - MISC.
URSOLIGN CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
USTEKINUMAB INJ	-	NC	DERMATOLOGICALS
USTEKINUMAB-AEKN 45MG/0.5ML	-	NC	DERMATOLOGICALS
USTEKINUMAB-AEKN 90MG/ML	-	NC	DERMATOLOGICALS
UTA CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VABOMERE INJ	-	6	ANTI-INFECTIVE AGENTS - MISC.
VAFSEO TAB	-	NC	HEMATOPOIETIC AGENTS
VAGIFEM TAB	-	NC	VAGINAL PRODUCTS
valacyclovir tab (VALTREX equiv)	-	2	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5	DERMATOLOGICALS
VALCYTE SOLN	-	NC	ANTIVIRALS
VALCYTE TAB	-	NC	ANTIVIRALS
valganciclovir soln (VALCYTE equiv)	-	3	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	3	ANTIVIRALS

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VALIUM TAB	-	NC	ANTIANXIETY AGENTS
valproate inj (DEPACON equiv)	-	NC	ANTICONVULSANTS
valproic acid cap (DEPAKENE equiv)	-	2	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	2	ANTICONVULSANTS
valsartan oral soln (VALSARTAN equiv)	-	NC	ANTIHYPERTENSIVES
valsartan tab (DIOVAN equiv)	-	2	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	2	ANTIHYPERTENSIVES
VALTOCO NASAL SPRAY (QL= 5 doses/fill)	QL	4	ANTICONVULSANTS
VALTREX TAB	-	NC	ANTIVIRALS
VALTYA 1/50 TAB	-	1	CONTRACEPTIVES
VANCOCIN CAP	-	NC	ANTI-INFECTIVE AGENTS MISC.
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2	ANTI-INFECTIVE AGENTS MISC.
vancomycin hcl soln (VANCOMYCIN equiv)	-	2	ANTI-INFECTIVE AGENTS MISC.
VANCOMYCIN ORAL SOLN	-	2	ANTI-INFECTIVE AGENTS MISC.
VANCOMYCIN SOLN	-	2	ANTI-INFECTIVE AGENTS MISC.
VANDAZOLE GEL	-	2	VAGINAL AND RELATED PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VANFLYTA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANOS CREAM	-	NC	DERMATOLOGICALS
VANRAFIA TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
vardenafil ODT (STAXYN equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
vardenafil tab (LEVITRA equiv)	-	EXC	CARDIOVASCULAR AGENTS - MISC.
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab starter pack (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARIVAX INJ	VAC	1	VACCINES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VAROPHEN KIT	-	NC	DERMATOLOGICALS
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	3	ANTIEMETICS
VASCEPA CAP	-	NC	ANTIHYPERLIPIDEMICS
VASERETIC TAB	-	NC	ANTIHYPERTENSIVES
vasolex oint (XENADERM equiv)	-	NC	DERMATOLOGICALS
VASOTEC TAB	-	NC	ANTIHYPERTENSIVES
VAXCHORA SUSP	VAC	EXC	VACCINES
VAXELIS INJ	VAC	1	TOXOIDS
VAXNEUVANCE INJ	VAC	1	VACCINES
V-C FORTE CAP	-	NC	MULTIVITAMINS
v-c forte cap (V-C FORTE equiv)	-	NC	MULTIVITAMINS
VECAMYL TAB	-	NC	ANTIHYPERTENSIVES
VECTICAL OINT	-	NC	DERMATOLOGICALS
VELIVET PAK	-	1	CONTRACEPTIVES
VELPHORO CHEW TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELSIPITY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELTASSA POWDER (QL= 1 packet/day)	PA-QL	3	ASSORTED CLASSES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VELTASSA POWDER 1GM (QL= 4 packets/day)	PA-QL	3	MISCELLANEOUS THERAPEUTIC CLASSES
VEMLIDY TAB	-	3	ANTIVIRALS
VENCLEXTA STARTER PACK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
venlafaxine ER cap (EFFEXOR XR equiv)	-	2	ANTIDEPRESSANTS
VENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	2	ANTIDEPRESSANTS
VENLAFAXINE TAB	-	NC	ANTIDEPRESSANTS
VENNGEL ONE KIT	-	NC	DERMATOLOGICALS
VENTAVIS INH SOLN	-	NC	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VEOZAH TAB (QL= 1 tab/day)	PA-QL	4	ENDOCRINE AND METABOLIC AGENTS - MISC.
VEPPANU TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VERAPAMIL ER CAP	-	4	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP, VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN equiv)	-	2	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	2	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	2	CALCIUM CHANNEL BLOCKERS
VERDESO FOAM	-	NC	DERMATOLOGICALS
VERDROCET TAB 2.5MG-325MG	-	NC	ANALGESICS - OPIOID
VEREGEN OINT	-	NC	DERMATOLOGICALS
VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
VERQUVO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
VERSACLOZ SUSP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE LS SUSP	-	NC	URINARY ANTISPASMODICS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VESICARE TAB	-	NC	URINARY ANTISPASMODICS
VFEND SUSP	-	NC	ANTIFUNGALS
VFEND TAB	-	NC	ANTIFUNGALS
V-GO INJ KIT (QL= 1 kit/day)	QL	3	MEDICAL DEVICES AND SUPPLIES
VIBERZI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VIBRAMYCIN CAP	-	NC	TETRACYCLINES
VIBRAMYCIN SUSP	-	NC	TETRACYCLINES
VICOPROFEN TAB	-	NC	ANALGESICS - OPIOID
VICTOZA INJ (QL= 9ml/30 days)	PA-QL	3/3 P	ANTIDIABETICS
vigabatrin powder pack (SABRIL POWDER equiv)	-	NC	ANTICONVULSANTS
vigabatrin tab (SABRIL equiv)	-	NC	ANTICONVULSANTS
vigadrone powder pack	-	NC	ANTICONVULSANTS
VIGAFYDE SOLN	-	NC	ANTICONVULSANTS
VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
VIIBRYD STARTER KIT	-	NC	ANTIDEPRESSANTS
VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5	MISCELLANEOUS THERAPEUTIC CLASSES
vilazodone hcl tab (VIIBRYD equiv)	-	3	ANTIDEPRESSANTS
VIMKUNYA INJ	VAC	EXC	VACCINES
VIMOVO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	NC	ANTICONVULSANTS
VIMPAT TAB	-	NC	ANTICONVULSANTS
viorele tab, kariva tab (MIRCETTE equiv)	-	1	CONTRACEPTIVES
VIRACEPT TAB	-	5	ANTIVIRALS
VIRAMUNE SUSP	-	NC/3P	ANTIVIRALS
VIRAMUNE TAB	-	NC/3P	ANTIVIRALS
VIRAMUNE XR TAB	-	NC/3P	ANTIVIRALS
VIREAD TAB	-	5	ANTIVIRALS
VIREAD TAB	-	NC/3P	ANTIVIRALS
VISTARIL CAP	-	NC	ANTIANXIETY AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VISTOGARD PAK	-	NC	ANTIDOTES
VITAFOL STRIPS	-	4	MULTIVITAMINS
vitamin D cap (Rx covered Only)	-	2	VITAMINS
vitamin D cap 1000unit	OTC	NC	VITAMINS
vitamin D cap 400unit	OTC	NC	VITAMINS
VITAMIN D TAB 400UNIT	OTC	NC	VITAMINS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VIVELLE-DOT, MINIVELLE PATCH	-	NC	ESTROGENS
VIVITROL INJ	MSP	5	ANTIDOTES
VIVJOA CAP	-	NC	ANTIFUNGALS
VIVLODEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIVOTIF CAP	VAC	EXC	VACCINES
VIZIMPRO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VIZZ OPHTH SOLN	-	NC	OPHTHALMIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VOCABRIA TAB	-	NC/ 3P	ANTIVIRALS
VOGELXO GEL PUMP 1%	-	NC	ANDROGENS-ANABOLIC
VOLTAREN GEL	OTC	EX C	DERMATOLOGICALS
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VONVENDI INJ	-	EX C	HEMATOLOGICAL AGENTS - MISC.
VOPAC 5 CREAM	-	NC	DERMATOLOGICALS
VOPAC CREAM	-	NC	DERMATOLOGICALS
VOPAC GB CREAM	-	NC	DERMATOLOGICALS
VOQUEZNA DUAL PAK	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
VOQUEZNA TAB	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS
VOQUEZNA TRIP PAK	-	NC	ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VORANIGO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VORANIGO TAB 10MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
voriconazole susp (VFEND equiv)	-	4	ANTIFUNGALS
voriconazole tab (VFEND equiv)	-	3	ANTIFUNGALS
VOSEVI TAB	-	NC	ANTIVIRALS
VOTRIENT TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	5	GASTROINTESTINAL AGENTS - MISC.
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
VOYDEYA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
VOYDEYA TAB THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
VOYXACT INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
VP-PNV-DHA CAP	-	2	MULTIVITAMINS
VRAYLAR CAP	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VRAYLAR PACK	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
VSL #3 CAP	-	NC	ANTIDIARRHEALS
VTAMA CREAM	-	NC	DERMATOLOGICALS
VTOL SOLN	-	NC	ANALGESICS - NONNARCOTIC
VUITY OPHTH SOLN 1.25%	-	NC	OPHTHALMIC AGENTS
VUMERITY CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYALEV INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
VYBRIQUE ORAL FILM	-	EXC	CARDIOVASCULAR AGENTS - MISC.
VYJUVEK GEL	-	EXC	DERMATOLOGICALS
VYKAT XR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
VYKAT XR TAB 150MG	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VYKAT XR TAB 75MG	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
VYNDAMAX CAP	-	NC	CARDIOVASCULAR AGENTS - MISC.
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	5	CARDIOVASCULAR AGENTS - MISC.
VYSCOXA SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VYTONE CREAM 1.9-1%	-	NC	DERMATOLOGICALS
VYTORIN TAB	-	NC	ANTIHYPERLIPIDEMICS
VYTORIN TAB 10-80MG	-	NC	ANTIHYPERLIPIDEMICS
VYVANSE CAP	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
VYVANSE CHEW TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
VYVGART HYTRULO INJ	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VYZULTA SOLN	-	NC	OPHTHALMIC AGENTS
WAINUA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
WAKIX TAB	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
warfarin tab (COUMADIN equiv)	-	2	ANTICOAGULANTS
WAYRILZ TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
WEGOVY HD INJ 7.2MG/0.75ML	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WEGOVY INJ	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
WEGOVY INJ 2.4MG/0.75ML	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WEGOVY TAB	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
WELCHOL PACK	-	NC	ANTIHYPERLIPIDEMICS
WELCHOL TAB	-	NC	ANTIHYPERLIPIDEMICS
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
WELLBUTRIN SR TAB	-	NC	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	NC	ANTIDEPRESSANTS
WESTCORT OINT	-	NC	DERMATOLOGICALS
WEZLANA INJ	-	NC	DERMATOLOGICALS
WEZLANA SYRINGE	-	NC	DERMATOLOGICALS
WIDAPLIK TAB	-	NC	ANTIHYPERTENSIVES
WILATE INJ	-	EX C	HEMATOLOGICAL AGENTS - MISC.
WINLEVI CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
WINREVAIR INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
WOUND-DRESSING GELS	-	NC	DERMATOLOGICALS
WPR PLUS	-	NC	DERMATOLOGICALS
wymzya FE tab (FEMCON FE equiv)	-	1	CONTRACEPTIVES
WYNZORA CREAM	-	NC	DERMATOLOGICALS
XACIATO GEL	-	NC	VAGINAL AND RELATED PRODUCTS
XADAGO TAB	-	NC	ANTIPARKINSON AGENTS
XALATAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XALKORI SPRINKLE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XANAX TAB	-	NC	ANTIANXIETY AGENTS
XANAX XR TAB	-	NC	ANTIANXIETY AGENTS
XARELTO STARTER PACK	-	3	ANTICOAGULANTS
XARELTO SUSP	-	3	ANTICOAGULANTS
XARELTO TAB	-	3	ANTICOAGULANTS
XCOPRI PAK 100-150MG	-	NC	ANTICONVULSANTS
XCOPRI PAK 150-200MG	-	NC	ANTICONVULSANTS
XCOPRI TAB 150MG, 200MG	-	NC	ANTICONVULSANTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XCOPRI TAB 25MG	-	NC	ANTICONVULSANTS
XCOPRI TAB 50MG, 100MG	-	NC	ANTICONVULSANTS
XCOPRI TITRATION PAK 12.5-25MG	-	NC	ANTICONVULSANTS
XCOPRI TITRATION PAK 150-200MG	-	NC	ANTICONVULSANTS
XCOPRI TITRATION PAK 50-100MG	-	NC	ANTICONVULSANTS
XDEMVY DROP	-	NC	OPHTHALMIC AGENTS
XELJANZ ORAL SOLN	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELPROS OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
XELSTRYM PAD	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
XEMBIFY INJ	-	NC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XENADERM OINT	-	NC	DERMATOLOGICALS
XENAZINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XENICAL CAP	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
XENLETA TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
XEPI CREAM	-	NC	DERMATOLOGICALS
XERESE CREAM	-	NC	DERMATOLOGICALS
XERMELO TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
XHANCE NASAL EXHALER	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	4	ANTI-INFECTIVE AGENTS - MISC.
XIFAXAN TAB 550MG (QL= 60 tabs/30 days)	QL	3	ANTI-INFECTIVE AGENTS - MISC.
XIGDUO XR TAB	-	NC	ANTIDIABETICS
XIGDUO XR TAB 2.5-1000 (QL= 2 tabs/day)	QL	3	ANTIDIABETICS
XIIDRA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
XOCOVA TAB	-	NC	ANTIVIRALS
XODOL TAB 10MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 5MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 7.5MG-300MG	-	NC	ANALGESICS - OPIOID

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XOFLUZA TAB (QL= 1 tab/fill)	QL	4	ANTIVIRALS
XOLAIR INJ	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 150MG/ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 300MG/2ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 150MG/ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 300MG/2ML	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLEGEL	-	NC	DERMATOLOGICALS
XOLREMDI CAP	-	NC	HEMATOPOIETIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XOPENEX NEB SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XPHOZAH TAB (QL= 2 tabs/day)	MSP-PA-QL	5	ENDOCRINE AND METABOLIC AGENTS - MISC.
XPOVIO PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XROMI SOLN (Prior Authorization required for members age 9 years and older)	PA	4	HEMATOPOIETIC AGENTS
XRYLIX PAK	-	NC	DERMATOLOGICALS
XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3	ANALGESICS - OPIOID
XTANDI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 40MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 80MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTORO OTIC SUSP	-	NC	OTIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	3	ANTIDIABETICS
XURIDEN POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
XYNTHA INJ	-	EXC	HEMATOLOGICAL AGENTS - MISC.
XYOSTED INJ	-	NC	ANDROGENS-ANABOLIC
XYREM SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYWAV SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYZAL SOLN	-	NC	ANTIHISTAMINES
XYZAL TAB	-	NC	ANTIHISTAMINES
XYZBAC TAB	-	EXC	DIETARY PRODUCTS / DIETARY MANAGEMENT PRODUCTS
YAZ TAB, YASMIN 28 TAB	-	NC	CONTRACEPTIVES
YBUPHEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YESINTEK INJ (QL= 1 inj/84 days)	MSP-PA-QL	5	DERMATOLOGICALS
YESINTEK SYRINGE	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
YESINTEK SYRINGE 90MG	-	NC	DERMATOLOGICALS
YEZTUGO INJ	-	NC/3P	ANTIVIRALS
YEZTUGO TAB	-	NC/3P	ANTIVIRALS
YF-VAX INJ	VAC	EXC	VACCINES
YONSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
YORVIPATH INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
YORVIPATH INJ 294MCG	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
YORVIPATH INJ 420MCG	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
YOSPRALA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
YUFLYMA KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUPELRI SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
YUSIMRY INJ (adalimumab-aqvh)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUTREPIA CAP	-	NC	CARDIOVASCULAR AGENTS - MISC.
YUVEZZI SOLN	-	NC	OPHTHALMIC AGENTS
YUVIWEL INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
zafemy patch (XULANE equiv)	-	1	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	3	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZANAFLEX CAP	-	NC	MUSCULOSKELETAL THERAPY AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZANAFLEX TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ZANOSAR INJ	M	6	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZARONTIN CAP	-	NC	ANTICONVULSANTS
ZARONTIN SOLN	-	NC	ANTICONVULSANTS
ZARXIO INJ	MSP	5	HEMATOPOIETIC AGENTS
ZAVESCA CAP	-	NC	HEMATOPOIETIC AGENTS
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	3	MIGRAINE PRODUCTS
ZECUITY PAD	-	NC	MIGRAINE PRODUCTS
ZEGALOGUE INJ	-	NC	ANTIDIABETICS
ZEGERID CAP	-	NC	ULCER DRUGS
ZEGERID POWDER PACK	-	NC	ULCER DRUGS
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	NC	ANTIPARKINSON AGENTS
ZELBORAF TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days)	PA-QL	3	DERMATOLOGICALS
ZEMPLAR CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZENBEXUS CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZENPEP CAP	-	3	DIGESTIVE AIDS
zenzedi tab 10mg (DEXEDRINE equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ZEPATIER TAB	-	NC	ANTIVIRALS
ZEPBOUND INJ	-	EXC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ZEPBOUND KWIKPEN INJ	-	EXC	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS

NC =Not Covered		**generic** =small letters		**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZEPBOUND VIAL INJ	-	EX C	ADHD / ANTI-NARCOLEPSY / ANTI-OBESITY / ANOREXIANTS
ZEPOSIA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZEPOSIA STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZERVIATE OPTH SOLN	-	4	OPHTHALMIC AGENTS
ZESTORETIC TAB	-	NC	ANTIHYPERTENSIVES
ZETIA TAB	-	NC	ANTIHYPERLIPIDEMICS
ZIAC TAB	-	NC	ANTIHYPERTENSIVES
ZIAGEN SOLN	-	NC/ 3P	ANTIVIRALS
ZIAGEN TAB	-	NC/ 3P	ANTIVIRALS
ZIANA GEL	-	NC	DERMATOLOGICALS
zidovudine cap (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	2	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	2	ANTIVIRALS
ZIEXTENZO INJ	-	NC	HEMATOPOIETIC AGENTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZILACAINE PAK	-	NC	DERMATOLOGICALS
ZILBRYSQ INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ZILBRYSQ INJ 23MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
ZILBRYSQ INJ 32.4MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
zileuton ER tab (ZYFLO CR equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZILXI FOAM	-	NC	DERMATOLOGICALS
ZIMHI SOLN	-	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
ZINBRYTA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZINC GLUCONATE TAB	OTC	2	MINERALS & ELECTROLYTES
ZIOPTAN OPHTH SOLN (QL= 1 vial/day)	PA-QL	4	OPHTHALMIC AGENTS
ziprasidone cap (GEODON equiv)	-	2	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ZIPSOR CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZIRGAN OPHTH GEL	-	3	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	4	MACROLIDES
ZITHROMAX SUSP	-	NC	MACROLIDES
ZITHROMAX TAB	-	NC	MACROLIDES
ZITUVIMET XR TAB	-	NC	ANTIDIABETICS
ZITUVIO TAB	-	NC	ANTIDIABETICS
ZOCOR TAB	-	NC	ANTIHYPERLIPIDEMICS
ZOCOR TAB 80MG	-	NC	ANTIHYPERLIPIDEMICS
ZOFRAN ODT	-	NC	ANTIEMETICS
ZOFRAN SOLN	-	NC	ANTIEMETICS
ZOFRAN TAB	-	NC	ANTIEMETICS
ZOKINVY CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ZOLINZA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/3(days)	QL	4	MIGRAINE PRODUCTS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZOLMITRIPTAN SPRAY, ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2	MIGRAINE PRODUCTS
ZOLOFT CONC	-	NC	ANTIDEPRESSANTS
ZOLOFT TAB	-	NC	ANTIDEPRESSANTS
ZOLPAK KIT	-	NC	DERMATOLOGICALS
ZOLPIDEM CAP	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day)	QL	2	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	2	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZOLPIMIST SPRAY	-	NC	HYPNOTICS / SEDATIVES SLEEP DISORDER AGENTS
ZOLYMBUS OPHTH GEL	-	NC	OPHTHALMIC AGENTS

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOMETA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	4	MIGRAINE PRODUCTS
ZOMIG TAB	-	NC	MIGRAINE PRODUCTS
ZONATUSS CAP 150MG	-	NC	COUGH / COLD / ALLERGY
ZONEGRAN CAP	-	NC	ANTICONVULSANTS
ZONISADE SUSP (Prior Authorization required for members age 9 years and older)	PA	4	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	2	ANTICONVULSANTS
ZONTIVITY TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ZORTRESS TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ZORVOLEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	3	DERMATOLOGICALS
ZORYVE CREAM 0.05%	-	NC	DERMATOLOGICALS
ZORYVE CREAM 0.15%	-	NC	DERMATOLOGICALS
ZORYVE FOAM (QL= 60 grams/30 days)	PA-QL	3	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZOVIRAX CAP	-	NC	ANTIVIRALS
ZOVIRAX CREAM	-	NC	DERMATOLOGICALS
ZOVIRAX OINT	-	4	DERMATOLOGICALS
ZOVIRAX SUSP	-	NC	ANTIVIRALS
ZOVIRAX TAB	-	NC	ANTIVIRALS
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	5	ANTICONVULSANTS
ZUBSOLV SL TAB	-	3	ANALGESICS - OPIOID
ZUNVEYL TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZUPLENZ SL FILM	-	NC	ANTIEMETICS
ZURAMPIC TAB	-	NC	GOUT AGENTS
ZURNAI INJ	-	3	ANTIDOTES AND SPECIFIC ANTAGONISTS
ZURZUVAE CAP 20MG, 25MG	-	NC	ANTIDEPRESSANTS
ZURZUVAE CAP 30MG	-	NC	ANTIDEPRESSANTS
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	1	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZYCLARA CREAM	-	NC	DERMATOLOGICALS

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZYCUBO INJ	-	NC	MINERALS & ELECTROLYTES
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO CR TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYFLO TAB	-	4	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA TAB (QL= 3 tabs/day)	MSP-PA-QL-SF	5	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
ZYLOPRIM TAB	-	NC	GOUT AGENTS
ZYLOTROL-L KIT	-	NC	DERMATOLOGICALS
ZYMAXID OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ZYMFENTRA INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
ZYPITAMAG TAB	-	NC	ANTIHYPERLIPIDEMICS
ZYPREXA RELPREVV INJ	-	4	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ZYPREXA TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZYPREXA ZYDIS TAB	-	NC	ANTIPSYCHOTICS / ANTIMANIC AGENTS
ZYRTEC CHILD CHEW ALLERGY	OTC	NC	ANTIHISTAMINES
ZYTIGA TAB 250MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYTIGA TAB 500MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYVOX SUSP	-	NC	ANTI-INFECTIVE AGENTS MISC.
ZYVOX TAB	-	NC	ANTI-INFECTIVE AGENTS MISC.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	2
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	2
dextroamphetamine ER cap (DEXEDRINE equiv)	-	2
dextroamphetamine tab (DEXEDRINE equiv)	-	2
lisdexamfetamine dimesylate cap (VYVANSE equiv)	-	2
methamphetamine hcl tab (METHAMPHETAMINE equiv)	-	2
lisdexamfetamine dimesylate chew tab (VYVANSE equiv)	-	3
dextroamphetamine soln (PROCENTRA equiv)	-	4
ADDERALL TAB	-	NC
ADDERALL XR CAP	-	NC
ADZENYS ER SUSP	-	NC
ADZENYS XR ODT	-	NC
amphetamine er odt (ADZENYS XR equiv)	-	NC
amphetamine tab (EVEKEO equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv)	-	NC
ARYNTA SOLN	-	NC
DESOXYN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
DEXEDRINE CAP	-	NC
dextroamphetamine sulfate tab 15mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 20mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 30mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv)	-	NC
DYANAVEL XR CHEW	-	NC
EVEKEO ODT	-	NC
EVEKEO TAB	-	NC
MYDAYIS CAP 12.5MG	-	NC
MYDAYIS CAP 25MG	-	NC
MYDAYIS CAP 37.5MG	-	NC
MYDAYIS CAP 50MG	-	NC
VYVANSE CAP	-	NC
VYVANSE CHEW TAB	-	NC
XELSTRYM PAD	-	NC
zenzedi tab 10mg (DEXEDRINE equiv)	-	NC
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC
ANALEPTICS		
caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
CAFCIT INJ	-	NC
ANOREXIANTS NON-AMPHETAMINE		
ADIPEX-P CAP	-	EXC
benzphetamine tab	-	EXC
DIETHYLPROPION ER TAB	-	EXC
diethylpropion tab	-	EXC
PHENDIMETRAZINE ER TAB	-	EXC
phendimetrazine tab (BONTRIL PDM equiv)	-	EXC
phentermine tab 8mg, lomaira tab 8mg	-	EXC
PLENITY CAP	-	EXC
ANTI-OBESITY AGENTS		
FOUNDAYO TAB	-	EXC
liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv)	-	EXC
SAXENDA INJ	-	EXC
WEGOVY HD INJ 7.2MG/0.75ML	-	EXC
WEGOVY INJ	-	EXC
WEGOVY INJ 1.7MG/0.75ML	-	EXC
WEGOVY INJ 2.4MG/0.75ML	-	EXC
WEGOVY TAB	-	EXC
XENICAL CAP	-	EXC
ZEPBOUND INJ	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
ZEPBOUND KWIKPEN INJ	-	EXC
ZEPBOUND VIAL INJ	-	EXC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA equiv)	-	2
clonidine ER tab (KAPVAY equiv)	-	2
guanfacine ER tab (INTUNIV equiv)	-	2
ATONCY SOLN, ATOMOXETINE HCL SOLN	-	NC
INTUNIV TAB	-	NC
KAPVAY TAB	-	NC
ONYDA XR SUSP	-	NC
QELBREE ER CAP	-	NC
STRATTERA CAP	-	NC
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB (QL= 1 tab/day)	PA-QL	3
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB	-	NC
STIMULANTS - MISC.		
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	QL	2
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	2
dexmethylphenidate tab (FOCALIN equiv)	-	2
methylphenidate CD cap (METADATE CD equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
methylphenidate ER cap (RITALIN LA equiv)	-	2
methylphenidate ER tab (CONCERTA equiv)	-	2
METHYLPHENIDATE ER TAB 27MG	-	2
METHYLPHENIDATE ER TAB 36MG	-	2
METHYLPHENIDATE ER TAB 54MG	-	2
methylphenidate soln (METHYLIN equiv)	-	2
methylphenidate tab (RITALIN equiv)	-	2
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	QL	2
METHYLIN SOLN	-	3
methylphenidate chew tab (METHYLIN equiv)	-	3
methylphenidate ER cap (APTENSIO XR equiv)	-	3
METHYLPHENIDATE ER TAB	-	3
AZSTARYS CAP	-	NC
CONCERTA TAB, RITALIN SR TAB	-	NC
COTEMPLA XR TAB, METHYLPHENIDATE ER TAB	-	NC
DAYTRANA PATCH	-	NC
FOCALIN TAB	-	NC
FOCALIN XR CAP	-	NC
methylphenidate ER tab 72mg	-	NC
METHYLPHENIDATE ER TAB, RELEXXII TAB	-	NC
methylphenidate td patch (DAYTRANA equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
NUVIGIL TAB	-	NC
PROVIGIL TAB	-	NC
QUILLIVANT XR SUSP	-	NC
RELEXXI ER TAB	-	NC
RITALIN LA CAP, APTENSIO XR CAP	-	NC
RITALIN TAB	-	NC
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
ODACTRA SL TAB	PA	4
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	5
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	5
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC
ALTERNATIVE MEDICINES		
ALTERNATIVE MEDICINE - R'S		
RESERVAPAK SYRUP	-	NC
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRANULES PACKET	-	NC
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
neomycin tab	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
AMINOGLYCOSIDES Cont.		
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	MSP-RS	2
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	5
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	5
BETHKIS NEB SOLN, TOBI NEB SOLN	-	NC
HUMATIN CAP	-	NC
KITABIS PAK NEB SOLN	-	NC
tobramycin neb soln (BETHKIS equiv)	-	NC
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
tofacitinib citrate tab (XELJANZ equiv) (QL= 2 tabs/day)	LMSP-PA-QL	2
RINVOQ ER TAB (QL= 1 tab/day)	MSP-PA-QL	5
RINVOQ ORAL SOLN (QL= 12ml/day)	MSP-PA-QL	5
OLUMIANT TAB	-	NC
tofacitinib citrate ER tab (XELJANZ equiv)	-	NC
tofacitinib citrate oral soln (XELJANZ equiv)	-	NC
XELJANZ ORAL SOLN	-	NC
XELJANZ TAB	-	NC
XELJANZ XR TAB	-	NC
ANTIRHEUMATIC ANTIMETABOLITES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
REDITREX INJ	-	NC
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fi 1 fill/plan year)	MSP-PA-QL	5
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	MSP-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	5
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	5
HADLIMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	5
HADLIMA INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5
HADLIMA PUSH INJ (QL= 2 inj/28 days)	MSP-PA-QL	5
HADLIMA PUSH INJ 40MG/0.8ML (QL= 2 inj/28 days)	MSP-PA-QL	5
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	MSP-PA-QL	5
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	MSP-PA-QL	5
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	MSP-PA-QL	5
HUMIRA INJ 80MG (QL= 2 syringes/28 days)	MSP-PA-QL	5
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan yea	MSP-PA-QL	5
HUMIRA INJ PEDIATRIC UC STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	MSP-PA-QL	5
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan yea	MSP-PA-QL	5
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	MSP-PA-QL	5
SIMLANDI INJ (adalimumab-ryvk) (QL= 2 inj/28 days)	MSP-PA-QL	5
SIMLANDI KIT (adalimumab-ryvk) (QL= 2 inj/28 days)	MSP-PA-QL	5
ABRILADA INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ADALIMUMAB-ADAZ INJ	-	NC
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv)	-	NC
ADALIMUMAB-ADAZ INJ 10/0.1ML	-	NC
ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv)	-	NC
ADALIMUMAB-RYVK INJ	-	NC
ADALIMUMAB-RYVK INJ (SIMLANDI equiv)	-	NC
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC
AMJEVITA INJ (adalimumab-atto)	-	NC
CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm)	-	NC
CYLTEZO INJ (adalimumab-adbm)	-	NC
HULIO INJ (adalimumab-fkjp)	-	NC
HULIO KIT (adalimumab-fkjp)	-	NC
HYRIMOZ INJ (adalimumab-adaz)	-	NC
HYRIMOZ PFS INJ (adalimumab-adaz)	-	NC
IDACIO INJ (adalimumab-aacf)	-	NC
SIMPONI ARIA INJ	-	NC
SIMPONI AUTO-INJECTOR 100MG	-	NC
SIMPONI AUTO-INJECTOR 50MG	-	NC
SIMPONI INJ 100MG	-	NC
SIMPONI INJ 50MG	-	NC
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
YUFLYMA KIT (adalimumab-aaty)	-	NC
YUSIMRY INJ (adalimumab-aqvh)	-	NC
GOLD COMPOUNDS		
AURANOFIN CAP, RIDAURA CAP	-	NC
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ	-	NC
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ	-	NC
INTERLEUKIN-6 RECEPTOR INHIBITORS		
AVTOZMA INJ (QL= 2 inj/28 days)	MSP-PA-QL	5
TYENNE INJ (QL= 2 inj/28 days)	MSP-PA-QL	5
ACTEMRA ACTPEN INJ	-	NC
ACTEMRA IV INJ	-	NC
ACTEMRA SC INJ	-	NC
KEVZARA INJ	-	NC
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap (CELEBREX equiv)	-	2
diclofenac potassium tab (CATAFLAM equiv)	-	2
diclofenac sodium EC tab (VOLTAREN equiv)	-	2
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	2
etodolac cap (LODINE equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
etodolac tab	-	2
FLURBIPROFEN TAB	-	2
flurbiprofen tab (ANSAID equiv)	-	2
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	2
ibuprofen tab	-	2
ibuprofen tab (Rx covered Only)	-	2
indomethacin cap (INDOCIN equiv)	-	2
indomethacin CR cap (INDOCIN SR equiv)	-	2
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	2
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	2
meloxicam tab (MOBIC equiv)	-	2
nabumetone tab (RELAFEN equiv)	-	2
naproxen sodium tab (ANAPROX equiv)	-	2
naproxen tab (NAPROSYN equiv)	-	2
piroxicam cap (FELDENE equiv)	-	2
sulindac tab (CLINORIL equiv)	-	2
mefenamic acid cap (PONSTEL equiv)	-	3
naproxen EC tab (NAPROSYN EC equiv)	-	3
oxaprozin tab (DAYPRO equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
etodolac ER tab (LODINE XL equiv)	-	4
FENOPROFEN TAB	-	4
KETOPROFEN ER CAP	-	4
MECLOFENAMATE CAP	-	4
ANAPROX TAB	-	NC
ARTHROTEC TAB	-	NC
CELEBREX CAP	-	NC
COMBOGESIC TAB	-	NC
COXANTO CAP	-	NC
DAYPRO TAB	-	NC
DICLOFENAC CAP	-	NC
diclofenac potassium cap (ZIPSOR equiv)	-	NC
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC
DUEXIS TAB	-	NC
FELDENE CAP	-	NC
fenoprofen calcium cap (NALFON equiv)	-	NC
FENOPROFEN CAP, NAFLON CAP	-	NC
FENOPRON CAP	-	NC
IBU 600-EZS KIT	-	NC
IBUPROFEN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ibuprofen-famotidine tab	-	NC
INDOCIN SUPP	-	NC
INDOCIN SUSP	-	NC
INDOMETHACIN CAP, TIVORBEX CAP	-	NC
indomethacin suppository (INDOCIN equiv)	-	NC
indomethacin susp (INDOCIN equiv)	-	NC
INFLATHERM PAK	-	NC
KETOPROFEN CAP	-	NC
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
LURBIRO TAB 100MG	-	NC
meloxicam cap (VIVLODEX equiv)	-	NC
MELOXICAM COMFORT KIT	-	NC
MELOXICAM SUSP, ZYBIC SUSP	-	NC
MOBIC TAB	-	NC
MOTRIN SUSP	-	NC
NAFLON CAP	-	NC
NAPRELAN CR TAB	-	NC
NAPROSYN EC TAB	-	NC
NAPROSYN EC TAB 500MG	-	NC
NAPROSYN SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
NAPROSYN TAB	-	NC
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC
NAPROXEN SOD ER TAB	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
NAPROXEN SUSP	-	NC
naproxen susp (NAPROSYN equiv)	-	NC
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC
ORUDIS CAP	-	NC
PONSTEL CAP	-	NC
QMIIZ ODT TAB	-	NC
RELAFEN DS TAB	-	NC
SPRIX NASAL SPRAY	-	NC
TOLECTIN DS CAP, TOLMETIN CAP	-	NC
TOLECTIN TAB	-	NC
TOLMETIN TAB, TOLECTIN TAB	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	NC
VYSCOXA SUSP	-	NC
YBUPHEN TAB	-	NC
ZIPSOR CAP	-	NC
ZORVOLEX CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	MSP-PA-QL	5
OTEZLA TAB (QL= 2 tabs/day)	MSP-PA-QL	5
OTEZLA XR TAB (QL= 1 tab/day)	MSP-PA-QL	5
OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days)	MSP-PA-QL	5
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	2
ARAVA TAB	-	NC
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ	-	NC
ORENCIA SC INJ 125MG/ML	-	NC
ORENCIA SC INJ 50MG/0.4ML	-	NC
ORENCIA SC INJ 87.5MG/0.7ML	-	NC
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	MSP-PA-QL	5
ENBREL INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	5
ENBREL MINI INJ (QL= 4 inj/28 days)	MSP-PA-QL	5
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	MSP-PA-QL	5
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
ALLZITAL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
BUTALBITAL/ACETAMINOPHEN CAP	-	NC
butalbital/acetaminophen/caffeine soln	-	NC
butalbital/acetaminophen/caffeine tab (FIORICET equiv)	-	NC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
DOLGIC PLUS TAB	-	NC
ESGIC TAB	-	NC
FIORICET CAP	-	NC
FIORINAL CAP	-	NC
VTOL SOLN	-	NC
ANALGESICS - SODIUM CHANNEL PAIN SIGNAL INHIBITORS		
JOURNAVX TAB	-	NC
SALICYLATES		
aspirin chew tab 81mg (Covered for male members age 45-79 years; Covered for female members (no age restriction))	OTC	1
aspirin ec tab 325mg	OTC	1
aspirin ec tab 81mg (Covered for male members age 45-79 years; Covered for female members age 55-79 years)	OTC	1
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	1
diflunisal tab (DOLOBID equiv)	-	2
SALSALATE TAB	-	3
salsalate tab (DISALCID equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
DOLOBID TAB	-	NC
ANALGESICS - OPIOID		
OPIOID AGONISTS		
codeine sulfate tab	-	2
DISKETS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	2
hydromorphone tab (DILAUDID equiv)	-	2
methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opio ER Dependency))	ST	2
methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid opioid naïve (Opioid ER Dependency))	ST	2
methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioi ER Dependency))	ST	2
morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through II opioid if opioid naïve (Opioid ER Dependency))	ST	2
MORPHINE SULFATE ORAL SOLN 10 MG/5ML	-	2
MORPHINE SULFATE ORAL SOLN 100MG/5ML	-	2
morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv)	-	2
morphine sulfate soln	-	2
MORPHINE SULFATE SOLN 20MG/5ML	-	2
morphine sulfate tab	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
oxycodone cap (OXYIR equiv)	-	2
oxycodone tab (ROXICODONE equiv)	-	2
tramadol tab (ULTRAM equiv)	-	2
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	3
fentanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	3
HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy requires ste through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3
MORPHINE SULFATE SUPP	-	3
NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid opioid naïve (Opioid ER Dependency))	QL-ST	3
oxycodone conc (ROXICODONE equiv)	-	3
oxycodone soln (ROXICODONE equiv)	-	3
OXYIR CAP	-	3
XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	3
hydromorphone ER tab (EXALGO equiv) (QL= 1 tab/day; Step Therapy requires ste through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
MORPHINE SULFATE ER BEAD CAP (Step Therapy requires step through IR opio if opioid naïve (Opioid ER Dependency))	ST	4
NUCYNTA TAB	-	4
tapentadol hcl tab (NUCYNTA equiv)	-	4
tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid opioid naïve (Opioid ER Dependency))	ST	4
TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	4
ABSTRAL SL TAB	-	NC
ACTIQ LOZENGE	-	NC
DEMEROL TAB	-	NC
DILAUDID TAB	-	NC
DSUVIA SL TAB	-	NC
FENTANYL BUCCAL TAB	-	NC
FENTANYL CITRATE LOLLIPOP	-	NC
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC
FENTORA TAB	-	NC
HYDROCODONE BITARTRATE ER CAP	-	NC
HYDROMORPHONE SUPP	-	NC
KADIAN CAP	-	NC
LAZANDA NASAL SPRAY	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
levorphanol tab (LEVORPHANOL equiv)	-	NC
meperidine tab (DEMEROL equiv)	-	NC
METHADOSE CONC	-	NC
MORPHABOND TAB	-	NC
MS CONTIN TAB	-	NC
OPANA TAB	-	NC
OXYCODONE TAB	-	NC
OXYCONTIN CR TAB	-	NC
oxymorphone tab	-	NC
QDOLO SOLN, TRAMADOL SOLN	-	NC
ROXICODONE TAB	-	NC
ROXYBOND TAB	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC
TAPENTADOL ER TAB 100MG	-	NC
TAPENTADOL ER TAB 150MG	-	NC
TAPENTADOL ER TAB 200MG	-	NC
TAPENTADOL ER TAB 250MG	-	NC
TAPENTADOL ER TAB 50MG	-	NC
TAPENTADOL SOLN	-	NC
TRAMADOL ER CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
TRAMADOL HCL TAB	-	NC
tramadol hcl tab 100mg	-	NC
ULTRAM TAB	-	NC
OPIOID COMBINATIONS		
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	2
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	2
hydrocodone/acetaminophen tab (LORTAB equiv)	-	2
oxycodone/acetaminophen tab (PERCOCET equiv)	-	2
tramadol/acetaminophen tab (ULTRACET equiv)	-	2
APAP/CODEINE SOLN	-	3
OXYCODONE/ACETAMINOPHEN SOLN	-	3
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	4
hydrocodone/acetaminophen tab 2.5-325mg (NORCO equiv)	-	4
HYDROCODONE/IBUPROFEN TAB	-	4
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	4
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	4
LORTAB ELIXIR	-	4
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC
APADAZ TAB	-	NC
FIORICET/CODEINE CAP	-	NC
FIORINAL/CODEINE CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC
LORTAB	-	NC
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC
PERCOCET TAB	-	NC
PRIMLEV TAB 10-300MG	-	NC
PRIMLEV TAB 5-300MG	-	NC
PROLATE TAB 7.5-300MG	-	NC
SEGLENTIS TAB	-	NC
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC
TYLENOL/CODEINE TAB	-	NC
ULTRACET TAB	-	NC
VERDROCET TAB 2.5MG-325MG	-	NC
VICOPROFEN TAB	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
buprenorphine/naloxone sl film (SUBOXONE equiv)	-	2
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	2
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	3
ZUBSOLV SL TAB	-	3
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	4
PENTAZOCINE/NALOXONE TAB	-	4
pentazocine/naloxone tab (TALWIN NX equiv)	-	4
BELBUCA FILM	-	NC
BUNAVAIL FILM	-	NC
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC
buprenorphine SL tab (SUBUTEX equiv)	-	NC
BUTRANS PATCH	-	NC
nalbuphine inj	-	NC
SUBLOCADE SOLN, BRIXADI SOLN	-	NC
SUBOXONE SL FILM	-	NC
ANDROGENS-ANABOLIC		
ANABOLIC STEROIDS		
ANADROL TAB	-	4
ANDROGENS		
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
danazol cap (DANOCRINE equiv)	-	3
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	3
TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day)	PA-QL	3
testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	3
testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	3
testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv) (QL= 4 bottles/30 days)	PA-QL	3
TESTOSTERONE GEL PUMP 1% (QL= 4 bottles/30 days)	PA-QL	3
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	3
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	3
methyltestosterone cap	PA	4
testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day)	PA-QL	4
testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day)	PA-QL	4
TESTOSTERONE GEL 20.25MG/1.25GM (QL= 1 packet/day)	PA-QL	4
ANDROGEL 1% 25MG	-	NC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC
ANDROGEL 1.62% 1.25GM	-	NC
ANDROGEL 1.62% 2.5GM	-	NC
ANDROGEL PUMP 1.62%	-	NC
FORTESTA GEL 2%	-	NC
KYZATREX CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC
METHITEST TAB	-	NC
NATESTO GEL	-	NC
NATESTO NASAL GEL	-	NC
STRIANT FILM	-	NC
TESTOSTERONE GEL 10MG/ACT	-	NC
testosterone gel 2% (FORTESTA equiv)	-	NC
TESTOSTERONE GEL, VOGELXO GEL	-	NC
VOGELXO GEL PUMP 1%	-	NC
XYOSTED INJ	-	NC
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
hydrocortisone enema (CORTENEMA equiv)	-	3
CORTIFOAM	-	4
CORTENEMA	-	NC
RECTAL COMBINATIONS		
PROCTOFOAM HC FOAM	-	3
ANALPRAM-E KIT	-	4
ANALPRAM-HC CREAM	-	NC
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC
PROCORT CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANORECTAL AGENTS Cont.		
RECTAL STEROIDS		
proctosol HC cream (ANUSOL HC equiv)	-	2
ANUSOL-HC CREAM	-	NC
hydrocortisone supp (ANUSOL HC equiv)	-	NC
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS		
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	PA	4
UCERIS RECTAL FOAM	PA	4
RECTAL COMBINATIONS		
LIDOCAINE/HC CREAM	-	3
ANALPRAM HC CREAM 2.5-1%	-	NC
ANALPRAM-HC CREAM	-	NC
HYDROCORTISONE/PRAMOXINE SUPP	-	NC
RECTAL LOCAL ANESTHETICS		
LIDOCAINE SUPP	-	NC
RECTAL STEROIDS		
HYDROCORTISONE CREAM	-	2
ANUCORT-HC SUPP	-	NC
VASODILATING AGENTS		
nitroglycerin oint (RECTIV equiv)	-	4
RECTIV OINT	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANTHELMINTICS		
ANTHELMINTICS		
mebendazole chew tab	-	2
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	3
ivermectin tab (STROMECTOL equiv)	-	3
praziquantel tab (BILTRICIDE equiv)	-	3
albendazole tab (ALBENZA equiv)	-	4
ALBENZA TAB	-	NC
BILTRICIDE TAB	-	NC
EGATEN TAB	-	NC
EMVERM TAB	-	NC
IVERMECTIN TAB	-	NC
STROMECTOL TAB	-	NC
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
ranolazine tab (RANEXA equiv)	-	2
ASPRUZYO SPRINKLE GRANULES	-	NC
RANEXA TAB	-	NC
NITRATES		
isosorbide dinitrate tab (ISORDIL equiv)	-	2
isosorbide mononitrate ER tab (IMDUR equiv)	-	2
isosorbide mononitrate tab (MONOKET equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIANGINAL AGENTS Cont.		
NITROGLYCERIN ER CAP	-	2
nitroglycerin patch (NITRO-DUR equiv)	-	2
nitroglycerin SL tab (NITROSTAT equiv)	-	2
nitroglycerin oint	-	3
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	4
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	4
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	4
GONITRO POWDER	-	NC
ISORDIL TITRADOSE TAB	-	NC
NITRO-DUR PATCH	-	NC
NITROLINGUAL PUMP SPRAY	-	NC
NITROSTAT SL TAB	-	NC
ANTIANXIETY AGENTS		
ANTIANXIETY AGENTS - MISC.		
buspirone tab (BUSPAR equiv)	-	2
hydroxyzine pamoate cap (VISTARIL equiv)	-	2
HYDROXYZINE PAMOATE CAP 100MG	-	2
hydroxyzine syrup (ATARAX equiv)	-	2
hydroxyzine tab (ATARAX equiv)	-	2
meprobamate tab (MILTOWN equiv)	-	4
BUCAPSOL CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIANXIETY AGENTS Cont.		
BUSPIRONE TAB	-	NC
VISTARIL CAP	-	NC
BENZODIAZEPINES		
alprazolam tab (XANAX equiv)	-	2
diazepam conc (VALIUM equiv)	-	2
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	2
diazepam tab (VALIUM equiv)	-	2
lorazepam conc (ATIVAN equiv)	-	2
lorazepam tab (ATIVAN equiv)	-	2
alprazolam ER tab (XANAX XR equiv)	-	3
alprazolam ODT (NIRAVAM equiv)	-	4
ATIVAN TAB	-	NC
chlordiazepoxide cap (LIBRIUM equiv)	-	NC
clorazepate tab (TRANXENE-T equiv)	-	NC
LOREEV XR CAP	-	NC
NIRAVAM ODT	-	NC
oxazepam cap (SERAX equiv)	-	NC
TRANXENE-T TAB	-	NC
VALIUM TAB	-	NC
XANAX TAB	-	NC
XANAX XR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide cap (NORPACE equiv)	-	2
quinidine sulfate tab	-	2
NORPACE CR CAP	-	3
quinidine gluconate CR tab	-	3
NORPACE CAP	-	NC
procainamide inj	-	NC
QUINIDINE SULFATE TAB	-	NC
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap	-	3
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	2
propafenone tab (RYTHMOL equiv)	-	2
propafenone ER cap (RYTHMOL SR equiv)	-	3
RYTHMOL SR CAP	-	NC
ANTIARRHYTHMICS TYPE III		
amiodarone tab (CORDARONE equiv)	-	2
dofetilide cap (TIKOSYN equiv)	-	3
MULTAQ TAB	-	3
CORDARONE TAB	-	NC
TIKOSYN CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
TEZSPIRE INJ (QL= 1 pen/28 days)	MSP-PA-QL	5
FASENRA PEN INJ	-	NC
NUCALA INJ	-	NC
OMLYCLO SYRINGE	-	NC
OMLYCLO SYRINGE 150MG/ML	-	NC
OMLYCLO SYRINGE 300MG/2ML	-	NC
XOLAIR INJ	-	NC
XOLAIR INJ 150MG/ML	-	NC
XOLAIR INJ 300MG/2ML	-	NC
XOLAIR SYRINGE	-	NC
XOLAIR SYRINGE 150MG/ML	-	NC
XOLAIR SYRINGE 300MG/2ML	-	NC
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	NC
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium neb soln (ATROVENT equiv)	-	2
ATROVENT HFA AERO	-	3
INCRUSE ELLIPTA INHALER	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therap requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), or BUDESONIDE/FORMOTEROL)	QL-ST	3
SPIRIVA HANDIHALER (For use with Handihaler device)	PA	4
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	PA	4
tiotropium bromide cap inhaler (SPIRIVA equiv) (For use with Handihaler device)	PA	4
ipratropium bromide hfa inhaler aerosol (ATROVENT equiv)	-	NC
TUDORZA PRESSAIR INHALER	-	NC
UMECLIDINIUM ELLIPTA INHALER 62.5MCG/INH	-	NC
YUPELRI SOLN	-	NC
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	2
montelukast tab (SINGULAIR equiv)	-	2
montelukast granule pack (SINGULAIR equiv)	-	3
zafirlukast tab (ACCOLATE equiv)	-	3
ZYFLO TAB	-	4
ACCOLATE TAB	-	NC
SINGULAIR CHEW TAB	-	NC
SINGULAIR GRANULE PACK	-	NC
SINGULAIR TAB	-	NC
zileuton ER tab (ZYFLO CR equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
ZYFLO CR TAB	-	NC
PHOSPHODIESTERASE 3 & 4 (PDE3 & PDE4) INHIBITORS		
OHTUVAYRE SUSP	-	NC
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
roflumilast tab (DALIRESP equiv)	-	3
DALIRESP TAB	-	NC
STEROID INHALANTS		
budesonide inh susp (PULMICORT equiv)	-	2
ALVESCO INHALER	-	3
ARNUITY ELLIPTA INHALER	-	3
ASMANEX HFA INHALER	-	3
ASMANEX INHALER	-	3
QVAR REDIHALER	-	3
FLUTICASONE DISKUS INHALER	-	4
FLUTICASONE HFA INHALER	-	4
fluticasone propionate hfa inhal aero (FLUTICASONE equiv)	-	4
AEROSPAN INH	-	NC
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC
FLOVENT DISKUS INHALER	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
FLOVENT HFA INHALER	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/ACT	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/ACT	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT	-	NC
PULMICORT FLEXHALER	-	NC
PULMICORT INH SUSP	-	NC
QVAR AERO	-	NC
SYMPATHOMIMETICS		
albuterol HFA (18gm) inhaler (VENTOLIN equiv) (QL= 2 inhalers/30 days)	QL	2
albuterol HFA (6.7gm, 8.5gm) inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	2
albuterol neb soln	-	2
ALBUTEROL NEBULIZER SOLN	-	2
albuterol sulfate syrup	-	2
albuterol/ipratropium neb soln (DUONEB equiv)	-	2
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	2
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	2
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	2
ADVAIR HFA INHALER	-	3
albuterol sulfate tab	-	3
BREO ELLIPTA INHALER	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	3
budesonide/formoterol inhaler (SYMBICORT equiv)	-	3
COMBIVENT RESPIMAT INHALER	-	3
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	3
levalbuterol neb soln (XOPENEX equiv)	-	3
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	3
terbutaline sulfate tab (BRETHINE equiv)	-	3
ARCAPTA NEOHALER	-	4
formoterol fumarate neb soln (PERFOROMIST equiv)	-	4
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/3(days)	QL	4
PERFOROMIST NEB SOLN	-	4
ADVAIR DISKUS INHALER	-	NC
AIRDUO POWDER INHALER W/SENSOR	-	NC
AIRDUO RESPICLICK	-	NC
AIRSUPRA INH	-	NC
ANORO ELLIPTA INHALER	-	NC
arformoterol tartrate neb soln (BROVANA equiv)	-	NC
BEVESPI AEROSPHERE INHALER	-	NC
BREZTRI AEROSPHERE INHALER	-	NC
BREZTRI AEROSPHERE INHALER 160-18-4.8 MCG/ACT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
BROVANA NEB SOLN	-	NC
DUAKLIR INHALER	-	NC
DULERA INHALER	-	NC
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC
PROAIR RESPICLICK INHALER	-	NC
SEREVENT DISKUS INHALER	-	NC
STIOLTO INHALER	-	NC
SYMBICORT INHALER	-	NC
TRELEGY ELLIPTA INHALER	-	NC
UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT	-	NC
VENTOLIN HFA INHALER	-	NC
XOPENEX NEB SOLN	-	NC
XANTHINES		
theophylline ER tab (UNIPHYL equiv)	-	2
theophylline soln	-	2
ELIXOPHYLLIN ELIXIR	-	3
THEOPHYLLINE TAB ER	-	3
theophylline tab er (THEOPHYLLINE ER equiv)	-	3
THEO-24 CAP	-	4
ANTICOAGULANTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	2
COUMADIN TAB	-	NC
DIRECT FACTOR XA INHIBITORS		
rivaroxaban for susp (XARELTO equiv)	-	2
rivaroxaban tab 2.5mg (XARELTO equiv)	-	2
ELIQUIS SPRINKLE CAP	-	3
ELIQUIS TAB FOR ORAL SUSP	-	3
ELIQUIS TAB, ELIQUIS STARTER PACK	-	3
XARELTO STARTER PACK	-	3
XARELTO SUSP	-	3
XARELTO TAB	-	3
SAVAYSA TAB	-	NC
HEPARINS AND HEPARINOID-LIKE AGENTS		
enoxaparin inj (LOVENOX equiv)	-	3
fondaparinux inj (ARIXTRA equiv)	-	3
ARIXTRA INJ	-	NC
FRAGMIN INJ	-	NC
heparin porcine inj	-	NC
LOVENOX INJ	-	NC
THROMBIN INHIBITORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICOAGULANTS Cont.		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	3
PRADAXA CAP	-	4
PRADAXA PELLET PACK	-	NC
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA SUSP	-	NC
FYCOMPA TAB	-	NC
perampanel susp (FYCOMPA equiv)	-	NC
perampanel tab (FYCOMPA equiv)	-	NC
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older)	PA	2
clonazepam tab (KLONOPIN equiv)	-	2
diazepam rectal gel (QL= 4 doses/fill)	QL	3
clonazepam ODT (KLONOPIN equiv)	-	4
VALTOCO NASAL SPRAY (QL= 5 doses/fill)	QL	4
clobazam tab (ONFI equiv)	-	NC
DIASTAT ACDL GEL	-	NC
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	-	NC
KLONOPIN TAB	-	NC
LIBERVANT FILM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
MIDAZOLAM INJ	-	NC
NAYZILAM SPRAY	-	NC
ONFI SUSP	-	NC
ONFI TAB	-	NC
SYMPAZAN ORAL FILM	-	NC
ANTICONVULSANTS - MISC.		
carbamazepine chew tab (TEGRETOL equiv)	-	2
carbamazepine susp (TEGRETOL equiv)	-	2
carbamazepine tab (TEGRETOL equiv)	-	2
gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day)	QL	2
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	2
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	2
lacosamide oral solution (VIMPAT equiv)	-	2
lacosamide tab (VIMPAT equiv)	-	2
lamotrigine chew tab (LAMICTAL equiv)	-	2
lamotrigine tab (LAMICTAL equiv)	-	2
levetiracetam ER tab (KEPPRA XR equiv)	-	2
levetiracetam soln (KEPPRA equiv)	-	2
levetiracetam tab (KEPPRA equiv)	-	2
oxcarbazepine susp (TRILEPTAL equiv)	-	2
oxcarbazepine tab (TRILEPTAL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	2
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	2
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	2
primidone tab (MYSOLINE equiv)	-	2
topiramate sprinkle cap (TOPAMAX equiv)	-	2
topiramate tab (TOPAMAX equiv)	-	2
zonisamide cap (ZONEGRAN equiv)	-	2
carbamazepine ER cap (CARBATROL equiv)	-	3
carbamazepine ER tab (TEGRETOL XR equiv)	-	3
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	3
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	3
rufinamide susp (BANZEL equiv) (Prior Authorization required for members age 9 years and older)	PA	3
rufinamide tab (BANZEL equiv)	-	3
EPRONTIA SOLN (Prior Authorization required for members age 9 years and older)	PA	4
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	4
lamotrigine ER tab (LAMICTAL XR equiv)	-	4
lamotrigine starter kit (LAMICTAL STARTER KIT equiv)	-	4
SUBVENITE SUSP (Prior Authorization required for members age 9 years and olde	PA	4
topiramate oral soln (EPRONTIA equiv) (Prior Authorization required for members a 9 years and older)	PA	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
ZONISADE SUSP (Prior Authorization required for members age 9 years and older	PA	4
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	5
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	5
APTIOM TAB	-	NC
BANZEL SUSP	-	NC
BANZEL TAB	-	NC
brivaracetam inj (BRIVIACT equiv)	-	NC
brivaracetam oral soln 10mg/ml (BRIVIACT equiv)	-	NC
brivaracetam tab (BRIVIACT equiv)	-	NC
BRIVIACT INJ	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
CARBAMAZEPINE CHEW TAB	-	NC
CARBATROL CAP	-	NC
DIACOMIT CAP	-	NC
DIACOMIT POWDER PACK	-	NC
ELEPSIA XR TAB	-	NC
eslicarbazepine acetate tab (APTIOM equiv)	-	NC
FINTEPLA SOLN	-	NC
gabapentin cap 200mg (RELGAABI equiv)	-	NC
GABARONE TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
KEPPRA SOLN	-	NC
KEPPRA TAB	-	NC
KEPPRA XR TAB	-	NC
LAMICTAL CHEW TAB	-	NC
LAMICTAL ODT	-	NC
LAMICTAL ODT KIT	-	NC
LAMICTAL STARTER KIT	-	NC
LAMICTAL TAB	-	NC
LAMICTAL XR TAB	-	NC
lamotrigine ODT (LAMICTAL equiv)	-	NC
lamotrigine ODT kit (LAMICTAL equiv)	-	NC
LEVETIRACETAM TAB FOR ORAL SUSP, SPRITAM TAB FOR ORAL SUSP	-	NC
LYRICA CAP	-	NC
LYRICA CAP 225MG	-	NC
LYRICA CAP 300MG	-	NC
LYRICA SOLN	-	NC
MOTPOLY XR CAP	-	NC
MYSOLINE TAB	-	NC
NEURONTIN CAP	-	NC
NEURONTIN SOLN	-	NC
NEURONTIN TAB 600MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
NEURONTIN TAB 800MG	-	NC
oxcarbazepine er tab (OXTELLAR equiv)	-	NC
OXTELLAR XR TAB	-	NC
PRIMIDONE TAB	-	NC
QUDEXY XR CAP	-	NC
TEGRETOL SUSP	-	NC
TEGRETOL TAB	-	NC
TEGRETOL XR TAB	-	NC
TOPAMAX SPRINKLE CAP	-	NC
TOPAMAX TAB	-	NC
topiramate ER cap (QUDEXY equiv)	-	NC
topiramate er cap (TROKENDI XR equiv)	-	NC
TRILEPTAL SUSP	-	NC
TRILEPTAL TAB	-	NC
TROKENDI XR CAP	-	NC
VIMPAT SOLN	-	NC
VIMPAT TAB	-	NC
ZONEGRAN CAP	-	NC
CARBAMATES		
felbamate susp (FELBATOL equiv)	-	3
felbamate tab (FELBATOL equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
FELBATOL SUSP	-	NC
FELBATOL TAB	-	NC
XCOPRI PAK 100-150MG	-	NC
XCOPRI PAK 150-200MG	-	NC
XCOPRI TAB 150MG, 200MG	-	NC
XCOPRI TAB 25MG	-	NC
XCOPRI TAB 50MG, 100MG	-	NC
XCOPRI TITRATION PAK 12.5-25MG	-	NC
XCOPRI TITRATION PAK 150-200MG	-	NC
XCOPRI TITRATION PAK 50-100MG	-	NC
GABA MODULATORS		
TIAGABINE TAB	-	3
tiagabine tab (GABITRIL equiv)	-	3
GABITRIL TAB	-	NC
SABRIL POWDER PACK	-	NC
SABRIL TAB	-	NC
vigabatrin powder pack (SABRIL POWDER equiv)	-	NC
vigabatrin tab (SABRIL equiv)	-	NC
vigadrone powder pack	-	NC
VIGAFYDE SOLN	-	NC
HYDANTOINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
phenytoin cap (DILANTIN equiv)	-	2
phenytoin susp (DILANTIN equiv)	-	2
DILANTIN CAP 30MG	-	3
phenytoin chew tab (DILANTIN equiv)	-	3
DILANTIN CAP 100MG	-	NC
DILANTIN INFATABS	-	NC
DILANTIN SUSP	-	NC
SUCCINIMIDES		
ethosuximide soln (ZARONTIN equiv)	-	2
ethosuximide cap (ZARONTIN equiv)	-	3
methsuximide cap (CELONTIN equiv)	-	3
CELONTIN CAP	-	4
ZARONTIN CAP	-	NC
ZARONTIN SOLN	-	NC
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	2
divalproex sodium DR tab (DEPAKOTE equiv)	-	2
divalproex sprinkle cap (DEPAKOTE equiv)	-	2
valproic acid cap (DEPAKENE equiv)	-	2
valproic acid syrup (DEPAKENE equiv)	-	2
DEPACON INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
DEPAKENE CAP	-	NC
DEPAKENE SYRUP	-	NC
DEPAKOTE ER TAB	-	NC
DEPAKOTE SPRINKLE CAP	-	NC
DEPAKOTE TAB	-	NC
STAVZOR CAP	-	NC
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	2
mirtazapine tab (REMERON equiv)	-	2
REMERON SOLUTAB	-	NC
REMERON TAB	-	NC
ANTIDEPRESSANT COMBINATIONS		
AUVELITY TAB	-	NC
AUVELITY TAB TITRATION PACK	-	NC
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	2
bupropion tab (WELLBUTRIN equiv)	-	2
bupropion XL tab (WELLBUTRIN XL equiv)	-	2
APLENZIN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
BUPROPION XL TAB, FORFIVO XL TAB	-	NC
WELLBUTRIN SR TAB	-	NC
WELLBUTRIN XL TAB	-	NC
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID		
ZURZUVAE CAP 20MG, 25MG	-	NC
ZURZUVAE CAP 30MG	-	NC
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
PHENELZINE SULFATE TAB	-	2
phenelzine tab (NARDIL equiv)	-	2
tranylcypromine tab (PARNATE equiv)	-	3
EMSAM PATCH	-	4
NARDIL TAB 15MG	-	4
MARPLAN TAB	-	NC
PARNATE TAB	-	NC
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	2
citalopram tab (CELEXA equiv)	-	2
escitalopram tab (LEXAPRO equiv)	-	2
fluoxetine cap (PROZAC equiv)	-	2
fluoxetine soln (PROZAC equiv)	-	2
fluoxetine tab (PROZAC equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
fluvoxamine tab (LUVOX equiv)	-	2
paroxetine tab (PAXIL equiv)	-	2
sertraline conc (ZOLOFT equiv)	-	2
sertraline tab (ZOLOFT equiv)	-	2
escitalopram soln (LEXAPRO equiv)	-	3
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	3
paroxetine ER tab (PAXIL CR equiv)	-	3
FLUOXETINE TAB	-	4
PAROXETINE SUSP	-	4
PAXIL ORAL SUSP	-	4
CELEXA TAB	-	NC
CITALOPRAM CAP	-	NC
citalopram hydrobromide cap	-	NC
ESCITALOPRAM CAP	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC
LEXAPRO TAB	-	NC
PAXIL CR TAB	-	NC
PAXIL TAB	-	NC
PEXEVA TAB	-	NC
PROZAC CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
PROZAC WEEKLY CAP	-	NC
SERTRALINE CAP	-	NC
sertraline hcl cap	-	NC
ZOLOFT CONC	-	NC
ZOLOFT TAB	-	NC
SEROTONIN MODULATORS		
trazodone tab (DESYREL equiv)	-	2
vilazodone hcl tab (VIIBRYD equiv)	-	3
NEFAZODONE TAB	-	4
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL-¢	4
EXXUA TAB/EXXUA TITRATION PACK	-	NC
RALDESY SOLN	-	NC
trazodone tab 300mg (DESYREL equiv)	-	NC
VIIBRYD STARTER KIT	-	NC
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
desvenlafaxine ER tab (PRISTIQ equiv)	-	2
duloxetine EC cap (CYMBALTA equiv)	-	2
venlafaxine ER cap (EFFEXOR XR equiv)	-	2
venlafaxine tab (EFFEXOR equiv)	-	2
CYMBALTA CAP	-	NC
DESVENLAFAXINE ER TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
DRIZALMA DR CAP	-	NC
duloxetine cap 40mg (IRENKA equiv)	-	NC
DULOXETINE DR CAP	-	NC
EFFEXOR XR CAP	-	NC
FETZIMA CAP	-	NC
FETZIMA TITRATION PACK	-	NC
PRISTIQ TAB	-	NC
venlafaxine ER tab	-	NC
VENLAFAXINE TAB	-	NC
TRICYCLIC AGENTS		
amitriptyline tab (ELAVIL equiv)	-	2
amoxapine tab (AMOXAPINE equiv)	-	2
doxepin cap (SINEQUAN equiv)	-	2
doxepin conc (SINEQUAN equiv)	-	2
DOXEPIN HCL CAP	-	2
DOXEPIN HCL CONC	-	2
imipramine tab (TOFRANIL equiv)	-	2
nortriptyline cap (PAMELOR equiv)	-	2
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	2
desipramine tab (NORPRAMIN equiv)	-	3
clomipramine cap (ANAFRANIL equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
imipramine pamoate cap (TOFRANIL PM equiv)	-	4
protriptyline tab (VIVACTIL equiv)	-	4
trimipramine cap (SURMONTIL equiv)	-	4
ANAFRANIL CAP	-	NC
NORPRAMIN TAB	-	NC
PAMELOR CAP	-	NC
SURMONTIL CAP	-	NC
TOFRANIL TAB	-	NC
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab (PRECOSE equiv)	-	2
MIGLITOL TAB	-	4
miglitol tab (MIGLITOL equiv)	-	4
PRECOSE TAB	-	NC
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN INJ	-	NC
ANTIDIABETIC COMBINATIONS		
dapagliflozin-metformin er tab (XIGDUO XR equiv) (QL= 1 tab/day)	QL	2
dapagliflozin-metformin er tab 5-1000MG (XIGDUO XR equiv) (QL= 2 tabs/day)	QL	2
glipizide/metformin tab (METAGLIP equiv)	-	2
glyburide/metformin tab (GLUCOVANCE equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
GLYXAMBI TAB (QL= 1 tab/day)	QL	3
JANUMET XR TAB (QL= 2 tabs/day)	QL	3
JENTADUETO TAB (QL= 2 tabs/day)	QL	3
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	3
sitagliptin phosphate-metformin hcl er tab (JANUMET equiv) (QL= 2 tabs/day)	QL	3
sitagliptin phosphate-metformin hcl tab (JANUMET equiv) (QL= 2 tabs/day)	QL	3
SOLIQUA INJ (QL= 15ml/25 days)	PA-QL	3
SYNJARDY TAB (QL= 2 tabs/day)	QL	3
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	3
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	3
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	3
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	3
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	3
XIGDUO XR TAB 2.5-1000 (QL= 2 tabs/day)	QL	3
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	3
ACTOPLUS MET TAB	-	NC
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC
ALOGLIPTIN-METFORMIN TAB	-	NC
ALOGLIPTIN-PIOGILTAZONE TAB	-	NC
DUETACT TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
INVOKAMET TAB	-	NC
INVOKAMET XR TAB	-	NC
JANUMET TAB	-	NC
KOMBIGLYZE XR TAB	-	NC
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC
PRANDIMET TAB	-	NC
QTERN TAB	-	NC
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC
SEGLUROMET TAB	-	NC
SITAGLIPTIN/METFORMIN TAB	-	NC
STEGLUJAN TAB	-	NC
XIGDUO XR TAB	-	NC
ZITUVIMET XR TAB	-	NC
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	2
metformin tab (GLUCOPHAGE equiv)	-	2
metformin soln (RIOMET equiv)	-	4
FORTAMET TAB	-	NC
GLUCOPHAGE TAB	-	NC
GLUCOPHAGE XR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
GLUMETZA TAB 1000MG	-	NC
GLUMETZA TAB 500MG	-	NC
metformin ER osmotic tab (FORTAMET equiv)	-	NC
metformin hcl tab 625MG	-	NC
metformin hcl tab 750MG	-	NC
METFORMIN TAB	-	NC
RIOMET SOLN	-	NC
DIABETIC OTHER		
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	3
glucagon (rdna) for inj kit (QL= 2 inj/fill)	QL	3
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	3
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	3
GVOKE INJ (QL= 2 inj/fill)	QL	3
GVOKE INJ KIT (QL= 2 inj/fill)	QL	3
GVOKE PFS INJ (QL= 2 inj/fill)	QL	3
diazoxide susp (PROGLYCEM equiv)	-	4
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day)	MSP-PA-QL	5
KORLYM TAB	-	NC
PROGLYCEM SUSP	-	NC
ZEGALOGUE INJ	-	NC
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	3
sitagliptin phosphate tab (JANUVIA equiv) (QL= 1 tab/day)	QL-¢	3
TRADJENTA TAB (QL= 1 tab/day)	QL	3
ALOGLIPTIN TAB	-	NC
ALOGLIPTIN TAB, NESINA TAB	-	NC
BRYNOVIN SOLN	-	NC
ONGLYZA TAB	-	NC
saxagliptin hcl tab (ONGLYZA equiv)	-	NC
ZITUVIO TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	4
INCRETIN MIMETIC AGENTS		
liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days)	PA-QL	3/3P
MOUNJARO INJ (QL= 4 inj/28 days)	PA-QL	3/3P
OZEMPIC INJ (QL= 1 pack/28 days)	PA-QL	3/3P
TRULICITY INJ (QL= 4 pens/28 days)	PA-QL	3/3P
VICTOZA INJ (QL= 9ml/30 days)	PA-QL	3/3P
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
OZEMPIC INJ (QL= 1 pack/28 days)	PA-QL	3/3P
OZEMPIC TAB, RYBELSUS TAB (QL=1 tab/day)	PA-QL	3/3P
BYDUREON BCISE AUTO INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
BYDUREON INJ	-	NC
BYDUREON PEN INJ	-	NC
EXENATIDE INJ (BYETTA INJ EQUIV)	-	NC
TANZEUM INJ	-	NC
INSULIN		
INSULIN LISPRO INJ (HUMALOG equiv)	-	2
HUMALOG JR KWIKPEN INJ	-	3
HUMALOG KWIKPEN INJ	-	3
HUMALOG MIX INJ	-	3
HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN	-	3
HUMALOG PEN INJ	-	3
HUMALOG TEMPO PEN	-	3
HUMULIN MIX INJ	OTC	3
HUMULIN MIX PEN INJ	OTC	3
HUMULIN N INJ	OTC	3
HUMULIN N PEN INJ	OTC	3
HUMULIN R INJ	OTC	3
HUMULIN R INJ U-500	-	3
HUMULIN R U-500 KWIKPEN INJ	-	3
INSULIN GLARGINE INJ	-	3
INSULIN GLARGINE SOLN PEN-INJ	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
INSULIN LISPRO JR KWIKPEN INJ	-	3
INSULIN LISPRO KWIKPEN INJ	-	3
LANTUS INJ	-	3
LANTUS SOLOSTAR INJ	-	3
LEVEMIR FLEXTOUCH INJ	-	3
LEVEMIR INJ	-	3
LYUMJEV INJ	-	3
LYUMJEV KWIKPEN INJ	-	3
LYUMJEV TEMPO PEN	-	3
TOUJEO MAX SOLOSTAR INJ	-	3
TOUJEO SOLOSTAR INJ	-	3
TRESIBA FLEXTOUCH INJ	-	3
TRESIBA INJ	-	3
ADMELOG INJ, HUMALOG INJ	-	NC
ADMELOG SOLOSTAR, HUMALOG TEMPO PEN	-	NC
APIDRA INJ	-	NC
APIDRA SOLOSTAR INJ	-	NC
AWIQLI FLEX INJ	-	NC
BASAGLAR KWIKPEN	-	NC
DEGLUDEC FLEXTOUCH INJ	-	NC
DEGLUDEC INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
FIASP FLEXTOUCH INJ	-	NC
FIASP INJ	-	NC
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	NC
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC
INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML	-	NC
KIRSTY INJ	-	NC
LYUMJEV TEMPO PEN	-	NC
MERILOG INJ	-	NC
MERILOG SOLOSTAR INJ	-	NC
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC
NOVOLIN 70/30 INJ	OTC	NC
NOVOLIN 70/30 RELION INJ	OTC	NC
NOVOLIN N FLEXPEN INJ	OTC	NC
NOVOLIN N INJ	OTC	NC
NOVOLIN N RELION 100UNIT/ML	OTC	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
NOVOLIN R FLEXPEN INJ	OTC	NC
NOVOLIN R INJ	OTC	NC
NOVOLIN R RELION INJ	OTC	NC
NOVOLOG FLEXPEN INJ	-	NC
NOVOLOG FLEXPEN RELION INJ	-	NC
NOVOLOG INJ	-	NC
NOVOLOG MIX FLEXPEN INJ	-	NC
NOVOLOG MIX INJ	-	NC
NOVOLOG PENFILL INJ	-	NC
REZVOGLAR INJ	-	NC
SEMGLEE INJ	-	NC
SEMGLEE INJ (SINGLE PEN)	-	NC
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	NC
SEMGLEE PEN INJ	-	NC
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	NC
SEMGLEE SOLN	-	NC
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	2
ACTOS TAB	-	NC
MEGLITINIDE ANALOGUES		
repaglinide tab (PRANDIN equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
nateglinide tab (STARLIX equiv)	-	NC
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
dapagliflozin tab (FARXIGA equiv) (QL= 1 tab/day)	QL	2
FARXIGA TAB (QL= 1 tab/day)	QL	3
JARDIANCE TAB (QL= 1 tab/day)	QL	3
BEXAGLIFLOZN TAB	-	NC
INVOKANA TAB	-	NC
STEGLATRO TAB	-	NC
SULFONYLUREAS		
glimepiride tab (AMARYL equiv)	-	2
glipizide ER tab (GLUCOTROL XL equiv)	-	2
glipizide tab (GLUCOTROL equiv)	-	2
GLYBURID MCR TAB	-	2
glyburide tab (MICRONASE equiv)	-	2
AMARYL TAB	-	NC
GLIMEPIRIDE TAB	-	NC
GLIPIZIDE TAB	-	NC
GLUCOTROL TAB	-	NC
GLUCOTROL XL TAB	-	NC
GLYNASE TAB	-	NC
ANTIDIARRHEAL/PROBIOTIC AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIARRHEAL/PROBIOTIC AGENTS Cont.		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	4
OPIUM TINCTURE	-	4
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB	-	NC
ANTIDIARRHEAL AGENTS - MISC.		
REZYST CHEW TAB	-	NC
VSL #3 CAP	-	NC
ANTIDIARRHEAL COMBINATIONS		
EVIVO LIQUID	-	NC
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	2
MOTOFEN TAB	-	4
LOMOTIL TAB	-	NC
loperamide cap	-	NC
PAREGORIC TINCTURE	-	NC
ANTIDOTES		
ANTIDOTES		
VISTOGARD PAK	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDOTES Cont.		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	3
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	5
OPIOID ANTAGONISTS		
naloxone inj	-	2
naltrexone tab (REVIA equiv)	-	2
VIVITROL INJ	MSP	5
EVZIO INJ	-	NC
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-355	LD-PA	2
FERRIPROX TAB 1000MG (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	5
deferasirox granules packet (JADENU equiv)	-	NC
deferasirox tab (JADENU equiv)	-	NC
deferasirox tab for oral susp (EXJADE equiv)	-	NC
EXJADE TAB	-	NC
FERRIPROX TAB 500MG	-	NC
JADENU SPRINKLE	-	NC
JADENU TAB	-	NC
ANTIDOTES AND SPECIFIC ANTAGONISTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDOTES AND SPECIFIC ANTAGONISTS Cont.		
CETYLEV TAB	-	NC
OPIOID ANTAGONISTS		
naloxone hcl nasal spray (NARCAN equiv)	OTC	2
naloxone prefilled inj	-	2
NARCAN NASAL SPRAY	OTC	2
RIVIVE, REXTOVY SPRAY	OTC	2
KLOXXADO NASAL SPRAY	-	3
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	3
OPVEE NASAL SPRAY	-	3
ZIMHI SOLN	-	3
ZURNAI INJ	-	3
EVZIO INJ	-	NC
REZENOPY SPRAY 10MG/0.11ML	-	NC
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill)	QL	2
ondansetron ODT (ZOFRAN equiv)	-	2
ondansetron soln (ZOFRAN equiv)	-	2
ondansetron tab (ZOFRAN equiv)	-	2
ANZEMET TAB (QL= 9 tabs/fill)	QL	4
SANCUSO PATCH (QL= 4 patches/fill)	QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
GRANISOL ORAL SOLN	-	NC
KYTRIL TAB	-	NC
ONDANSETRON TAB	-	NC
ONDANSETRON TAB ODT	-	NC
SUSTOL INJ	-	NC
ZOFRAN ODT	-	NC
ZOFRAN SOLN	-	NC
ZOFRAN TAB	-	NC
ZUPLENZ SL FILM	-	NC
ANTIEMETICS - ANTICHOLINERGIC		
meclizine chew tab (BONINE equiv)	OTC	2
meclizine tab (ANTIVERT equiv)	OTC	2
trimethobenzamide cap (TIGAN equiv)	-	2
scopolamine patch (TRANSDERM-SCOP equiv)	-	3
MECLIZINE CHEW TAB	-	NC
meclizine hcl tab (ANTIVERT equiv)	-	NC
TIGAN CAP	-	NC
TIGAN INJ	-	NC
TRANSDERM-SCOP PATCH	-	NC
trimethobenzamide hcl inj (TIGAN equiv)	-	NC
ANTIEMETICS - MISCELLANEOUS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
dronabinol cap (MARINOL equiv)	PA	3
AKYNZEO CAP	-	NC
DICLEGIS TAB	-	NC
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC
DRONABINOL SOLN, SYNDROS SOLN	-	NC
MARINOL CAP	-	NC
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	3
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	3
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	3
EMEND PAK	-	NC
EMEND SUSP	-	NC
NEREUS CAP	-	NC
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)		
micafungin inj (MYCAMINE equiv)	M	6
MYCAMINE INJ	M	6
BREXAFEMME TAB	-	NC
ANTIFUNGALS		
nystatin tab	-	2
terbinafine tab (LAMISIL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
flucytosine cap (ANCOBON equiv)	-	3
griseofulvin micro tab (GRIFULVIN V equiv)	-	3
griseofulvin susp (GRIFULVIN equiv)	-	3
griseofulvin tab (GRIS-PEG equiv)	-	3
AMPHOTERICIN B IV SOLN	-	NC
ANCOBON CAP	-	NC
FULVICIN P/G TAB	-	NC
FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB	-	NC
GRIS-PEG TAB	-	NC
LAMISIL TAB	-	NC
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole susp (DIFLUCAN equiv)	-	2
fluconazole tab (DIFLUCAN equiv)	-	2
ketoconazole tab (NIZORAL equiv)	-	2
itraconazole cap (SPORANOX equiv)	-	3
voriconazole tab (VFEND equiv)	-	3
itraconazole soln (SPORANOX equiv)	PA	4
NOXAFIL PAK	-	4
posaconazole DR tab (NOXAFIL equiv)	-	4
posaconazole susp (NOXAFIL equiv)	-	4
voriconazole susp (VFEND equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
CRESEMBA CAP	-	NC
DIFLUCAN SUSP	-	NC
DIFLUCAN TAB	-	NC
NOXAFIL SUSP	-	NC
NOXAFIL TAB	-	NC
SPORANOX CAP	-	NC
SPORANOX SOLN	-	NC
TOLSURA CAP	-	NC
VFEND SUSP	-	NC
VFEND TAB	-	NC
VIVJOA CAP	-	NC
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
CORPHENA ORAL SOLN, RYCLORA ORAL SOLN	-	NC
MICLARA LIQUID	OTC	NC
ANTIHISTAMINES - ETHANOLAMINES		
diphenhydramine inj (BENADRYL equiv)	-	2
CARBINOXAMINE SOLN	-	4
carbinoxamine tab (PALGIC equiv)	-	4
CLEMASTINE TAB, CLEMASZ TAB	-	4
carbinoxamine maleate tab 6mg	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
CARBZAH SOLN 4MG/5ML	-	NC
CLEMASTINE SYRUP	-	NC
CLEMASTINE TAB (GENUS LIFESCIENCES)	-	NC
CLEMSZA TAB 2.68MG	-	NC
KARBINAL ER SUSP	-	NC
ANTIHISTAMINES - NON-SEDATING		
CLARINEX SYRUP	-	4
levocetirizine soln (XYZAL equiv)	-	4
levocetirizine tab (XYZAL equiv)	-	4
CLARITIN CHEW TAB	OTC	EXC
DESLORATADINE ODT	-	EXC
DESLORATADINE SOLN	-	EXC
desloratadine tab (CLARINEX equiv)	-	EXC
loratadine cap (CLARITIN equiv)	OTC	EXC
ALLEGRA ODT	OTC	NC
cetirizine chew tab (ZYRTEC equiv)	OTC	NC
CLARINEX TAB	-	NC
XYZAL SOLN	-	NC
XYZAL TAB	-	NC
ZYRTEC CHILD CHEW ALLERGY	OTC	NC
ANTIHISTAMINES - PHENOTHIAZINES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
promethazine syrup	-	2
promethazine tab (PHENERGAN equiv)	-	2
promethazine supp (PHENERGAN equiv)	-	3
PROMETHEGAN SUPP	-	3
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	2
cyproheptadine tab	-	2
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3
ANTIHYPERLIPIDEMICS - COMBINATIONS		
NEXLIZET TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvasta lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3
EZETIMIBE/ATORVASTATIN TAB	-	NC
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv)	-	NC
OMEGA-3 RX PAK COMPLETE	-	NC
ROSZET TAB	-	NC
ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB	-	NC
VYTORIN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
VYTORIN TAB 10-80MG	-	NC
ANTIHYPERLIPIDEMICS - MISC.		
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	2
icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day)	QL	3
KYNAMRO INJ	-	NC
LOVAZA CAP	-	NC
VASCEPA CAP	-	NC
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	2
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	2
cholestyramine powder (QUESTRAN equiv)	-	2
cholestyramine powder pack (QUESTRAN equiv)	-	2
colestipol tab (COLESTID equiv)	-	2
colesevelam pack (WELCHOL equiv)	-	3
colesevelam tab (WELCHOL equiv)	-	3
colestipol granule (COLESTID equiv)	-	4
colestipol powder packet (COLESTID equiv)	-	4
COLESTID GRANULE	-	NC
COLESTID POWDER PACK	-	NC
COLESTID TAB	-	NC
QUESTRAN LITE POWDER	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
QUESTRAN POWDER	-	NC
QUESTRAN POWDER PACK	-	NC
WELCHOL PACK	-	NC
WELCHOL TAB	-	NC
FIBRIC ACID DERIVATIVES		
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	2
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	2
fenofibric acid DR cap (TRILIPIX equiv)	-	2
gemfibrozil tab (LOPID equiv)	-	2
FENOFIBRIC TAB	-	4
FENOFIBRIC TAB, FIBRICOR TAB	-	4
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC
ANTARA CAP, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC
FENOFIBRATE CAP, LIPOFEN CAP	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
FENOGLIDE TAB	-	NC
LOPID TAB	-	NC
TRICOR TAB	-	NC
TRIGLIDE TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
TRILIPIX CAP	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab (LIPITOR equiv)	-	1
lovastatin tab (MEVACOR equiv)	-	1
pravastatin tab (PRAVACHOL equiv)	-	1
rosuvastatin tab (CRESTOR equiv)	-	1
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	1
fluvastatin cap (LESCOL equiv)	-	3
pitavastatin calcium tab (LIVALO equiv)	-	3
ATORVALIQ SUSP (Prior Authorization required for members age 9 years and olde	PA	4
FLOLIPID SUSP (Prior Authorization required for members age 9 years and older)	PA	4
fluvastatin ER tab (LESCOL XL equiv)	-	4
LIVALO TAB	-	4
ADVICOR TAB	-	NC
ALTOPREV TAB	-	NC
CRESTOR TAB	-	NC
EZALLOR SPRINKLE CAP	-	NC
LESCOL XL TAB	-	NC
LIPITOR TAB	-	NC
SIMCOR TAB	-	NC
simvastatin tab 80mg (ZOCOR equiv) (80 mg simvastatin is not covered)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
ZOCOR TAB	-	NC
ZOCOR TAB 80MG	-	NC
ZYPITAMAG TAB	-	NC
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	2
ZETIA TAB	-	NC
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP	-	NC
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	2
NIACOR TAB	-	NC
NIASPAN ER TAB	-	NC
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	3
LEROCHOL SOLN	-	NC
LIPFENDRA TAB	-	NC
ANTIHYPERTENSIVES		
ACE INHIBITORS		
benazepril tab (LOTENSIN equiv)	-	2
captopril tab (CAPOTEN equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
enalapril tab (VASOTEC equiv)	-	2
fosinopril tab (MONOPRIL equiv)	-	2
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	2
PERINDOPRIL TAB	-	2
perindopril tab (ACEON equiv)	-	2
quinapril tab (ACCUPRIL equiv)	-	2
ramipril cap (ALTACE equiv)	-	2
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for membe age 9 years and older)	PA	3
EPANED SOLN (Prior Authorization required for members age 9 years and older)	PA	4
QBRELIS SOLN (Prior Authorization required for members age 9 years and older)	PA	4
ACCUPRIL TAB	-	NC
ALTACE CAP	-	NC
LOTENSIN TAB	-	NC
MAVIK TAB	-	NC
moexipril tab (UNIVASC equiv)	-	NC
PRINIVIL TAB, ZESTRIL TAB	-	NC
trandolapril tab (MAVIK equiv)	-	NC
VASOTEC TAB	-	NC
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLINE equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
DEMSER CAP	-	NC
DIBENZYLINE CAP	-	NC
metyrosine cap (DEMSER equiv)	-	NC
ALDOSTERONE SYNTHASE INHIBITORS		
BAXFENDY TAB	-	NC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan tab (ATACAND equiv)	-	2
irbesartan tab (AVAPRO equiv)	-	2
losartan tab (COZAAR equiv)	-	2
olmesartan tab (BENICAR equiv)	-	2
telmisartan tab (MICARDIS equiv)	-	2
valsartan tab (DIOVAN equiv)	-	2
ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older)	PA-QL	4
ATACAND TAB	-	NC
AVAPRO TAB	-	NC
azilsartan medoxomil tab (EDARBI equiv)	-	NC
BENICAR TAB	-	NC
COZAAR TAB	-	NC
DIOVAN TAB	-	NC
EDARBI TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
MICARDIS TAB	-	NC
valsartan oral soln (VALSARTAN equiv)	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine tab (CATAPRES equiv)	-	2
doxazosin tab (CARDURA equiv)	-	2
guanfacine IR tab (TENEX equiv)	-	2
methyldopa tab (ALDOMET equiv)	-	2
prazosin cap (MINIPRESS equiv)	-	2
terazosin cap (HYTRIN equiv)	-	2
clonidine patch (CATAPRES-TTS equiv)	-	3
METHYLDOPA TAB	-	4
CARDURA TAB	-	NC
CATAPRES-TTS PATCH	-	NC
CLONIDINE TAB	-	NC
JAVADIN SOLN	-	NC
MINIPRESS CAP	-	NC
NEXICLON XR TAB	-	NC
TEZRULY SOLN	-	NC
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	2
amlodipine/olmesartan tab (AZOR equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
amlodipine/valsartan tab (EXFORGE equiv)	-	2
atenolol/chlorthalidone tab (TENORETIC equiv)	-	2
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	2
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	2
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	2
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	2
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	2
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	2
telmisartan/amlodipine tab (TWYNSTA equiv)	-	3
ACCURETIC TAB	-	NC
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC
ATACAND HCT TAB	-	NC
AVALIDE TAB	-	NC
BENICAR HCT TAB	-	NC
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	NC
BYVALSON TAB	-	NC
CAPTOPRIL/HYDROCHLOROTHIAZIDE TAB	-	NC
DIOVAN HCT TAB	-	NC
DUTOPROL TAB	-	NC
EDARBYCLOR TAB	-	NC
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
EXFORGE TAB	-	NC
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	NC
HYZAAR TAB	-	NC
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	NC
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	NC
LOTENSIN HCT TAB	-	NC
LOTREL CAP	-	NC
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	NC
MICARDIS HCT TAB	-	NC
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	NC
PRESTALIA TAB	-	NC
QUINAPRIL/HCTZ TAB	-	NC
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	NC
TARKA TAB	-	NC
TELMISARTAN/AMLODIPINE TAB	-	NC
TENORETIC TAB	-	NC
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC
TRIBENZOR TAB	-	NC
TWYNSTA TAB	-	NC
VASERETIC TAB	-	NC
WIDAPLIK TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
ZESTORETIC TAB	-	NC
ZIAC TAB	-	NC
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB	-	NC
DIRECT RENIN INHIBITORS		
aliskiren tab (TEKTURNA equiv)	-	NC
TEKTURNA TAB	-	NC
ENDOTHELIN RECEPTOR ANTAGONISTS		
TRYVIO TAB	-	NC
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	2
INSPRA TAB	-	NC
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	2
minoxidil tab (LONITEN equiv)	-	2
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
metronidazole tab (FLAGYL equiv)	-	2
tinidazole tab (TINDAMAX equiv)	-	2
TRIMETHOPRIM TAB	-	2
trimethoprim tab (PROLOPRIM equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
pentamidine neb soln (NEBUPENT equiv)	-	3
XIFAXAN TAB 550MG (QL= 60 tabs/30 days)	QL	3
FIRST METRONIDAZOLE SUSP	-	4
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	QL	4
AEMCOLO TAB	-	NC
FLAGYL CAP	-	NC
FLAGYL TAB	-	NC
IMPAVIDO CAP	-	NC
LIKMEZ SUSP	-	NC
metronidazole cap (FLAGYL equiv)	-	NC
METRONIDAZOLE TAB	-	NC
NEBUPENT NEB SOLN	-	NC
TINDAMAX TAB	-	NC
ANTI-INFECTIVE MISC. - COMBINATIONS		
smz/tmp (DS) tab (BACTRIM DS equiv)	-	2
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	2
BACTRIM DS TAB	-	NC
HYOPHEN TAB	-	NC
UTA cap	-	NC
ANTIPROTOZOAL AGENTS		
atovaquone susp (MEPRON equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	3
ALINIA TAB	-	NC
LAMPIT TAB	-	NC
MEPRON SUSP	-	NC
CARBAPENEMS		
meropenem inj (MERREM equiv)	-	4
VABOMERE INJ	-	6
GLYCOPEPTIDES		
FIRVANQ SOLN 25MG/ML	-	2
FIRVANQ SOLN 50MG/ML	-	2
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	2
vancomycin hcl soln (VANCOMYCIN equiv)	-	2
VANCOMYCIN ORAL SOLN	-	2
VANCOMYCIN SOLN	-	2
VANCOCIN CAP	-	NC
LEPROSTATICS		
dapsone tab	-	2
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	2
clindamycin soln (CLEOCIN equiv)	-	3
CLEOCIN CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
CLEOCIN SOLN	-	NC
MONOBACTAMS		
CAYSTON INH SOLN	-	NC
OXAZOLIDINONES		
linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	3
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	3
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	3
SIVEXTRO TAB	-	NC
ZYVOX SUSP	-	NC
ZYVOX TAB	-	NC
PENEMS		
ORLYNVAH TAB	-	NC
PLEUROMUTILINS		
XENLETA TAB	-	NC
URINARY ANTI-INFECTIVES		
METHENAM MAN TAB	-	2
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	2
nitrofurantoin monohydrate cap (MACROBID equiv)	-	2
methenamine hippurate tab (HIPREX equiv)	-	3
fosfomycin tromethamine powder pack (MONUROL equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
nitrofurantoin susp (FURADANTIN equiv) (Prior Authorization required for members age 9 years and older)	PA	4
BLUJEPA TAB	-	NC
HIPREX TAB	-	NC
MACROBID CAP	-	NC
MACRODANTIN CAP	-	NC
MACRODANTIN CAP 25MG	-	NC
METHENAMINE ORAL SOLN	-	NC
MONUROL GRANULE PACK	-	NC
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC
NITROFURANTOIN SUSP	-	NC
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	2
COARTEM TAB	-	4
MALARONE TAB	-	NC
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC
ANTIMALARIALS		
CHLOROQUINE TAB	-	2
chloroquine tab (ARALEN equiv)	-	2
HYDROXYCHLOROQUINE TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIMALARIALS Cont.		
hydroxychloroquine tab (PLAQUENIL equiv)	-	2
primaquine tab (PRIMAQUINE equiv)	-	2
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
mefloquine tab (LARIAM equiv)	-	3
ARAKODA TAB	-	NC
DARAPRIM TAB	-	NC
KRINTAFEL TAB	-	NC
PLAQUENIL TAB	-	NC
PRIMAQUINE TAB	-	NC
QUALAQUIN CAP	-	NC
quinine sulfate cap (QUALAQUIN equiv)	-	NC
SOVUNA TAB 200MG	-	NC
SOVUNA TAB 300MG	-	NC
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
pyridostigmine tab (MESTINON equiv)	-	2
pyridostigmine CR tab (MESTINON equiv)	-	3
GUANIDINE TAB	-	4
pyridstigmine soln (MESTINON equiv)	-	4
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIMYASTHENIC/CHOLINERGIC AGENTS Cont.		
MESTINON TAB	-	NC
MESTINON TIMESPAN TAB	-	NC
PYRIDOSTIGMINE TAB 30MG	-	NC
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS		
RIFATER TAB	-	4
ANTIMYCOBACTERIAL AGENTS		
isoniazid tab	-	2
pyrazinamide tab	-	2
ethambutol tab (MYAMBUTOL equiv)	-	3
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	3
PRIFTIN TAB	-	3
rifabutin cap (MYCOBUTIN equiv)	-	3
rifampin cap (RIFADIN equiv)	-	3
rifapentine tab (PRIFTIN equiv)	-	3
isoniazid syrup (ISONIAZID equiv)	-	4
TRECATOR TAB (Restricted to Infectious Disease Specialist)	RS	4
SIRTURO TAB (QL= 4 tabs/day; Restricted to Infectious Disease Specialist)	MSP-QL-RS	5
CAPASTAT INJ	M	6
CYCLOSERINE CAP	-	NC
MYAMBUTOL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIMYCOBACTERIAL AGENTS Cont.		
MYCOBUTIN CAP	-	NC
PASER GRANULE	-	NC
RIFADIN CAP	-	NC
ANTINEOPLASTICS		
ANTINEOPLASTICS MISC.		
tretinoin cap (VESANOID equiv)	MSP	2
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	MSP-PA	5
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
temozolomide cap (TEMODAR equiv)	MSP	2
cyclophosphamide cap	-	3
CYCLOPHOSPHAMIDE TAB	-	3
GLEOSTINE CAP	-	3
lomustine cap (GLEOSTINE equiv)	-	3
MYLERAN TAB	MSP	5
ZANOSAR INJ	M	6
ALKERAN INJ	-	NC
CYCLOPHOSPHAMIDE CAP	-	NC
LEUKERAN TAB	-	NC
melphalan inj (ALKERAN equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TEMODAR CAP	-	NC
TREANDA INJ	-	NC
ANTIMETABOLITES		
capecitabine tab (XELODA equiv)	MSP	2
methotrexate inj	-	2
methotrexate tab (TREXALL equiv)	-	2
mercaptopurine tab (PURINETHOL equiv)	-	3
mercaptopurine susp (PURIXAN equiv) (Prior Authorization required for members a(9 years and older)	PA	4
FLUDARABINE INJ	-	NC
JYLAMVO SOLN, XATMEP SOLN	-	NC
ONUREG TAB	-	NC
TABLOID TAB	-	NC
TREXALL TAB	-	NC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
FRUZAQLA CAP 1MG (QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
FRUZAQLA CAP 5MG (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
INLYTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
INLYTA TAB 1MG (QL= 8 tabs/day)	MSP-PA-QL-SF	5
LENVIMA CAP (QL= 3 caps/day; Only available through AcariaHealth 800-511-514 Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL-SF	5
ANTINEOPLASTIC - ANTIBODIES		
RITUXAN INJ	-	NC
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
HERNEXEOS TAB	-	NC
TUKYSA TAB	-	NC
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK	-	NC
VENCLEXTA TAB	-	NC
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	5
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tab/day)	MSP-PA-QL-SF	5
gefitinib tab (IRESSA equiv) (QL= 1 tab/day)	MSP-PA-QL-SF	5
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
LAZCLUZE TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TAGRISSO TAB	-	NC
TARCEVA TAB	-	NC
VIZIMPRO TAB	-	NC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP (QL= 1 cap/day)	MSP-PA-QL	5
ODOMZO CAP (QL= 1 cap/day)	MSP-PA-QL	5
DAURISMO TAB	-	NC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1
exemestane tab (AROMASIN equiv) ($0 copay for female members only age 35 yea and older; All other members covered at generic copay)	-	1
tamoxifen tab (NOLVADEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1
abiraterone tab 250mg (ZYTIGA equiv)	MSP	2
bicalutamide tab (CASODEX equiv)	-	2
letrozole tab (FEMARA equiv)	-	2
megestrol susp (MEGACE equiv)	-	2
megestrol tab (MEGACE equiv)	-	2
NILUTAMIDE TAB	MSP	2
nilutamide tab (NILANDRON equiv)	MSP	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
EMCYT CAP	-	3
EULEXIN CAP	-	3
FLUTAMIDE CAP	-	3
flutamide cap (EULEXIN equiv)	-	3
toremifene tab (FARESTON equiv)	-	3
ELIGARD INJ, VABRINITY INJ	MSP	5
ELIGARD INJ, VABRINTY INJ	MSP	5
ERLEADA TAB (QL= 4 tabs/day)	MSP-PA-QL	5
ERLEADA TAB 240MG (QL= 1 tab/day)	MSP-PA-QL	5
leuprolide inj (LUPRON equiv)	INF-MSP	5
LUPRON DEPOT INJ	MSP	5
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	5
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC
AKEEGA TAB	-	NC
ARIMIDEX TAB	-	NC
AROMASIN TAB	-	NC
CASODEX TAB	-	NC
FARESTON TAB	-	NC
FEMARA TAB	-	NC
HYDROXYPROGESTERONE CAPROATE INJ	-	NC
INLURIYO TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
LIFYORLI CAP DOSE PACK	-	NC
NUBEQA TAB	-	NC
ORGOVYX TAB	-	NC
ORSERDU TAB	-	NC
ORSERDU TAB 345MG	-	NC
VEPPANU TAB	-	NC
XTANDI CAP	-	NC
XTANDI TAB 40MG	-	NC
XTANDI TAB 80MG	-	NC
YONSA TAB	-	NC
ZYTIGA TAB 250MG	-	NC
ZYTIGA TAB 500MG	-	NC
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
ANTINEOPLASTIC - IMMUNOMODULATORS		
pomalidomide cap (POMALYST equiv)	-	NC
POMALYST CAP	-	NC
ZENBEXUS CAP	-	NC
ANTINEOPLASTIC - MENIN INHIBITORS		
KOMZIFTI CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
REVUFORJ TAB	-	NC
REVUFORJ TAB 110MG	-	NC
REVUFORJ TAB 25MG	-	NC
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5
ANTINEOPLASTIC - PROTEASE ACTIVATORS		
MODEYSO CAP	-	NC
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK	-	NC
ANTINEOPLASTIC COMBINATIONS		
KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	5
AVMAPKI FAKZYNJA CO-PACK	-	NC
INQOVI TAB	-	NC
LONSURF TAB	-	NC
ANTINEOPLASTIC ENZYME INHIBITORS		
bosutinib tab (BOSULIF equiv)	MSP-PA	2
dasatinib tab (SPRYCEL equiv)	MSP-PA	2
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	MSP-PA-QL	2
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	MSP-PA-QL	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
imatinib tab (GLEEVEC equiv)	MSP	2
lapatinib ditosylate tab (TYKERB equiv)	MSP-PA	2
nilotinib hcl cap (TASIGNA equiv)	MSP-PA	2
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	MSP-PA-QL	2
sorafenib tosylate tab (NEXAVAR equiv)	MSP-PA	2
sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day)	MSP-PA-QL	2
ALECENSA CAP (QL= 8 caps/day)	MSP-PA-QL	5
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5
AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 c Onco360 877-662-6633)	LD-PA-QL-SF	5
AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	5
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
BOSULIF CAP	MSP-PA	5
BOSULIF TAB	MSP-PA-SF	5
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL	5
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-430(Onco360 877-662-6633, or Walgreens 888-347-3416)	LD-PA-QL-SF	5
CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5
CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	5
everolimus tab 5mg (AFINITOR equiv) (QL= 2 tabs/day)	MSP-PA-QL	5
GAVRETO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 c Onco360 877-662-6633)	LD-PA-QL-SF	5
ICLUSIG TAB (Only available through AcariaHealth 800-511-5144)	LD-PA-SF	5
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	5
IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmac 877-977-9118)	LD-PA-QL	5
IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmac 877-977-9118)	LD-PA-QL	5
JAYPIRCA TAB (QL= 2 tabs/day)	MSP-PA-QL	5
KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	5
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	5
KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	5
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5
LORBRENA TAB 100MG (QL= 1 tab/day)	MSP-PA-QL-SF	5
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	5
LYNPARZA TAB (QL= 4 tabs/day; Only available through Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, or Optum 877-445-6874)	LD-PA-QL-SF	5
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	5
MEKINIST SOLN	MSP-PA	5
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	MSP-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
MEKINIST TAB 2MG (QL= 1 tab/day)	MSP-PA-QL	5
MEKTOVI TAB (QL= 6 caps/day; Only available through AcariaHealth 800-511-514 Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416)	LD-PA-QL	5
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	5
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	5
OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
PIQRAY TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	5
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306 Onco360 877-662-6633)	LD-PA-QL-SF	5
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL	5
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	5
RYDAPT CAP (QL= 56 caps/28 days)	MSP-PA-QL	5
SCEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 o Biologics 800-850-4306)	LD-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
SCEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	5
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5
TABRECTA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	5
TAFINLAR CAP (QL= 4 caps/day)	MSP-PA-QL	5
TAFINLAR TAB	MSP-PA	5
TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	5
TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-430 or Onco360 877-662-6633)	LD-PA-QL	5
TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5
VANFLYTA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
VERZENIO TAB (QL= 2 tabs/day)	MSP-PA-QL	5
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	5
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	5
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	5
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	5
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	5
ZYKADIA TAB (QL= 3 tabs/day)	MSP-PA-QL-SF	5
AFINITOR DISPERZ TAB	-	NC
AFINITOR TAB	-	NC
ALUNBRIG PAK	-	NC
BRUKINSA CAP	-	NC
BRUKINSA TAB	-	NC
CABOMETYX TAB	-	NC
CAVHANZA TAB	-	NC
COMETRIQ KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
DANZITEN TAB	-	NC
ENSACOVE CAP	-	NC
ENSACOVE CAP 100MG	-	NC
FOTIVDA CAP	-	NC
GLEEVEC TAB	-	NC
GOMEKLI CAP	-	NC
GOMEKLI CAP 1MG	-	NC
GOMEKLI TAB FOR ORAL SUSP	-	NC
HYRNUO TAB	-	NC
IBRANCE CAP	-	NC
IBRANCE TAB	-	NC
IBTROZI CAP	-	NC
IMBRUVICA SUSP	-	NC
IMBRUVICA TAB 140MG	-	NC
IMBRUVICA TAB 280MG	-	NC
IMKELDI SOLUTION	-	NC
INREBIC CAP	-	NC
ITOVEBI TAB	-	NC
JAKAFI TAB	-	NC
JAKAFI XR TAB	-	NC
JIDEYTRO TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
KOSELUGO CAP	-	NC
KOSELUGO SPRINKLE CAP	-	NC
LUMAKRAS TAB	-	NC
LUMAKRAS TAB 240MG	-	NC
LUMAKRAS TAB 320MG	-	NC
NEXAVAR TAB	-	NC
NILOTINB TAR CAP	-	NC
NILOTINIB D-TAR CAP	-	NC
OGSIVEO TAB	-	NC
OGSIVEO TAB 50MG	-	NC
OJEMDA SUSP	-	NC
OJEMDA TAB	-	NC
PAZOPANIB TAB 400MG	-	NC
PHYRAGO TAB	-	NC
RETEVMO CAP	-	NC
RETEVMO CAP 40MG	-	NC
RETEVMO TAB	-	NC
RETEVMO TAB 40MG	-	NC
ROMVIMZA CAP	-	NC
ROZLYTREK PAK	-	NC
SPRYCEL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
SUTENT CAP	-	NC
TALZENNA CAP 0.1MG	-	NC
TALZENNA CAP 0.25MG	-	NC
TALZENNA CAP 0.35MG	-	NC
TALZENNA CAP 0.5MG, 0.75MG, 1MG	-	NC
TASIGNA CAP	-	NC
TEPMETKO TAB	-	NC
TYKERB TAB	-	NC
VORANIGO TAB	-	NC
VORANIGO TAB 10MG	-	NC
VOTRIENT TAB	-	NC
XALKORI SPRINKLE CAP	-	NC
ZELBORAF TAB	-	NC
ZOLINZA CAP	-	NC
ANTINEOPLASTICS MISC.		
bexarotene cap (TARGRETIN equiv)	MSP-PA	2
hydroxyurea cap (HYDREA equiv)	-	2
MATULANE CAP	-	3
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 o Onco360 877-662-6633)	LD-PA-QL	5
BESREMI PEN INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	5
HYDREA CAP	-	NC
SYLATRON INJ	-	NC
TARGRETIN CAP	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	2
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
mesna tab (MESNEX equiv)	MSP	2
MESNEX TAB	MSP	5
IWILFIN TAB	-	NC
LEUCOVOR CA TAB	-	NC
MITOTIC INHIBITORS		
ETOPOSIDE CAP	MSP	5
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	3
LODOSYN TAB	-	NC
ANTIPARKINSON ANTICHOLINERGICS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
benztropine tab	-	2
trihexyphenidyl tab (ARTANE equiv)	-	2
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	3
COMTAN TAB	-	NC
TASMAR TAB	-	NC
tolcapone tab (TASMAR equiv)	-	NC
ANTIPARKINSON DOPAMINERGICS		
amantadine cap (SYMMETREL equiv)	-	2
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	2
carbidopa/levodopa ODT (PARCOPA equiv)	-	2
carbidopa/levodopa tab (SINEMET equiv)	-	2
pramipexole tab (MIRAPEX equiv)	-	2
ropinirole tab (REQUIP equiv)	-	2
amantadine tab	-	3
bromocriptine cap (PARLODEL equiv)	-	3
bromocriptine tab (PARLODEL equiv)	-	3
ropinirole ER tab (REQUIP XL equiv)	-	3
NEUPRO PATCH	-	4
pramipexole ER tab (MIRAPEX ER equiv)	-	4
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
CREXONT CAP	-	NC
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
MIRAPEX ER TAB	-	NC
MIRAPEX TAB	-	NC
PARLODEL CAP	-	NC
PARLODEL TAB	-	NC
REQUIP TAB	-	NC
REQUIP XL TAB	-	NC
SINEMET CR TAB	-	NC
SINEMET TAB	-	NC
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
selegiline cap (ELDEPRYL equiv)	-	2
selegiline tab (ELDEPRYL equiv)	-	2
rasagiline tab (AZILECT equiv)	-	3
AZILECT TAB	-	NC
ELDEPYRL CAP	-	NC
XADAGO TAB	-	NC
ZELAPAR ODT	-	NC
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ADJUVANTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPARKINSON AND RELATED THERAPY AGENTS Cont.		
NOURIANZ TAB	-	NC
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	2
ANTIPARKINSON DOPAMINERGICS		
amantadine soln (AMANTADINE equiv)	-	2
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	3
APOKYN INJ	-	NC
apomorphine inj (APOKYN equiv)	-	NC
CARBIDOPA/LEVODOPA CAP, RYTARY CAP	-	NC
DHIVY TAB	-	NC
INBRIJA INH POWDER	-	NC
KYNMOBI FILM	-	NC
KYNMOBI TITRATION KIT	-	NC
ONAPGO INJ	-	NC
OSMOLEX ER TAB	-	NC
STALEVO TAB	-	NC
VYALEV INJ	-	NC
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
LITHIUM CARBONATE CAP	-	2
lithium carbonate cap (ESKALITH ER equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
lithium carbonate ER tab (LITHOBID equiv)	-	2
lithium carbonate tab	-	2
lithium oral solution (LITHIUM equiv)	-	NC
LITHOBID TAB	-	NC
ANTIPSYCHOTICS - MISC.		
lurasidone hcl tab (LATUDA equiv)	-	2
ziprasidone cap (GEODON equiv)	-	2
EQUETRO CAP	-	3
CAPLYTA CAP	-	NC
GEODON CAP	-	NC
LATUDA TAB	-	NC
NUPLAZID CAP	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC
BENZISOXAZOLES		
risperidone soln (RISPERDAL equiv)	-	2
risperidone tab (RISPERDAL equiv)	-	2
paliperidone ER tab (INVEGA equiv)	-	3
RISPERDAL INJ	-	3
risperidone microspheres inj (RISPERDAL equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
RISPERIDONE ODT	-	3
risperidone ODT (RISPERDAL M equiv)	-	3
INVEGA SUSTENNA INJ	-	4
INVEGA TRINZA INJ	-	4
BYSANTI TAB	-	NC
BYSANTI TITRATION PACK	-	NC
ERZOFRI INJ 117MG/0.75ML	-	NC
ERZOFRI INJ 156MG/ML	-	NC
ERZOFRI INJ 234MG/1.5ML	-	NC
ERZOFRI INJ 351MG/2.25ML	-	NC
ERZOFRI INJ 39MG/0.25ML	-	NC
ERZOFRI INJ 78MG/0.5ML	-	NC
FANAPT TAB	-	NC
FANAPT TITRATION PACK	-	NC
INVEGA TAB	-	NC
RISPERDAL M ODT	-	NC
RISPERDAL SOLN	-	NC
RISPERDAL TAB	-	NC
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	2
haloperidol tab (HALDOL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
haloperidol decanoate inj (HALDOL equiv)	-	3
haloperidol lactate inj (HALDOL equiv)	-	3
DIBENZAPINES		
loxapine cap (LOXITANE equiv)	-	2
olanzapine tab (ZYPREXA equiv)	-	2
quetiapine tab (SEROQUEL equiv)	-	2
quetiapine XR tab (SEROQUEL XR equiv)	-	2
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day)	PA-QL	3
clozapine tab (CLOZARIL equiv)	-	3
olanzapine ODT (ZYPREXA equiv)	-	3
ZYPREXA RELPREVV INJ	-	4
ADASUVE INHALER	-	NC
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC
CLOZAPINE ODT, FAZACLO ODT	-	NC
CLOZARIL TAB	-	NC
FAZACLO ODT 12.5MG, 25MG, 100MG	-	NC
QUETIAPINE TAB	-	NC
SAPHRIS SL TAB	-	NC
SECUADO PATCH	-	NC
SEROQUEL TAB	-	NC
SEROQUEL XR TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
VERSACLOZ SUSP	-	NC
ZYPREXA TAB	-	NC
ZYPREXA ZYDIS TAB	-	NC
DIHYDROINDOLONES		
MOLINDONE TAB	-	NC
MUSCARINIC AGENTS		
COBENFY CAP	-	NC
COBENFY CAP STARTER PACK	-	NC
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	2
fluphenazine tab (PROLIXIN equiv)	-	2
prochlorperazine supp (COMPAZINE equiv)	-	2
prochlorperazine tab (COMPAZINE equiv)	-	2
thioridazine hcl tab (THIORIDAZINE equiv)	-	2
trifluoperazine tab (STELAZINE equiv)	-	2
fluphenazine decanoate inj	-	3
CHLORPROMAZINE CONC	-	NC
chlorpromazine hcl conc	-	NC
perphenazine tab (TRILAFON equiv)	-	NC
QUINOLINONE DERIVATIVES		
aripiprazole tab (ABILIFY equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
ABILIFY MAINTENA INJ	-	4
aripiprazole soln (ABILIFY equiv)	PA	4
REXULTI TAB (QL= 1 tab/day)	PA-QL	4
ARISTADA INJ	-	6
ABILIFY ASIMTUFII INJ 720MG/2.4ML (aripiprazole im er susp prefilled syringe equ	-	NC
ABILIFY ASIMTUFII INJ 960MG/3.2ML (aripiprazole im er susp prefilled syringe equ	-	NC
ABILIFY MYCITE PACK	-	NC
ABILIFY MYCITE TAB	-	NC
ABILIFY TAB	-	NC
aripiprazole ODT (ABILIFY equiv)	-	NC
OPIPZA FILM	-	NC
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	2
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
HYLAMEND GEL FIRST AID	-	NC
IODINE ANTISEPTICS		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
APRETUDE SUSP (QL= 7 inj/year)	PA-QL	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
DESCOVY TAB	PA	1
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	1
abacavir tab (ZIAGEN equiv)	-	2
abacavir/lamivudine tab (EPZICOM equiv)	-	2
efavirenz tab (SUSTIVA equiv)	-	2
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	2
emtricitabine cap (EMTRIVA equiv)	-	2
etravirine tab (INTELENCE equiv)	-	2
fosamprenavir tab (LEXIVA equiv)	-	2
lamivudine soln (EPIVIR equiv)	-	2
lamivudine tab (EPIVIR equiv)	-	2
lamivudine/zidovudine tab (COMBIVIR equiv)	-	2
lopinavir/ritonavir tab (KALETRA equiv)	-	2
maraviroc tab (SELZENTRY equiv)	-	2
ritonavir tab (NORVIR equiv)	-	2
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	2
zidovudine cap (RETROVIR equiv)	-	2
zidovudine syrup (RETROVIR equiv)	-	2
zidovudine tab (RETROVIR equiv)	-	2
atazanavir cap (REYATAZ equiv)	-	3
CIMDUO TAB	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
darunavir tab (PREZISTA equiv)	-	3
DELSTRIGO TAB	-	3
DOVATO TAB	-	3
EDURANT PED TAB	-	3
EDURANT TAB	-	3
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	3
EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB	-	3
emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv)	-	3
EVOTAZ TAB	-	3
ISENTRESS (HD) TAB	-	3
PREZCOBIX TAB	-	3
PREZISTA TAB	-	3
rilpivirine hcl tab (EDURANT equiv)	-	3
TIVICAY PD TAB	-	3
TIVICAY TAB	-	3
COMPLERA TAB	-	4
ISENTRESS CHEW TAB	-	4
ISENTRESS POWDER PACK	-	4
NORVIR POWDER PACK	-	4
abacavir soln (ZIAGEN equiv)	-	5
EMTRIVA SOLN	-	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
INTELENCE TAB	-	5
KALETRA TAB	-	5
lopinavir/ritonavir soln (KALETRA equiv)	-	5
PREZISTA SUSP	-	5
REYATAZ POWDER PACK	-	5
SELZENTRY SOLN	-	5
SELZENTRY TAB	-	5
VIRACEPT TAB	-	5
VIREAD TAB	-	5
PIFELTRO TAB	-	NC
APTIVUS CAP	-	NC/3P
ATRIPLA TAB	-	NC/3P
BIKTARVY TAB	-	NC/3P
CABENUVA IM SUSP	-	NC/3P
CABENUVA SUSP 600MG-900MG/3ML	-	NC/3P
COMBIVIR TAB	-	NC/3P

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters		**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution	
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit	
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	
PA	Prior Authorization	QL	Quantity Limit	
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months	
SMKG	Smoking Cessation	ST	Step Therapy	
VAC	Vaccine Program	¢	RxCENTS	

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
EMTRIVA CAP	-	NC/3 P
EPIVIR SOLN	-	NC/3 P
EPIVIR TAB	-	NC/3 P
EPZICOM TAB	-	NC/3 P
FUZEON INJ	-	NC/3 P
GENVOYA TAB	-	NC/3 P
IDVYNSO TAB	-	NC/3 P
JULUCA TAB	-	NC/3 P
KALETRA SOLN	-	NC/3 P
LEXIVA TAB	-	NC/3 P
NEVIRAPINE ER TAB	-	NC/3 P

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
nevirapine ER tab (VIRAMUNE XR equiv)	-	NC/3P
NEVIRAPINE SUSP	-	NC/3P
nevirapine tab (VIRAMUNE equiv)	-	NC/3P
NORVIR TAB	-	NC/3P
ODEFSEY TAB	-	NC/3P
PREZISTA TAB	-	NC/3P
RETROVIR CAP	-	NC/3P
RETROVIR SYRUP	-	NC/3P
RETROVIR TAB	-	NC/3P
REYATAZ CAP	-	NC/3P
RUKOBIA ER TAB	-	NC/3P

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
STRIBILD TAB	-	NC/3 P
SUNLENCA INJ	-	NC/3 P
SUNLENCA TAB	-	NC/3 P
SUNLENCA TAB 300MG	-	NC/3 P
SUSTIVA TAB	-	NC/3 P
SYMFI (LO) TAB	-	NC/3 P
SYMTUZA TAB	-	NC/3 P
TRIUMEQ PD TAB	-	NC/3 P
TRIUMEQ TAB	-	NC/3 P
TYBOST TAB	-	NC/3 P
VIRAMUNE SUSP	-	NC/3 P

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
VIRAMUNE TAB	-	NC/3 P
VIRAMUNE XR TAB	-	NC/3 P
VIREAD TAB	-	NC/3 P
VOCABRIA TAB	-	NC/3 P
YEZTUGO INJ	-	NC/3 P
YEZTUGO TAB	-	NC/3 P
ZIAGEN SOLN	-	NC/3 P
ZIAGEN TAB	-	NC/3 P
ANTIVIRAL COMBINATIONS		
PAXLOVID PAK (QL= 11 tabs/90 days)	QL	3
PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days)	QL	3
PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days)	QL	3
CMV AGENTS		
valganciclovir soln (VALCYTE equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
valganciclovir tab (VALCYTE equiv)	-	3
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days)	MSP-PA-QL	5
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	MSP-PA-QL	5
VALCYTE SOLN	-	NC
VALCYTE TAB	-	NC
HEPATITIS AGENTS		
lamivudine tab 100mg (EPIVIR HBV equiv)	-	2
RIBAVIRIN CAP	MSP	2
ribavirin cap (REBETOL equiv)	MSP	2
RIBAVIRIN TAB	MSP	2
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	MSP-PA-QL	3
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	MSP-PA-QL	3
VEMLIDY TAB	-	3
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	5
PEGASYS INJ	MSP	5
adefovir dipivoxil tab (HEPSERA equiv)	-	NC
BARACLUDE SOLN	-	NC
BARACLUDE TAB	-	NC
EPCLUSA PAK	-	NC
EPCLUSA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
HARVONI PELLET PAK	-	NC
HARVONI TAB	-	NC
HEPCLUDEX INJ	-	NC
MAVYRET PAK	-	NC
MAVYRET TAB	-	NC
SOVALDI PELLET PAK	-	NC
SOVALDI TAB	-	NC
VOSEVI TAB	-	NC
ZEPATIER TAB	-	NC
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	2
acyclovir susp (ZOVIRAX equiv)	-	2
acyclovir tab (ZOVIRAX equiv)	-	2
valacyclovir tab (VALTREX equiv)	-	2
famciclovir tab (FAMVIR equiv)	-	3
SITAVIG TAB	-	NC
VALTREX TAB	-	NC
ZOVIRAX CAP	-	NC
ZOVIRAX SUSP	-	NC
ZOVIRAX TAB	-	NC
INFLUENZA AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill)	QL	2
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill)	QL	2
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill)	QL	3
RIMANTADINE TAB	-	4
XOFLUZA TAB (QL= 1 tab/fill)	QL	4
FLUMADINE TAB	-	NC
RELENZA DISKHALER	-	NC
TAMIFLU CAP	-	NC
TAMIFLU CAP 30MG	-	NC
MISC. ANTIVIRALS		
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	3
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	3
XOCOVA TAB	-	NC
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
RIBAVIRIN INH	-	NC
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
CHELATING AGENTS		
D-PENAMINE TAB	-	3
IMMUNOMODULATORS		
THALOMID CAP	MSP-PA	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
IMMUNOSUPPRESSIVE AGENTS		
azathioprine tab (IMURAN equiv)	-	2
tacrolimus cap (PROGRAF equiv)	-	2
cyclosporine cap (SANDIMMUNE equiv)	-	5
cyclosporine modified cap (NEORAL equiv)	-	5
cyclosporine modified soln (NEORAL equiv)	-	5
mycophenolate DR tab (MYFORTIC equiv)	-	5
mycophenolate mofetil cap (CELLCEPT equiv)	-	5
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	5
mycophenolate mofetil tab (CELLCEPT equiv)	-	5
SANDIMMUNE SOLN 100MG/ML	-	5
sirolimus tab (RAPAMUNE equiv)	-	5
CELLCEPT CAP	-	NC
CELLCEPT SUSP	-	NC
CELLCEPT TAB	-	NC
ENVARSUS XR TAB	-	NC
IMURAN TAB	-	NC
MYFORTIC TAB	-	NC
NEORAL CAP	-	NC
NEORAL SOLN	-	NC
PROGRAF CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
RAPAMUNE TAB	-	NC
SANDIMMUNE CAP	-	NC
POTASSIUM REMOVING RESINS		
sodium polystyrene susp (SPS equiv)	-	2
sodium polystyrene powder (KAYEXALATE equiv)	-	3
VELTASSA POWDER (QL= 1 packet/day)	PA-QL	3
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	2
labetalol tab (NORMODYNE equiv)	-	2
carvedilol phosphate ER cap (COREG CR equiv)	-	NC
COREG CR CAP	-	NC
COREG TAB	-	NC
labetalol hcl tab 400mg	-	NC
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol cap (SECTRAL equiv)	-	2
atenolol tab (TENORMIN equiv)	-	2
betaxolol tab (KERLONE equiv)	-	2
bisoprolol tab (ZEBETA equiv)	-	2
metoprolol ER tab (TOPROL XL equiv)	-	2
metoprolol tab (LOPRESSOR equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
nebivolol hcl tab (BYSTOLIC equiv)	-	2
BISOPROLOL FUMARATE TAB	-	NC
BYSTOLIC TAB	-	NC
KAPSPARGO CAP	-	NC
KERLONE TAB	-	NC
LOPRESSOR SOLN	-	NC
LOPRESSOR TAB	-	NC
METOPROLOL TARTRATE TAB	-	NC
TENORMIN TAB	-	NC
TOPROL XL TAB	-	NC
BETA BLOCKERS NON-SELECTIVE		
propranolol ER cap (INDERAL LA equiv)	-	2
propranolol hcl oral soln 20mg/5ml	-	2
PROPRANOLOL SOLN	-	2
PROPRANOLOL SOLN 20MG/5ML	-	2
propranolol tab (INDERAL equiv)	-	2
sotalol AF tab (BETAPACE AF equiv)	-	2
sotalol tab (BETAPACE equiv)	-	2
TIMOLOL MALEATE TAB	-	2
timolol maleate tab (BLOCADREN equiv)	-	2
nadolol tab (CORGARD equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
BETAPACE AF TAB	-	NC
BETAPACE TAB	-	NC
CORGARD TAB	-	NC
HEMANGEOL ORAL SOLN	-	NC
HEMANGEOL SOLN	-	NC
INDERAL LA CAP	-	NC
INDERAL XL CAP, INNOPRAN XL CAP	-	NC
pindolol tab (VISKEN equiv)	-	NC
SOTYLIZE SOLN	-	NC
SOTYLIZE SOLN 5MG/ML	-	NC
BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
GRASTEK SL TAB	-	NC
ORALAIR SL TAB	-	NC
RAGWITEK SL TAB	-	NC
BIOLOGICALS MISC		
ADAGEN INJ	-	NC
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKER COMBINATIONS		
CONSENSI TAB	-	NC
CALCIUM CHANNEL BLOCKERS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
amlodipine tab (NORVASC equiv)	-	2
diltiazem ER cap (CARDIZEM CD equiv)	-	2
diltiazem ER cap (DILACOR XR equiv)	-	2
diltiazem ER cap (TIAZAC equiv)	-	2
diltiazem tab (CARDIZEM equiv)	-	2
felodipine ER tab (PLENDIL equiv)	-	2
nifedipine cap (PROCARDIA equiv)	-	2
nifedipine ER tab (ADALAT CC equiv)	-	2
verapamil SR cap (VERELAN equiv)	-	2
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	2
verapamil tab (CALAN equiv)	-	2
diltiazem ER cap (CARDIZEM SR equiv)	-	3
diltiazem ER tab (CARDIZEM LA equiv)	-	3
nicardipine cap (CARDENE equiv)	-	4
NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older)	PA	4
VERAPAMIL ER CAP	-	4
ADALAT CC TAB	-	NC
CALAN SR TAB	-	NC
CARDAMYST NASAL SPRAY	-	NC
CARDIZEM CD CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
CARDIZEM LA TAB	-	NC
CARDIZEM TAB	-	NC
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC
DILACOR XR CAP	-	NC
isradipine cap (DYNACIRC equiv)	-	NC
KATERZIA SUSP	-	NC
nimodipine cap (NIMOTOP equiv)	-	NC
nisoldipine ER tab (SULAR equiv)	-	NC
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	NC
NISOLDIPINE ER TAB 25.5MG	-	NC
NISOLDIPINE ER, SULAR ER TAB	-	NC
NORVASC TAB	-	NC
NYMALIZE SOLN	-	NC
SDAMLO SOLN	-	NC
TIAZAC CAP	-	NC
VERAPAMIL ER CAP, VERELAN CAP	-	NC
VERELAN CAP	-	NC
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin soln (LANOXIN equiv)	-	2
DIGOXIN SOLN 0.05MG/ML	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOTONICS Cont.		
digoxin tab (LANOXIN equiv)	-	2
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC
LANOXIN TAB	-	NC
LANOXIN TAB 62.5MCG	-	NC
CARDIOVASCULAR AGENTS - MISC.		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	5
MYQORZO TAB	-	NC
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day)	QL	2
amlodipine/atorvastatin tab (CADUET equiv)	-	NC
BIDIL TAB	-	NC
CADUET TAB	-	NC
ENTRESTO CAP	-	NC
ENTRESTO TAB	-	NC
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC
OPSYNVI TAB	-	NC
CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS		
LODOCO TAB	-	NC
CARDIOVASCULAR SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
INPEFA TAB	-	NC
IMPOTENCE AGENTS		
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; Step Therapy requires trial doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap)	QL-ST	2
avanafil tab (STENDRA equiv)	-	EXC
CIALIS TAB	-	EXC
LEVITRA TAB	-	EXC
sildenafil tab (VIAGRA equiv)	-	EXC
STENDRA TAB	-	EXC
tadalafil tab (CIALIS equiv)	-	EXC
vardenafil ODT (STAXYN equiv)	-	EXC
vardenafil tab (LEVITRA equiv)	-	EXC
VYBRIQUE ORAL FILM	-	EXC
CIALIS TAB 2.5MG, 5MG	-	NC
PROSTAGLANDIN VASODILATORS		
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accred 800-803-2523)	LD-PA-QL	5
ORENITRAM TAB	-	NC
ORENITRAM TAB MONTH PAK	-	NC
TYVASO DPI POWDER	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
TYVASO DPI POWDER 48-80MCG	-	NC
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	-	NC
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG	-	NC
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG	-	NC
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	-	NC
VENTAVIS INH SOLN	-	NC
YUTREPIA CAP	-	NC
PULMONARY HYPERTENSION - ACTIVIN SIGNALING INHIBITOR		
WINREVAIR INJ	-	NC
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	2
bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
macitentan tab (OPSUMIT equiv) (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	2
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Walgreen 888-347-3416)	LD-PA-QL	5
LETAIRIS TAB	-	NC
OPSUMIT TAB	-	NC
TRACLEER TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
TRACLEER TAB 62.5MG, 125MG	-	NC
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil tab 20mg (REVATIO equiv)	PA	2
tadalafil tab (PAH) (ADCIRCA equiv)	PA	2
sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older)	PA	3
TADLIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	4
ADCIRCA TAB	-	NC
LIQREV SUSP	-	NC
REVATIO SUSP	-	NC
REVATIO TAB	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
UPTRAVI THERAPY PACK (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
UPTRAVI INJ	-	NC
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB	-	NC
SINUS NODE INHIBITORS		
ivabradine hcl tab (CORLANOR equiv)	-	2
CORLANOR SOLN (Prior Authorization required for members age 9 years and olde	PA	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
CORLANOR TAB	-	4
TRANSTHYRETIN STABILIZERS		
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 (Walgreens 888-347-3416)	LD-PA-QL	5
ATTRUBY PACK	-	NC
VYNDAMAX CAP	-	NC
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB	-	NC
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	2
cefadroxil susp (DURICEF equiv)	-	2
cefadroxil tab (DURICEF equiv)	-	2
cephalexin cap (KEFLEX equiv)	-	2
cephalexin susp (KEFLEX equiv)	-	2
CEFADROXIL TAB	-	3
cephalexin cap 750mg (KEFLEX equiv)	-	NC
cephalexin tab	-	NC
KEFLEX CAP	-	NC
KEFLEX CAP 750MG	-	NC
CEPHALOSPORINS - 2ND GENERATION		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CEPHALOSPORINS Cont.		
cefprozil susp (CEFZIL equiv)	-	2
cefprozil tab (CEFZIL equiv)	-	2
cefuroxime tab (CEFTIN equiv)	-	2
CEFACLOR CAP	-	4
cefaclor cap (CECLOR equiv)	-	4
CEFACLOR ER TAB	-	4
CEFACLOR SUSP	-	4
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap (OMNICEF equiv)	-	2
cefdinir susp (OMNICEF equiv)	-	2
cefixime cap (SUPRAX equiv)	-	4
cefixime susp (SUPREX equiv)	-	4
CEFPODOXIME PROXETIL SUSP	-	4
cefpodoxime proxetil tab (VANTIN equiv)	-	4
SUPRAX CAP	-	4
SUPRAX SUSP 500MG/5ML	-	4
CEFIXIME TAB	-	NC
OMNICEF SUSP	-	NC
SUPRAX CAP	-	NC
SUPRAX SUSP	-	NC
CONTRACEPTIVES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	1
ARANELLE TAB	-	1
aranelle tab (TRI-NORINYL equiv)	-	1
AVERI TAB	-	1
aviane tab (ALESSE equiv)	-	1
BALCOLTRA TAB	-	1
cesia tab (CYCLESSA equiv)	-	1
cryselle tab	-	1
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	1
enpresse tab (TRI-LEVELEN equiv)	-	1
FEMLYV TAB	-	1
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	1
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	1
jolessa tab, amethia tab (SEASONALE, SEASONIQUE equiv)	-	1
kelnor tab (DEMULEN equiv)	-	1
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	1
LO LOESTRIN TAB	-	1
NATAZIA TAB	-	1
NEXTSTELLIS TAB	-	1
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
norethindrone acetate/ethinyl estradial FE chew tab (MINASTRIN equiv)	-	1
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	1
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	1
nortrel tab (OVCON 35 equiv)	-	1
SAFYRAL TAB	-	1
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	1
tri-legest tab (ESTROSTEP FE equiv)	-	1
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	1
TYBLUME TAB	-	1
VALTYA 1/50 TAB	-	1
VELIVET PAK	-	1
viorele tab, kariva tab (MIRCETTE equiv)	-	1
wymzya FE tab (FEMCON FE equiv)	-	1
BEYAZ TAB	-	4
TAYTULLA CAP	-	4
DESOGEN TAB	-	NC
ESTROSTEP FE TAB	-	NC
FALESSA KIT	-	NC
FEMCON FE CHEW TAB	-	NC
MINASTRIN CHEW TAB	-	NC
MIRCETTE TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
ORTHO TRI-CYCLEN (LO) TAB	-	NC
ORTHO-CYCLEN TAB	-	NC
OVCON 35 TAB	-	NC
SEASONIQUE TAB	-	NC
TRI-NORINYL TAB	-	NC
YAZ TAB, YASMIN 28 TAB	-	NC
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
TWIRLA PATCH	-	1
zafemy patch (XULANE equiv)	-	1
GWYN LO PATCH	-	NC
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA RING (QL= 1 ring/year)	QL	1
eluryng vaginal ring (NUVARING equiv)	-	1
NUVARING	-	NC
COPPER CONTRACEPTIVES - IUD		
MIDUELLA, PARAGARD IUD	-	1
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	1
levonorgestrel tab (PLAN B equiv)	OTC	1
PLAN B TAB	OTC	1
PROGESTIN CONTRACEPTIVES - IMPLANTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
NEXPLANON IMPLANT	-	1
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	1
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	1
DEPO-PROVERA INJ	-	NC
PROGESTIN CONTRACEPTIVES - IUD		
KYLEENA IUD	-	1
MIRENA IUD	-	1
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	1
SLYND TAB	-	1
NOR-QD TAB	-	NC
OPILL TAB	OTC	NC
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
DEXAMETHASONE CONC	-	2
dexamethasone elixir	-	2
DEXAMETHASONE PHOSPHATE INJ	-	2
DEXAMETHASONE SODIUM PHOSPHATE INJ	-	2
DEXAMETHASONE SOLN	-	2
DEXAMETHASONE TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
dexamethasone tab (DECADRON equiv)	-	2
HEMADY TAB	-	2
hydrocortisone tab (CORTEF equiv)	-	2
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	2
methylprednisolone dose pack (MEDROL equiv)	-	2
methylprednisolone tab (MEDROL equiv)	-	2
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	2
prednisolone soln	-	2
prednisolone soln (PEDIAPRED equiv)	-	2
prednisone tab (DELTASONE equiv)	-	2
triamcinolone acetate inj (KENALOG equiv)	-	2
budesonide SR cap (ENTOCORT EC equiv)	-	3
CORTISONE ACETATE TAB	-	3
hydrocortisone succinate inj 1000mg (SOLU-CORTEF equiv) (QL= 2 vials/fill)	QL	3
MEDROL TAB	-	3
prednisolone ODT (ORAPRED equiv)	-	3
PREDNISONE SOLN	-	3
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	3
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	3
SOLU-MEDROL INJ 2GM	-	3
budesonide ER tab (QL=1 tab/day)	PA-QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
DEPO-MEDROL INJ	-	4
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	4
KENALOG INJ	-	4
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	4
ORAPRED ODT TAB, PREDNISOLONE ODT TAB	-	4
PREDNISOLONE SOLN	-	4
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoR 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	5
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	5
KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-500 Prior Authorization required for members age 9 years and older)	LD-PA-QL	5
AGAMREE SUSP	-	NC
ALKINDI SPRINKLE CAP	-	NC
CORTEF TAB	-	NC
deflazacort susp (EMFLAZA equiv)	-	NC
deflazacort tab (EMFLAZA equiv)	-	NC
dexamethasone pak (DEXPAK equiv)	-	NC
DEXPAK TAB	-	NC
DXEVO 11-DAY PAK	-	NC
EMFLAZA SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
EMFLAZA TAB	-	NC
EOHILIA SUSP	-	NC
FLO-PRED SUSP	-	NC
LIDOLOG KIT	-	NC
MEDROL DOSE PACK	-	NC
MEDROL TAB	-	NC
MILLIPRED DP PAK	-	NC
MILLIPRED TAB	-	NC
ORAPRED SOLN	-	NC
ORTIKOS ER CAP	-	NC
prednisolone tab (MILLIPRED equiv)	-	NC
PREDNISONE DR TAB	-	NC
PREDNISONE DR TAB, RAYOS DR TAB	-	NC
prednisone pack	-	NC
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC
SOLU-MEDROL INJ	-	NC
SOLU-MEDROL PF INJ	-	NC
TARPEYO CAP	-	NC
UCERIS TAB	-	NC
MINERALOCORTICOIDS		
fludrocortisone tab (FLORINEF equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap (TESSALON equiv)	-	2
hydrocodone/homatropine syrup (HYCODAN equiv)	-	2
tussigon tab (HYCODAN equiv)	-	2
BENZONATATE CAP 150MG	-	NC
benzonatate cap 150mg (ZONATUSS equiv)	-	NC
HYCODAN SYRUP	-	NC
TESSALON CAP	-	NC
ZONATUSS CAP 150MG	-	NC
COUGH/COLD/ALLERGY COMBINATIONS		
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	2
promethazine DM syrup	-	2
PROMETHAZINE VC SYRUP	-	2
promethazine VC syrup (PHENERGAN VC equiv)	-	2
PROMETHAZINE VC/CODEINE SYRUP	-	2
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	2
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	2
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	4
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/ days)	QL	4
SEMPREX-D CAP	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
BROVEX PEB LIQUID	OTC	NC
CLARINEX-D TAB	-	NC
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC
HYCOFENIX SOLN	-	NC
INTENSE COUGH LIQUID	-	NC
lohist liquid (DECON-A equiv)	OTC	NC
MUCINEX LIQUID	-	NC
POLY-TUSSIN DM SYRUP	-	NC
TUSSICAPS	-	NC
TUXARIN ER TAB	-	NC
TUZISTRA XR SUSP	-	NC
EXPECTORANTS		
POTASSIUM IODIDE ORAL SOLN	-	3
GUAIFENESEN SYRUP	-	NC
guaifenesin tab (ALLFEN JR equiv)	-	NC
MISC. RESPIRATORY INHALANTS		
HYPER-SAL NEB SOLN 7%	-	NC
NEBUSAL NEB SOLN	-	NC
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	2
DERMATOLOGICALS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ACNE PRODUCTS		
clindamycin gel (CLEOCIN GEL equiv)	-	2
clindamycin lotion (CLEOCIN- T equiv)	-	2
clindamycin pad (CLEOCIN-T equiv)	-	2
clindamycin topical soln (CLEOCIN-T equiv)	-	2
DIFFERIN OTC GEL 0.1% (Acne Only - Prior Authorization required for members a 35 years and older)	OTC-PA	2
ERYTHROMYCIN GEL	-	2
erythromycin pad	-	2
erythromycin soln	-	2
RETIN-A CREAM (Acne Only - Prior Authorization required for members age 35 years and older)	PA	2
RETIN-A GEL (Acne Only - Prior Authorization required for members age 35 years and older)	PA	2
adapalene cream (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
adapalene gel (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	3
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	3
AVAR CLEANSE LIQ 10-5%	-	3
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	3
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	3
ERY PAD	-	3
erythromycin/benzoyl peroxide gel (BENZAMYCIN equiv)	-	3
SOD SUL/SULF LIQ 9-4.5%	-	3
sodium sulfacetamide lotion (KLARON equiv)	-	3
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	3
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	3
tretinoin cream (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
tretinoin gel (RETIN-A GEL equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
tretinoin microsphere gel (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
TRETINOIN MICROSPHERE GEL 0.04% (Acne Only - Prior Authorization required members age 35 years and older)	PA	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
TRETINOIN MICROSPHERE GEL 0.1% (Acne Only - Prior Authorization required f members age 35 years and older)	PA	3
TRETINOIN MICROSPHERE GEL PUMP 0.04% (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
TRETINOIN MICROSPHERE GEL PUMP 0.1% (Acne Only - Prior Authorization required for members age 35 years and older)	PA	3
ABSORICA CAP	-	NC
ABSORICA LD CAP	-	NC
ACZONE GEL	-	NC
ADAPALENE SOLN	-	NC
ADAPALENE PAD	-	NC
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC
AKLIEF CREAM	-	NC
ALTRENO LOTION	-	NC
AMZEEQ FOAM	-	NC
ARAZLO LOTION	-	NC
ATRALIN GEL 0.05%	-	NC
AVAR AEROSOL FOAM	-	NC
AVAR PAD	-	NC
AVAR-E EMOLL CREAM	-	NC
AVAR-E LS CREAM 10-2%	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
AZELEX CREAM	-	NC
BENZACLIN GEL	-	NC
BENZAMYCIN GEL	-	NC
BENZAMYCIN GEL PACK	-	NC
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC
BP 10-1 EMU	-	NC
CABTREO GEL	-	NC
CLARIFOAM EF FOAM	-	NC
CLENIA PLUS SUSP	-	NC
CLEOCIN-T GEL	-	NC
CLEOCIN-T LOTION	-	NC
CLEOCIN-T PAD	-	NC
CLEOCIN-T SOLN	-	NC
CLINDACIN KIT	-	NC
clindamycin foam (EVOCLIN equiv)	-	NC
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC
clindamycin/tretinoin gel (ZIANA equiv)	-	NC
CLINDAVIX KIT	-	NC
dapsone gel (ACZONE equiv)	-	NC
DIFFERIN CREAM	-	NC
DIFFERIN GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DIFFERIN LOTION	-	NC
DUAC GEL	-	NC
EPIDUO FORTE GEL 0.3-2.5%	-	NC
EPIDUO GEL 0.1-2.5%	-	NC
EPSOLAY CREAM	-	NC
EVOCLIN FOAM	-	NC
FABIOR AEROSOL FOAM	-	NC
isotretinoin cap 25mg (ABSORICA equiv)	-	NC
isotretinoin cap 35mg (ABSORICA equiv)	-	NC
KLARON LOTION	-	NC
NUCARACLINPA KIT	-	NC
NUCARARXPAK KIT	-	NC
ONEXTON GEL1.2-3.75%	-	NC
PLEXION CREAM 9.8-4.8%	-	NC
RETIN-A MICRO GEL/GEL PUMP	-	NC
RETIN-A MICRO GEL/GEL PUMP, TRETINOIN MICROSPHERE GEL/GEL PUMP	-	NC
ROSULA EMULSION	-	NC
SOD SUL/SULF SUSP 10-5%	-	NC
SOD SUL/SULF SUSP 8-4%	-	NC
SODIUM SULFACETAMIDE/SULFUR CREAM 10-2%	-	NC
SODIUM SULFACETAMIDE/SULFUR EMULSION	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC
SODIUM SULFACETAMIDE/SULFUR LOTION	-	NC
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC
SODIUM SULFACETAMIDE/SULFUR WASH	-	NC
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	NC
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC
SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-4.8%	-	NC
SUMADAN WASH 9-4.5%	-	NC
SUMADEN XLT KIT	-	NC
SUMAXIN WASH	-	NC
tretinoin gel 0.05% (ATRALIN equiv)	-	NC
TRETINOIN MICROSPHERE GEL/GEL PUMP	-	NC
TWYNEO CREAM	-	NC
WINLEVI CREAM	-	NC
ZIANA GEL	-	NC
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
VEREGEN OINT	-	NC
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES		
RENOVA CREAM	-	EXC
KYBELLA INJ	-	NC
ANALGESICS - TOPICAL		
BACLOFEN CREAM COMPOUND KIT	-	NC
TRAMADOL COMPOUND KIT	-	NC
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream	-	2
gentamicin sulfate oint	-	2
mupirocin oint (BACTROBAN OINT equiv)	-	2
CENTANY OINT	-	4
ALTABAX OINT	-	NC
BACTROBAN CREAM	-	NC
mupirocin cream (BACTROBAN equiv)	-	NC
NEO-SYNALAR CREAM	-	NC
XEPI CREAM	-	NC
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	2
ciclopirox gel (LOPROX GEL equiv)	-	2
ciclopirox nail soln (PENLAC equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ciclopirox topical susp (LOPROX SUSP equiv)	-	2
clotrimazole/betamethasone cream (LORTRISONE CREAM equiv)	-	2
econazole cream (SPECTAZOLE equiv)	-	2
ketoconazole cream (NIZORAL CREAM equiv)	-	2
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	2
nystatin cream (MYCOSTATIN CREAM equiv)	-	2
nystatin oint	-	2
nystatin topical powder	-	2
nystatin/triamcinolone cream	-	2
nystatin/triamcinolone oint	-	2
ciclopirox shampoo (LOPROX SHAMPOO equiv)	-	3
tavaborole soln (KERYDIN equiv) (QL= 10ml/30 days; Step Therapy requires trial of both ciclopirox nail soln and terbinafine tab)	QL-ST	3
EXELDERM SOLN	-	4
MENTAX CREAM	-	4
naftifine cream (NAFTIN equiv)	-	4
oxiconazole nitrate cream (OXISTAT equiv)	-	4
ALCORTIN A GEL	-	NC
ALOQUIN GEL	-	NC
clotrimazole cream (LOTRIMIN AF equiv)	OTC	NC
clotrimazole soln	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	NC
clotrimazole/betamethasone lotion (LOTRISONE LOTION equiv)	-	NC
ECONASIL KIT	-	NC
ECONAZOLE NITRATE FOAM, ECOZA FOAM	-	NC
ECOZA FOAM	-	NC
ERTACZO CREAM	-	NC
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC
HC/IODOQUIN CREAM	-	NC
HIXDEFRIMA SOLN	-	NC
IODOQUINOL/HC ALOE GEL	-	NC
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	NC
IODOQUINOL-HYDROCORTISONE CREAM	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOPROX CREAM	-	NC
LOPROX SHAMPOO	-	NC
LOTRIMIN AF CREAM	-	NC
LOTRISONE CREAM	-	NC
LULICONAZOLE CREAM, LUZU CREAM	-	NC
NAFTIFINE CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
naftifine hcl gel 2% (NAFTIN equiv)	-	NC
NAFTIN GEL 2%	-	NC
NIZORAL SHAMPOO	-	NC
NYATA KIT	-	NC
ONYCHO-MED KIT	-	NC
OXISTAT CREAM	-	NC
OXISTAT LOTION	-	NC
PEDIZOLPAK THERAPY PACK	-	NC
PENLAC SOLN	-	NC
VYTONE CREAM 1.9-1%	-	NC
XOLEGEL	-	NC
ZOLPAK KIT	-	NC
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	2
diclofenac soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill)	QL	3
VOLTAREN GEL	OTC	EXC
DICLOFENAC PATCH, FLECTOR PATCH	-	NC
diclofenac sodium gel kit (VENNGEL equiv)	-	NC
diclofenac sodium soln 2% (PENNSAID equiv)	-	NC
DICLONA GEL	-	NC
DICLOTREX PAK	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC
INFLAMMA-K KIT	-	NC
LEXTOL PAK	-	NC
LICART PATCH	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
PROFINAC PAK	-	NC
REXAPHENAC CREAM	-	NC
VAROPHEN KIT	-	NC
VENNGEL ONE KIT	-	NC
VOPAC 5 CREAM	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC
XRYLIX PAK	-	NC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
bexarotene gel (TARGRETIN equiv)	MSP-PA	2
fluorouracil cream (EFUDEX CREAM equiv)	-	2
CARAC CREAM	-	3
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	3
FLUOROURACIL SOLN	-	3
fluorouracil soln (FLUOROURACIL equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
FLUOROURACIL CREAM 0.5%	-	4
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5
CARAC CREAM	-	NC
EFUDEX CREAM	-	NC
FLUORAC CREAM	-	NC
KLISYRI OINT	-	NC
PANRETIN GEL	-	NC
ROAOXIA GEL	-	NC
SOLARAVIX PAK	-	NC
TARGRETIN GEL	-	NC
ANTIPRURITICS - TOPICAL		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	PA	4
DOXEPIN HCL CREAM	-	NC
ANTIPSORIATICS		
acitretin cap (SORIATANE equiv)	-	3
calcipotriene cream (DOVONEX CREAM equiv)	-	3
calcipotriene oint	-	3
calcipotriene soln (DOVONEX SOLN equiv)	-	3
CALCIPOTRIENE SOLN 0.005%	-	3
METHOXSALEN CAP	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
methoxsalen cap (OXSORALEN ULTRA equiv)	-	3
CALCITRIOL OINT	-	4
tazarotene cream 0.05% (TAZORAC equiv)	-	4
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	MSP-PA-QL	5
SKYRIZI INJ 55MG/0.37ML (QL= 1 inj/84 days)	MSP-PA-QL	5
STELARA INJ (QL= 1 inj/84 days)	MSP-PA-QL	5
STEQEYMA INJ (QL= 1 inj/84 days)	MSP-PA-QL	5
STEQEYMA INJ 90MG (QL= 1 inj/84 days)	MSP-PA-QL	5
TALTZ INJ (QL= 1 inj/28 days)	MSP-PA-QL	5
TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days)	MSP-PA-QL	5
TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days)	MSP-PA-QL	5
YESINTEK INJ (QL= 1 inj/84 days)	MSP-PA-QL	5
BIMZELX INJ	-	NC
BIMZELX INJ 320MG/2ML	-	NC
BIMZELX SYRINGE	-	NC
BIMZELX SYRINGE 320MG/2ML	-	NC
calcipotriene cream (TRIONEX equiv)	-	NC
CALCIPOTRIENE FOAM	-	NC
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC
CALSODORE PAK	-	NC
COSENTYX INJ (1-PACK)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
COSENTYX INJ (2-PACK)	-	NC
COSENTYX INJ 300MG/2ML	-	NC
COSENTYX UNO INJ	-	NC
DOVONEX CREAM	-	NC
ICOTYDE TAB	-	NC
IMULDOSA SYRINGE	-	NC
NUDERMRXPAK PAK	-	NC
OTULFI INJ	-	NC
OTULFI, USTEKINUMAB-AAUZ SYRINGE	-	NC
OXSORALEN ULTRA CAP	-	NC
PELLIX SOLN	-	NC
PYZCHIVA INJ	-	NC
SELARSDI INJ	-	NC
SILIQ INJ	-	NC
SORIATANE CAP	-	NC
SOTYKTU TAB	-	NC
SPEVIGO INJ	-	NC
STARJEMZA INJ	-	NC
STARJEMZA PFS INJ	-	NC
STEQEYMA VIAL	-	NC
tazarotene cream 0.1% (TAZORAC equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
tazarotene gel (TAZORAC equiv)	-	NC
TAZORAC CREAM	-	NC
TAZORAC GEL	-	NC
TREMFYA INJ	-	NC
TRIONEX PAK	-	NC
USTEKINUMAB INJ	-	NC
USTEKINUMAB-AEKN 45MG/0.5ML	-	NC
USTEKINUMAB-AEKN 90MG/ML	-	NC
VECTICAL OINT	-	NC
VTAMA CREAM	-	NC
WEZLANA INJ	-	NC
WEZLANA SYRINGE	-	NC
YESINTEK SYRINGE	-	NC
YESINTEK SYRINGE 90MG	-	NC
ANTISEBORRHEIC PRODUCTS		
SELENIUM SUL SHA	-	3
selenium sulfide shampoo (SELSEB equiv)	-	3
ESKATA SOLN	-	NC
OVACE PLUS CREAM	-	NC
OVACE PLUS GEL WASH	-	NC
OVACE PLUS LIQ WASH 10%	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
OVACE PLUS LOTION	-	NC
OVACE PLUS SHAMPOO	-	NC
OVACE PLUS FOAM	-	NC
PROMISEB CREAM	-	NC
SELENIUM SUL SHA 2%	-	NC
SELENIUM SULFIDE LOTION	-	NC
selenium sulfide lotion 2.5% (SELSUN equiv)	-	NC
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC
SELRX SHAMPOO 2.3%	-	NC
SODIUM SULFA LIQ WASH	-	NC
sodium sulfacetamide shampoo (OVACE equiv)	-	NC
sodium sulfacetamide wash (OVACE WASH equiv)	-	NC
ANTIVIRALS - TOPICAL		
acyclovir oint (ZOVIRAX equiv)	-	2
ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days)	PA-QL	3
ZOVIRAX OINT	-	4
acyclovir cream (ZOVIRAX equiv)	-	NC
DENAVIR CREAM	-	NC
penciclovir cream (DENAVIR equiv)	-	NC
XERESE CREAM	-	NC
ZOVIRAX CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
BURN PRODUCTS		
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	2
SULFAMYLON CREAM	-	3
MAFENIDE ACETATE SOLN PACK	-	NC
SILVADENE CREAM	-	NC
SULFAMYLON PACK	-	NC
CORTICOSTEROIDS - TOPICAL		
BETAMETH VALERATE LOTION	-	2
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	2
betamethasone augmented oint (DIPROLENE OINT equiv)	-	2
betamethasone diproprionate cream (DIPROSONE CREAM equiv)	-	2
betamethasone diproprionate lotion	-	2
betamethasone valerate cream	-	2
betamethasone valerate lotion	-	2
betamethasone valerate oint	-	2
clobetasol propionate cream (TEMOVATE equiv)	-	2
clobetasol propionate oint (TEMOVATE equiv)	-	2
clobetasol propionate soln (TEMOVATE equiv)	-	2
fluocinolone acetonide cream	-	2
fluocinolone acetonide oint	-	2
fluocinolone acetonide soln	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
fluocinonide cream 0.05% (LIDEX equiv)	-	2
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	2
fluocinonide emollient cream	-	2
fluocinonide gel	-	2
fluocinonide oint	-	2
fluocinonide soln	-	2
fluticasone propionate cream (CUTIVATE equiv)	-	2
fluticasone propionate oint (CUTIVATE equiv)	-	2
hydrocortisone cream (PROCTOCORT equiv)	-	2
hydrocortisone lotion (HYTONE equiv)	-	2
HYDROCORTISONE LOTION 2.5%	-	2
hydrocortisone oint	-	2
mometasone cream (ELOCON equiv)	-	2
mometasone oint (ELOCON equiv)	-	2
mometasone soln (ELOCON equiv)	-	2
triamcinolone cream	-	2
TRIAMCINOLONE LOTION	-	2
triamcinolone oint	-	2
alclometasone cream (ACLOVATE equiv)	-	3
ALCLOMETASONE OINT	-	3
alclometasone oint (ACLOVATE OINT equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
BETAMETHASONE AUGMENTED GEL	-	3
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	3
betamethasone diproprionate oint (DIPROSONE OINT equiv)	-	3
clobetasol foam (OLUX equiv)	-	3
clobetasol lotion (CLOBEX equiv)	-	3
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	3
clobetasol propionate gel (TEMOVATE GEL equiv)	-	3
clobetasol shampoo (CLOBEX equiv)	-	3
clobetasol spray (CLOBEX equiv)	-	3
DERMA-SMOOTH/FS OIL	-	3
desonide cream (DESOWEN equiv)	-	3
desonide oint	-	3
desoximetasone cream (TOPICORT CREAM equiv)	-	3
desoximetasone oint (TOPICORT equiv)	-	3
EPIFOAM AEROSOL	-	3
fluocinolone acetonide oil (DERMA-SMOOTH/FS equiv)	-	3
halobetasol propionate cream (ULTRAVATE equiv)	-	3
halobetasol propionate oint (ULTRAVATE equiv)	-	3
AMCINONIDE LOTION	-	4
CORDRAN TAPE	-	4
NUCORT LOTION	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ALA-SCALP LOTION	-	NC
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE OINTMENT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
BESER KIT 0.05%	-	NC
betamethasone augmented gel	-	NC
betamethasone valerate foam (LUXIQ FOAM equiv)	-	NC
BRYHALI LOTION	-	NC
calcipotriene/betamethasone dipropionate susp	-	NC
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC
CAPEX SHAMPOO	-	NC
clobetasol E foam (OLUX E equiv)	-	NC
CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM	-	NC
CLOBETAVIX KIT	-	NC
CLOBEX LOTION	-	NC
CLOBEX SHAMPOO	-	NC
CLOBEX SPRAY	-	NC
CLOCORTOLONE CREAM	-	NC
CLODERM CREAM	-	NC
CORDRAN CREAM	-	NC
CORDRAN CREAM 0.025%	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CORDRAN LOTION	-	NC
CORDRAN OINTMENT	-	NC
CUTIVATE LOTION	-	NC
DERMACINRX KIT	-	NC
DESONATE GEL	-	NC
desonide gel	-	NC
desonide lotion	-	NC
DESOWEN CREAM	-	NC
DESOWEN CREAM KIT	-	NC
DESOWEN LOTION	-	NC
DESOWEN LOTION KIT	-	NC
DESOWEN OINT	-	NC
DESOWEN OINT KIT	-	NC
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC
DESOXIMETASONE GEL	-	NC
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC
DIFLORASONE CREAM	-	NC
DIFLORASONE CREAM, PSORCON CREAM	-	NC
diflorasone oint	-	NC
DIPROLENE AF CREAM	-	NC
DIPROLENE OINT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
DUOBRII LOTION	-	NC
ELOCON CREAM	-	NC
ELOCON OINT	-	NC
ENSTILAR FOAM	-	NC
FLUOPAR KIT	-	NC
FLUOVIX PAK	-	NC
FLURANDRENOL LOTION	-	NC
flurandrenolide cream (CORDRAN equiv)	-	NC
flurandrenolide oint (CORDRAN equiv)	-	NC
FLUTICASONE LOTION	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
halcinonide cream (HALOG equiv)	-	NC
HALCINONIDE SOLN	-	NC
halcinonide soln (HALOG equiv)	-	NC
HALOBETASOL AER	-	NC
HALOBETASOL AERO	-	NC
HALOG CREAM	-	NC
HALOG OINT	-	NC
HALOG SOLN	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
HC BUTYRATE CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
HC BUTYRATE SOLN	-	NC
HC PRAMOXINE CREAM 1-2.5%	-	NC
HC/PRAMOXINE CREAM 1-2.35%	-	NC
HC-LIDOCAINE CREAM	-	NC
HYDROCORTISONE ACETATE CREAM, MICORT-HC CREAM	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
HYDROCORTISONE BUTYRATE OINT	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone lotion (LOCOID equiv)	-	NC
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC
HYDROCORTISONE PAK	-	NC
hydrocortisone valerate cream	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
hydrocortisone/pramoxine cream 2.5-1% (PRAMOSONE equiv)	-	NC
HYDROXYM GEL	-	NC
IMPEKLO LOTION	-	NC
IMPOYZ CREAM	-	NC
KENALOG SPRAY	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID LOTION	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MEXPAROX HC CREAM	-	NC
NOVACORT GEL	-	NC
OLUX E FOAM	-	NC
OLUX FOAM	-	NC
PANDEL CREAM	-	NC
paramox hc gel (NOVACORT GEL equiv)	-	NC
PRAMOSONE CREAM 1%	-	NC
PRAMOSONE CREAM 2.5-1%	-	NC
PRAMOSONE LOTION	-	NC
PRAMOSONE OINT	-	NC
PROCTOCORT CREAM	-	NC
QUINIXIL PAK	-	NC
QUINOSONE KIT	-	NC
SERNIVO SPRAY	-	NC
SILALITE PAK MIS	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
TACLONEX OINT	-	NC
TASOPROL CREAM KIT	-	NC
TEMOVATE CREAM	-	NC
TEMOVATE OINT	-	NC
TEXACORT SOLN	-	NC
TOPICORT CREAM	-	NC
TOPICORT CREAM 0.05%	-	NC
TOPICORT GEL	-	NC
TOPICORT OINT	-	NC
TOPICORT OINT 0.05%	-	NC
TOVET KIT	-	NC
triamcinolone acetonide oint (TRIANEX equiv)	-	NC
TRIAMCINOLONE SPRAY	-	NC
triamcinolone spray (KENALOG equiv)	-	NC
TRIAMVEX KIT	-	NC
TRIANEX OINT	-	NC
TRILOCICLO KIT	-	NC
ULTRAVATE CREAM	-	NC
ULTRAVATE LOTION	-	NC
ULTRAVATE OINT	-	NC
ULTRAVATE PAC KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
VANOS CREAM	-	NC
VERDESO FOAM	-	NC
WESTCORT OINT	-	NC
WYNZORA CREAM	-	NC
ECZEMA AGENTS		
OPZELURA CREAM (QL= 12 tubes/year)	PA-QL	4
ADBRY INJ (QL= 2 inj/28 days)	MSP-PA-QL	5
ADBRY INJ (QL= 4 inj/28 days)	MSP-PA-QL	5
ANZUPGO CREAM	-	NC
DUPIXENT INJ	-	NC
DUPIXENT PEN INJ	-	NC
EBGLYSS INJ	-	NC
EBGLYSS PEN INJ	-	NC
EMOLLIENT/KERATOLYTIC AGENTS		
CARMOL LOTION	-	NC
GORDON'S UREA OINT 40%	-	NC
KERAFOAM	-	NC
KERALAC CREAM	-	NC
UMECTA EMULSION	-	NC
UMECTA SUSP	-	NC
URAMAXIN CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
URAMAXIN GEL	-	NC
urea cream	-	NC
UREA EMULSION	-	NC
urea gel (URAMAXIN equiv)	-	NC
UREA LOT	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only)	-	2
ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only)	-	2
HYLINATE LOTION	-	NC
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	3
vasolex oint (XENADERM equiv)	-	NC
XENADERM OINT	-	NC
HAIR GROWTH AGENTS		
bimatoprost ophth soln (LATISSE equiv)	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC
LEQSELVI TAB	-	NC
LITFULO CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
HAIR REDUCTION AGENTS		
URANOVIA CREAM	-	EXC
IMMUNOMODULATING AGENTS - SYSTEMIC		
NEMLUVIO INJ	-	NC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	2
ALDARA CREAM	-	NC
IMIQUIMOD CREAM 3.75%	-	NC
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC
ZYCLARA CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
tacrolimus oint (PROTOPIC OINT equiv)	-	2
pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older)	-	3
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	5
ELIDEL CREAM	-	NC
OXIANUJO CREAM	-	NC
PROTOPIC OINT	-	NC
KERATOLYTIC/ANTIMITOTIC AGENTS		
PODOCON SOLN	-	3
PODOFILOX SOLN	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
podofilox soln (CONDYLOX equiv)	-	3
CONDYLOX GEL	-	NC
GEAMETDRAY GEL	-	NC
METDRAY GEL	-	NC
podofilox gel (CONDYLOX equiv)	-	NC
SALEX LOTION KIT	-	NC
SALICATE LIQUID	-	NC
SALICYLIC AC SOLN ER, XALIX SOLN	-	NC
SALIMEZ FORTE CREAM	-	NC
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS		
SALEX SHAMPOO	-	4
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	2
lidocaine gel (GLYDO equiv)	-	2
LIDOCAINE OINT (QL= 107gm/30 days)	QL	2
lidocaine soln (XYLOCAINE equiv)	-	2
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	QL	3
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	QL	4
SYNERA PATCH	-	4
ADAZIN CREAM	-	NC
ANASTIA LOTION	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
APRIZIO PAK KIT	-	NC
BENZOCAINE/LIDOCAINE/TETRACAINE OINT	-	NC
capsaicin/menthol topical patch (SINELEE equiv)	-	NC
DERMALID PAK	-	NC
GEN7T LOTION	-	NC
GEN7T PAD 3.5%	-	NC
GEN7T PLUS LOTION	-	NC
GEN7T PLUS PAD	-	NC
L.E.T. GEL	-	NC
LIDAMANTLE LOTION	-	NC
LIDO/MENTHOL SPRAY	-	NC
LIDO/RAC/TET GEL	-	NC
LIDOCAINE CREAM	-	NC
lidocaine cream 3.88% (LIDOTRAL equiv)	-	NC
lidocaine gel (XYLOCAINE equiv)	-	NC
lidocaine hcl cream 4.12%	-	NC
lidocaine oint/transparent dressing kit (LIDOPAC equiv)	-	NC
lidocaine patch 3.5% (GEN7T equiv)	OTC	NC
lidocaine/prilocaine cream (EMLA equiv)	-	NC
LIDOCAINE/TETRACAINE CREAM	-	NC
LIDOCIN GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
LIDODERM PATCH	-	NC
LIDO-EP-TETR SOLN	-	NC
LIDOSTREAM KIT	-	NC
LIDOTRAL CREAM	-	NC
LIDOTREX GEL	-	NC
LIDOVEX CREAM	-	NC
LMR PLUS KIT	-	NC
MEDI-PATCH W/LIDOCAINE PATCH	-	NC
MENTHOREAL10 THERAPY PACK	-	NC
MICROVIX LP PAK	-	NC
NENDRUX GEL	-	NC
nulido pad (NULIDO equiv)	-	NC
NUVAKAAN II KIT	-	NC
PLIAGLIS CREAM	-	NC
PLIAGLIS KIT	-	NC
SILVERA PAD	-	NC
SOLAICE PATCH	-	NC
WPR PLUS	-	NC
ZILACAINE PAK	-	NC
ZYLOTROL-L KIT	-	NC
MISC. DERMATOLOGICAL PRODUCTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic =**small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
EPICERAM EMULSION	-	NC
NEOSALUS FOAM	-	NC
NEOSALUS LOTION	-	NC
MISC. TOPICAL		
DRYSOL SOLN	-	2
DERMACINRX CREAM	-	NC
HYCLODEX SOLN	-	NC
QBREXZA PAD	-	NC
SOFDRA GEL	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	3
ZORYVE FOAM (QL= 60 grams/30 days)	PA-QL	3
EUCRISA OINT	-	NC
ZORYVE CREAM 0.05%	-	NC
ZORYVE CREAM 0.15%	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
BLANCHE CREAM	-	EXC
TRI-LUMA CREAM	-	EXC
ROSACEA AGENTS		
azelaic acid gel (FINACEA equiv)	-	2
metronidazole cream (METROCREAM equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
metronidazole gel 0.75% (METROGEL equiv)	-	2
ivermectin cream (SOOLANTRA equiv) (QL= 45 grams/30 days)	QL	3
metronidazole gel (METROGEL equiv)	-	3
metronidazole lotion (METROLOTION equiv)	-	3
brimonidine tartrate gel (MIRVASO equiv)	-	EXC
MIRVASO GEL	-	EXC
oxymetazoline hcl cream (RHOFADE equiv)	-	EXC
RHOFADE CREAM	-	EXC
DAZOMON GEL	-	NC
doxycycline (rosacea) cap delayed release (ORACEA equiv)	-	NC
EMROSI CAP	-	NC
FINACEA FOAM	-	NC
FINACEA GEL	-	NC
IVERMECTIN CREAM	-	NC
METROCREAM	-	NC
METROGEL 1%	-	NC
METROLOTION	-	NC
NORITATE CREAM	-	NC
ORACEA CAP	-	NC
ROSADAN KIT	-	NC
SOOLANTRA CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ZILXI FOAM	-	NC
SCABICIDES & PEDICULICIDES		
permethrin cream (ELIMITE CREAM equiv)	-	2
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	3
LINDANE SHAMPOO	-	4
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	4
NATROBA SUSP (QL= 1 bottle/fill)	QL	4
NATROBA SUSP 0.90% (QL= 1 bottle/fill)	QL	4
CROTAN LOTION	-	NC
ELIMITE CREAM	-	NC
EURAX CREAM	-	NC
IVERMECTIN LOTION	-	NC
OVIDE LOTION	-	NC
SKLICE LOTION	-	NC
SCAR TREATMENT PRODUCTS		
SCARCIN GEL	-	NC
SCARCIN LIQUID ROLL-ON	-	NC
SILIPAC KIT	-	NC
WOUND CARE PRODUCTS		
VYJUVEK GEL	-	EXC
ALEVICYN SOLN DERMAL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
BIAFINE EMULSION	-	NC
COLLANEX EXTERNAL POWDER	-	NC
FILSUVEZ GEL	-	NC
KERAMATRIX	-	NC
KERASTAT CREAM	-	NC
KERASTAT GEL	-	NC
REXASIL KIT	-	NC
WOUND-DRESSING GELS	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC BIOLOGICALS		
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC
DIAGNOSTIC DRUGS		
GLUCAGON DIAGNOSTIC INJ	-	NC
MACRILEN PACK	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	3
DIAGNOSTIC TESTS		
CLINISTIX TEST STRIP	OTC	2
KETO-DIASTIX TEST STRIP	OTC	2
KETOSTIX	OTC	2
ACCU-CHEK GUIDE TEST STRIP	OTC	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
FREESTYLE INSULINX TEST STRIP	OTC	3
FREESTYLE PRECISION NEO TEST STRIP	OTC	3
FREESTYLE TEST STRIP	OTC	3
GLUCOCARD EXPRESSION TEST STRIPS	-	3
GLUCOCARD SHINE TEST STRIPS	-	3
GLUCOCARD VITAL TEST STRIPS	-	3
PRECISION XTRA TEST STRIP	OTC	3
COVID-19 TEST	OTC	EXC
CUE COVID-19 TEST CARTRIDGE	OTC	EXC
CUE HEALTH MONITOR	OTC	EXC
PRECISION XTRA KETONE TEST STRIP	OTC	NC
TEST STRIP (all other test strips)	OTC	NC
RADIOGRAPHIC CONTRAST MEDIA		
iohexol inj (OMNIPAQUE equiv)	-	NC
OMNIPAQUE INJ	-	NC
OMNIPAQUE SOLN	-	NC
SITZMARKS CAP	-	NC
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
ASTAMED MYO CAP	-	EXC
DEPLIN CAP	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS Cont.		
ELIGEN B12 TAB	-	EXC
FALESSA TAB	-	EXC
FOLTANX TAB	-	EXC
GLYGEST PAK	-	EXC
L-METHYLFOLATE TAB	-	EXC
LUVIRA CAP	-	EXC
METANX CAP	-	EXC
OLLIZAC POWDER	-	EXC
PODIAPN CAP	-	EXC
XYZBAC TAB	-	EXC
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
ZENPEP CAP	-	3
CREON CAP	-	NC
PANCREAZE CAP, PERTZYE CAP	-	NC
SUCRAID SOLN	-	NC
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide tab	-	2
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	3
methazolamide tab (NEPTAZANE equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIURETICS Cont.		
dichlorphenamide tab (KEVEYIS equiv)	-	NC
KEVEYIS TAB	-	NC
NEPTAZANE TAB	-	NC
DIURETIC COMBINATIONS		
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	2
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	2
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	2
ALDACTAZIDE TAB 50-50MG	-	4
ALDACTAZIDE TAB	-	NC
AMILORIDE/HCTZ TAB	-	NC
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	NC
MAXZIDE TAB	-	NC
LOOP DIURETICS		
bumetanide tab (BUMEX equiv)	-	2
FUROSEMIDE SOLN	-	2
furosemide soln (LASIX equiv)	-	2
furosemide tab (LASIX equiv)	-	2
torsemide tab (DEMADEX equiv)	-	2
torsemide tab 20mg (SOAANZ equiv)	-	2
ethacrynic tab (EDECRIN equiv)	-	3
LASIX ONYU INJ 80MG/2.67ML (QL= 6 cartridges/fill)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIURETICS Cont.		
ENBUMYST SOLN 0.5MG/0.1ML (QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112)	LD-QL	5
FUROSCIX KIT (QL= 8 inj/fill; Only available through Onco360 or CareMed 877-662-6633)	LD-QL	5
EDECRIN TAB	-	NC
FUROSCIX READYFLOW INJ	-	NC
LASIX TAB	-	NC
SOAANZ TAB	-	NC
OSMOTIC DIURETICS		
MANNITOL INJ	-	NC
POTASSIUM SPARING DIURETICS		
amiloride tab (MIDAMOR equiv)	-	2
spironolactone tab (ALDACTONE equiv)	-	2
triamterene cap (DYRENIUM equiv)	-	3
ALDACTONE TAB	-	NC
DYRENIUM CAP	-	NC
spironolactone susp (CAROSPIR equiv)	-	NC
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorthalidone tab	-	2
hydrochlorothiazide cap (MICROZIDE equiv)	-	2
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIURETICS Cont.		
indapamide tab (LOZOL equiv)	-	2
metolazone tab (ZAROXOLYN equiv)	-	2
DIURIL SUSP	-	3
INZIRQO SUSP (Prior Authorization required for members age 9 years and older)	PA	4
THALITONE TAB	-	NC
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB	-	NC
RECORLEV TAB	-	NC
BONE DENSITY REGULATORS		
alendronate tab (FOSAMAX equiv)	-	2
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	2
ALENDRONATE TAB 40MG	-	3
calcitonin nasal spray (MIACALCIN equiv)	-	3
risedronate tab (ACTONEL equiv)	-	3
alendronate sodium oral soln (FOSAMAX equiv)	-	4
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	4
ACTONEL TAB	-	NC
ATELVIA TAB	-	NC
BINOSTO TAB	-	NC
BONIVA TAB 150MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
BONSITY INJ	-	NC
calcitonin inj (MIACALCIN equiv)	-	NC
FORTEO INJ	-	NC
FOSAMAX TAB	-	NC
FOSAMAX+D TAB	-	NC
MIACALCIN INJ	-	NC
pamidronate inj	-	NC
PROLIA INJ	-	NC
teriparatide (recombinant) soln pen-inj (FORTEO equiv)	-	NC
TYMLOS INJ	-	NC
ZOMETA INJ	-	NC
CORTICOTROPIN		
ACTHAR GEL AUTO-INJECTOR	-	NC
ACTHAR GEL INJ	-	NC
CORTROPHIN INJ	-	NC
CORTROPHIN INJ GEL	-	NC
CORTICOTROPIN-RELEASING FACTOR (CRF) RECEPTOR ANTAGONISTS		
CRENESSITY CAP	-	NC
CRENESSITY SOLN	-	NC
FERTILITY REGULATORS		
PREGNYL INJ, NOVAREL INJ	INF-M	6

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
clomiphene citrate tab (CLOMID equiv)	INF	NC
CLOMIPHENE TAB	-	NC
FOLLISTIM AQ INJ	INF	NC
GONAL-F RFF INJ	INF	NC
GONAL-F RFF INJ, GONAL-F INJ	INF	NC
MENOPUR INJ	INF	NC
OVIDREL INJ	INF	NC
GNRH/LHRH ANTAGONISTS		
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	3
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	3
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	NC
CETROTIDE KIT	INF	NC
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ	-	NC
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
EGRIFTA WR KIT	-	EXC
GROWTH HORMONES		
SOGROYA INJ	MSP-PA	4
GENOTROPIN INJ	MSP-PA	5
GENOTROPIN INJ 5MG	MSP-PA	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
OMNITROPE INJ	MSP-PA	5
HUMATROPE INJ, ZOMACTON INJ	-	NC
NGENLA INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
SKYTROFA INJ	-	NC
ZOMACTON INJ	-	NC
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	1
EVISTA TAB	-	NC
OSPHENA TAB	-	NC
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD	5
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL NASAL SOLN	-	3
LUPRON DEPOT PED INJ	MSP	5
LUPRON DEPOT-PED INJ	MSP	5
LUPANETA PACK	-	NC
MENOPAUSAL SYMPTOMS SUPPRESSANTS		
VEOZAH TAB (QL= 1 tab/day)	PA-QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
LYNKUET CAP	-	NC
METABOLIC MODIFIERS		
calcitriol cap (ROCALTROL equiv)	-	2
calcitriol soln (ROCALTROL equiv)	-	2
levocarnitine soln (CARNITOR equiv)	-	2
levocarnitine tab (CARNITOR equiv)	-	2
cinacalcet tab (SENSIPAR equiv)	-	3
DOXERCALCIFEROL CAP	-	3
doxercalciferol cap (HECTOROL equiv)	-	3
sodium phenylbutyrate powder (BUPHENYL equiv)	-	3
sodium phenylbutyrate tab (BUPHENYL equiv)	-	3
CYSTADANE POWDER (Only available through AnovoRx 844-288-5007)	LD	5
sapropterin dihydrochloride powder packet (KUVAN equiv)	MSP	5
sapropterin dihydrochloride soluble tab (KUVAN equiv)	MSP	5
XPHOZAH TAB (QL= 2 tabs/day)	MSP-PA-QL	5
ALDURAZYME INJ	-	NC
betaine powder for oral solution (CYSTADANE equiv)	-	NC
BUPHENYL POWDER	-	NC
BUPHENYL TAB	-	NC
CALCITRIOL INJ	-	NC
CARBAGLU TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
carglumic acid tab (CARBAGLU equiv)	-	NC
CARNITOR SOLN	-	NC
CARNITOR TAB	-	NC
CITRULLINE EASY TAB	-	NC
FABRAZYME INJ	-	NC
FORZINITY INJ	-	NC
GALAFOLD CAP	-	NC
glycerol phenylbutyrate liquid (RAVICTI equiv)	-	NC
HARLIKU TAB	-	NC
HECTOROL CAP	-	NC
IMCIVREE INJ	-	NC
KUVAN POWDER PACK	-	NC
KUVAN TAB	-	NC
KYGEVVI POWDER	-	NC
LOARGYS INJ	-	NC
MYALEPT INJ	-	NC
nitisinone cap (ORFADIN equiv)	-	NC
NITYR TAB	-	NC
OLPRUVA PACK	-	NC
OPFOLDA CAP	-	NC
ORFADIN CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
ORFADIN SUSP	-	NC
PALYNZIQ INJ	-	NC
paricalcitol cap (ZEMPLAR equiv)	-	NC
PHEBURANE ORAL PELLETS	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
REDEMPLO PFS INJ	-	NC
ROCALTROL CAP	-	NC
ROCALTROL SOLN	-	NC
SENSIPAR TAB	-	NC
SEPHIENCE POWDER	-	NC
STRENSIQ INJ	-	NC
TRYNGOLZA INJ	-	NC
TRYNGOLZA INJ 50MG/0.8ML	-	NC
VYKAT XR TAB	-	NC
VYKAT XR TAB 150MG	-	NC
VYKAT XR TAB 75MG	-	NC
XURIDEN POWDER	-	NC
YORVIPATH INJ	-	NC
YORVIPATH INJ 294MCG	-	NC
YORVIPATH INJ 420MCG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
ZEMPLAR CAP	-	NC
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB (QL= 1 tab/day)	PA-QL	3
NATRIURETIC PEPTIDES		
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	5
YUVIWEL INJ	-	NC
POSTERIOR PITUITARY HORMONES		
desmopressin acetate inj (DDAVP equiv)	-	3
desmopressin acetate nasal spray (DDAVP equiv)	-	3
desmopressin acetate tab (DDAVP equiv)	-	3
DESMOPRESSIN NASAL SOLN 1.5MG/ML	-	3
DESMOPRESSIN NASAL SPRAY	-	3
DDAVP INJ	-	NC
DDAVP NASAL SPRAY	-	NC
DDAVP TAB	-	NC
DESMODA SOLN	-	NC
NOCDURNA SL TAB	-	NC
NOCTIVA EMULSION SPRAY	-	NC
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab 200mg (MIFIPREX equiv)	-	2
MIFEPREX TAB	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	2
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	MSP	5
OCTREOTIDE INJ 100MCG	MSP	5
BYNFEZIA PEN INJ	-	NC
MYCAPSSA CAP	-	NC
PALSONIFY TAB	-	NC
SANDOSTATIN INJ	-	NC
SIGNIFOR INJ	-	NC
VASOPRESSIN RECEPTOR ANTAGONISTS		
tolvaptan tab therapy pack (JYNARQUE equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	2
SAMSCA TAB 15MG	MSP	5
tolvaptan tab (JYNARQUE equiv)	MSP	5
tolvaptan tab (SAMSCA equiv)	MSP	5
JYNARQUE PAK	-	NC
SAMSCA TAB	-	NC
ESTROGENS		
ESTROGEN COMBINATIONS		
estradiol/norethindrone tab (ACTIVELLA equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ESTROGENS Cont.		
jinteli tab (FEMHRT equiv)	-	2
COMBIPATCH	-	3
PREMPHASE TAB, PREMPRO TAB	-	3
ACTIVELLA TAB	-	NC
ANGELIQ TAB	-	NC
BIJUVA CAP	-	NC
CLIMARA PRO PATCH	-	NC
COVARYX HS TAB	-	NC
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	NC
ESTRATEST TAB	-	NC
FEMHRT TAB	-	NC
MYFEMBREE TAB	-	NC
ORIAHNN CAP	-	NC
ESTROGENS		
estradiol patch (CLIMARA equiv)	-	2
estradiol patch (VIVELLE-DOT, MINIVELLE equiv)	-	2
estradiol tab (ESTRACE equiv)	-	2
ESTROPIPATE TAB	-	2
estropipate tab (OGEN equiv)	-	2
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	3
estrogens, conjugated tab (PREMARIN equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ESTROGENS Cont.		
PREMARIN TAB	-	3
ALORA PATCH	-	4
DELESTROGEN INJ (QL= 5ml/fill)	QL	4
MENEST TAB	-	4
CLIMARA PATCH	-	NC
DEPO-ESTRADIOL IM	-	NC
DIVIGEL GEL	-	NC
DIVIGEL GEL, ELESTRIN GEL	-	NC
ESTRACE TAB	-	NC
estradiol td gel (DIVIGEL equiv)	-	NC
EVAMIST SPRAY	-	NC
MENOSTAR PATCH	-	NC
VIVELLE-DOT, MINIVELLE PATCH	-	NC
FLUOROQUINOLONES		
FLUOROQUINOLONES		
ciprofloxacin tab (CIPRO equiv)	-	2
levofloxacin soln (LEVAQUIN equiv)	-	2
levofloxacin tab (LEVAQUIN equiv)	-	2
OFLOXACIN TAB	-	2
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	3
ciprofloxacin susp (CIPRO equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
FLUOROQUINOLONES Cont.		
moxifloxacin tab (AVELOX equiv)	-	3
CIPRO SUSP	-	4
CIPROFLOXACIN 100MG TAB	-	4
AVELOX TAB	-	NC
CIPRO TAB	-	NC
FACTIVE TAB	-	NC
LEVAQUIN TAB	-	NC
PROQUIN XR TAB	-	NC
GASTROINTESTINAL AGENTS - MISC.		
5-HT4 RECEPTOR AGONISTS		
prucalopride succinate tab (MOTEGRITY equiv) (QL= 1 tab/day)	QL	2
MOTEGRITY TAB (QL= 1 tab/day)	QL	4
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB (QL= 1 tab/day)	PA-QL	3
BILE ACID SYNTHESIS DISORDER AGENTS		
CHENODAL TAB, CTEXLI TAB	-	NC
CHOLBAM CAP	-	NC
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB	-	NC
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
ursodiol tab (URSO (FORTE) equiv)	-	2
ACTIGALL CAP	-	NC
CHENODAL TAB, CTEXLI TAB	-	NC
RELTONE CAP	-	NC
URSO FORTE TAB	-	NC
URSODIOL CAP	-	NC
URSOLIGN CAP	-	NC
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	3
GASTROCROM CONC	-	NC
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	QL	2
AMITIZA CAP	-	NC
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	2
metoclopramide tab (REGLAN equiv)	-	2
GIMOTI NASAL SPRAY	-	NC
METOZOLV ODT	-	NC
REGLAN TAB	-	NC
HEPATOTROPICS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
REZDIFFRA TAB	-	NC/3 P
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 1200MCG (QL= 2 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5
BYLVAY CAP 400MCG (QL= 6 caps/day; Only available through PantheRx Pharma 855-726-8479)	LD-PA-QL	5
BYLVAY SPRINKLE CAP 200MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	5
LIVMARLI SOLN 19MG/ML	-	NC
LIVMARLI TAB	-	NC
LIVMARLI TAB 30MG	-	NC
LYNAVOY TAB	-	NC
INFLAMMATORY BOWEL AGENTS		
balsalazide cap (COLAZAL equiv)	-	2
sulfasalazine EC tab (AZULFIDINE equiv)	-	2
sulfasalazine tab (AZULFIDINE equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
MESALAMINE DR CAP	-	3
mesalamine DR cap (DELZICOL equiv)	-	3
mesalamine DR tab (LIALDA equiv)	-	3
mesalamine enema (ROWASA equiv)	-	3
mesalamine ER cap (APRISO equiv)	-	3
mesalamine supp (CANASA equiv)	-	3
DIPENTUM CAP	-	4
mesalamine tab (ASACOL equiv)	-	4
SFROWASA ENEMA	-	4
CIMZIA INJ 200MG/ML (QL= 2 inj/28 days)	MSP-PA-QL	5
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	MSP-PA-QL	5
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	MSP-PA-QL	5
APRISO CAP	-	NC
ASACOL HD TAB	-	NC
ASACOL HD TAB, MESALAMINE TAB	-	NC
AZULFIDINE EN TAB	-	NC
AZULFIDINE TAB	-	NC
CIMZIA INJ	-	NC
COLAZAL CAP	-	NC
DELZICOL CAP	-	NC
ENTYVIO SC INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
LIALDA TAB	-	NC
mesalamine ER cap (PENTASA CR equiv)	-	NC
OMVOH INJ	-	NC
OTULFI INJ	-	NC
PENTASA CR CAP	-	NC
ROWASA KIT	-	NC
TREMFYA INDUCTION INJ 200MG/ML	-	NC
TREMFYA INJ 200MG/2ML	-	NC
VELSIPITY TAB	-	NC
ZYMFENTRA INJ	-	NC
INTESTINAL ACIDIFIERS		
lactulose soln	-	2
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTRONEX equiv)	-	4
LINZESS CAP (QL= 1 cap/day)	PA-QL	4
IBSRELA TAB	-	NC
LOTRONEX TAB	-	NC
VIBERZI TAB	-	NC
LIVE FECAL MICROBIOTA		
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	5
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
MOVANTIK TAB (QL= 1 tab/day)	PA-QL	3
SYMPROIC TAB (QL= 1 tab/day)	PA-QL	3
alvimopan cap (ENTEREG equiv)	-	NC
ENTEREG CAP	-	NC
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS		
IQIRVO TAB	-	NC
LIVDELZI CAP	-	NC
PHOSPHATE BINDER AGENTS		
calcium acetate cap (PHOSLO equiv)	-	2
calcium acetate tab (ELIPHOS equiv)	-	2
FOSRENOL POWDER PACK	-	3
lanthanum carbonate chew tab (FOSRENOL equiv)	-	3
SEVELAMER CARBONATE TAB	-	3
sevelamer powder pak (RENVELA equiv)	-	3
sevelamer tab (RENVELA TAB equiv)	-	3
AURYXIA TAB	-	4
ferric citrate tab	-	4
sevelamer hydrochloride tab (RENAGEL equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
ELIPHOS TAB	-	NC
FOSRENOL CHEW TAB	-	NC
PHOSLO CAP	-	NC
RENAGEL TAB 800MG	-	NC
RENVELA TAB	-	NC
VELPHORO CHEW TAB	-	NC
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT	-	NC
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB	-	NC
GENERAL ANESTHETICS		
ANESTHETICS - MISC.		
KETAMINE HCL TROCHES	-	NC
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		
CYTRA K CRYSTALS	-	2
CYTRA-3 SYRUP	-	2
K CITRATE SOLN CITR ACD	-	2
K/NA CITRATE SOL CITR ACD	-	2
ORACIT SOLN	-	2
potassium citrate CR tab (UROCIT-K equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	2
sodium citrate/citric acid soln (BICITRA equiv)	-	2
UROCIT-K TAB	-	NC
CYSTINOSIS AGENTS		
CYSTAGON CAP	-	NC
PROCYSBI GRANULES PACKET	-	NC
GENITOURINARY IRRIGANTS		
RENACIDIN SOLN	-	NC
SODIUM CHLORIDE 0.9% IRR SOLN	-	NC
HYPEROXALURIA AGENTS		
RIVFLOZA INJ	-	NC
RIVFLOZA INJ 160MG	-	NC
RIVFLOZA VIAL	-	NC
IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-972 or Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	5
TRUTAKNA INJ	-	NC
VANRAFIA TAB	-	NC
VOYXACT INJ	-	NC
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
PENTOSAN CAP	-	NC
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	2
dutasteride cap (AVODART equiv)	-	2
finasteride tab (PROSCAR equiv)	-	2
silodosin cap (RAPAFLO equiv)	-	2
tamsulosin cap (FLOMAX equiv)	-	2
dutasteride/tamsulosin cap (JALYN equiv)	-	3
AVODART CAP	-	NC
CARDURA XL TAB	-	NC
ENTADFI CAP	-	NC
FLOMAX CAP	-	NC
JALYN CAP	-	NC
PROSCAR TAB	-	NC
RAPAFLO CAP	-	NC
UROXATRAL TAB	-	NC
URINARY ANALGESICS		
PHENAZOPYRIDINE TAB	-	2
phenazopyridine tab (PYRIDIUM equiv)	-	2
PYRIDIUM TAB 100MG	-	NC
PYRIDIUM TAB 200MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
URINARY STONE AGENTS		
LITHOSTAT TAB	-	4
tiopronin tab (THIOLA equiv)	MSP-PA	5
tiopronin tab delayed release (THIOLA EC equiv)	MSP-PA	5
THIOLA EC TAB	-	NC
THIOLA TAB	-	NC
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	2
DUZALLO TAB	-	NC
GOUT AGENTS		
allopurinol tab (ZYLOPRIM equiv)	-	2
colchicine tab (COLCRYS equiv)	-	2
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST	2
allopurinol tab 200mg	-	NC
COLCHICINE CAP	-	NC
colchicine cap (COLCHICINE equiv)	-	NC
COLCRYS TAB	-	NC
GLOPERBA SOLN	-	NC
ULORIC TAB	-	NC
ZURAMPIC TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GOUT AGENTS Cont.		
ZYLOPRIM TAB	-	NC
URICOSURICS		
probenecid tab (BENEMID equiv)	-	2
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ	MSP-PA	5
ADVATE, KOVALTRY INJ	-	EXC
ADYNOVATE INJ	-	EXC
AFSTYLA KIT	-	EXC
ALPHANATE, HUMATE-P INJ	-	EXC
ALPHANINE SD INJ	-	EXC
ALPROLIX INJ	-	EXC
ALTUVIIIO INJ	-	EXC
BENEFIX INJ	-	EXC
COAGADEX INJ	-	EXC
CORIFACT KIT	-	EXC
ELOCTATE INJ	-	EXC
ESPEROCT INJ	-	EXC
FEIBA INJ	-	EXC
FIBRYGA INJ	-	EXC
HEMOFIL M, KOATE INJ	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
IDELVION INJ	-	EXC
IXINITY INJ	-	EXC
JIVI INJ	-	EXC
KOGENATE FS INJ	-	EXC
NOVOEIGHT INJ	-	EXC
NOVOSEVEN RT INJ	-	EXC
NUWIQ INJ	-	EXC
NUWIQ KIT	-	EXC
OBIZUR INJ	-	EXC
PROFILNINE INJ	-	EXC
REBINYN INJ	-	EXC
RECOMBINATE INJ	-	EXC
RIASTAP INJ	-	EXC
RIXUBIS INJ	-	EXC
SEVENFACT INJ	-	EXC
TRETTEN INJ	-	EXC
VONVENDI INJ	-	EXC
WILATE INJ	-	EXC
XYNTHA INJ	-	EXC
ALHEMO INJ	-	NC
FESILTY INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
HYMPAVZI INJ	-	NC
QFITLIA INJ	-	NC
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	MSP-PA	5
FIRAZYR INJ	-	NC
COMPLEMENT INHIBITORS		
BERINERT INJ (Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, or Walgreens 888-347-3416)	LD-PA	5
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523	LD-PA-QL	5
HAEGARDA INJ (Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, OptionCare 972-536-7355, Optum 877-445-6874, Orsini 800-410-8575, or Walgreens 888-347-3416)	LD-PA	5
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	5
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	5
EMPAVELI INJ	-	NC
FABHALTA CAP	-	NC
VOYDEYA TAB	-	NC
VOYDEYA TAB THERAPY PACK	-	NC
ZILBRYSQ INJ	-	NC
ZILBRYSQ INJ 23MG	-	NC
ZILBRYSQ INJ 32.4MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB	-	NC
WAYRILZ TAB	-	NC
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	2
PLASMA FACTOR XIIA INHIBITORS		
ANDEMBRY INJ	-	NC
PLASMA KALLIKREIN INHIBITORS		
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5
EKTERLY TAB	-	NC
ORLADEYO CAP	-	NC
ORLADEYO PACK	-	NC
TAKHZYRO INJ	-	NC
PLATELET AGGREGATION INHIBITORS		
anagrelide cap (AGRYLIN equiv)	-	2
cilostazol tab (PLETAL equiv)	-	2
clopidogrel tab 75mg (PLAVIX equiv)	-	2
dipyridamole tab (PERSANTINE equiv)	-	2
prasugrel tab (EFFIENT equiv)	-	2
aspirin/dipyridamole cap (AGGRENOX equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
ticagrelor tab (BRILINTA equiv)	-	3
ASPIRIN/OMEPRAZOLE ER TAB	-	4
AGRYLIN CAP	-	NC
BRILINTA TAB	-	NC
CABLIVI INJ KIT	-	NC
CLOPIDOGREL THERAPY PACK	-	NC
EFFIENT TAB	-	NC
PLAVIX TAB 300MG	-	NC
PLAVIX TAB 75MG	-	NC
YOSPRALA TAB	-	NC
ZONTIVITY TAB	-	NC
PREKALLIKREIN-DIRECTED ANTISENSE OLIGONUCLEOTIDES (ASO)		
DAWNZERA INJ	-	NC
PYRUVATE KINASE ACTIVATORS		
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
AQVESME TAB 100MG	-	NC
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
miglustat cap (ZAVESCA equiv)	-	NC
ZAVESCA CAP	-	NC
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	3
OXBRYTA TAB	-	NC
SIKLOS TAB	-	NC
AGENTS FOR SICKLE CELL DISEASE		
l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day)	MSP-PA-QL	2
XROMI SOLN (Prior Authorization required for members age 9 years and older)	PA	4
ENDARI POWDER PACKET	-	NC
OXBRYTA TAB FOR ORAL SUSP	-	NC
COBALAMINS		
cyanocobalamin inj	-	2
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	4
NASCOBAL SPRAY	-	4
FOLIC ACID/FOLATES		
folic acid tab 1mg ($0 copay for female members only; All other members covered a generic copay)	-	1
folic acid tab 400mcg (Covered for female members only)	OTC	1
folic acid tab 800mcg (Covered for female members only)	OTC	1
QUIOFIC SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
HEMATOPOIETIC GROWTH FACTORS		
eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day	MSP-PA-QL	2
eltrombopag olamine tab 12.5mg, 25mg (PROMACTA equiv) (QL= 1 tab/day)	MSP-PA-QL	2
eltrombopag olamine tab 50mg (PROMACTA equiv) (QL= 2 tabs/day)	MSP-PA-QL	2
eltrombopag olamine tab 75mg (PROMACTA equiv) (QL= 2 tabs/day)	MSP-PA-QL	2
PROCRIT INJ	-	3
RETACRIT INJ	-	3
DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
FULPHILA INJ	MSP	5
NIVESTYM INJ	MSP	5
ZARXIO INJ	MSP	5
ALVAIZ TAB	-	NC
ARANESP INJ	-	NC
ARMLUPEG INJ	-	NC
FILKRI INJ	-	NC
FYLNETRA INJ	-	NC
GRANIX INJ	-	NC
LEUKINE INJ	-	NC
MIRCERA INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
MULPLETA TAB	-	NC
NEULASTA INJ	-	NC
NEUPOGEN INJ	-	NC
NYPOZI INJ	-	NC
NYVEPRIA INJ	-	NC
PROMACTA POWDER	-	NC
PROMACTA TAB	-	NC
REBLOZYL INJ	-	NC
RELEUKO INJ	-	NC
RELEUKO PREFILLED SYRINGE INJ	-	NC
STIMUFEND INJ	-	NC
UDENYCA INJ	-	NC
VAFSEO TAB	-	NC
ZIEXTENZO INJ	-	NC
HEMATOPOIETIC MIXTURES		
FEROTRINSIC CAP	-	2
ferrex 150 forte cap	-	2
IRON POLYSACCH/THREONIC ACID/B12/FA CAP	-	2
MULTIGEN FOLIC TAB	-	2
MULTIGEN PLUS TAB	-	2
MULTIGEN TAB	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
POLY-IRON CAP 150 FORTE	-	2
NEPHRON FA TAB	-	3
FERREX 28 TAB	-	4
ICAR-C PLUS TAB 100-250-0.025-1 MG	-	4
BENTIVITE TAB	-	NC
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CORVITA 150 TAB	-	NC
CYFOLEX CAP	-	NC
FEONYX TAB	-	NC
FERIVA 21/7 TAB	-	NC
FERRO-PLEX TAB	-	NC
folbee tab (FOLGARD RX equiv)	-	NC
FOLGARD RX TAB	-	NC
FOLITE TAB	-	NC
FOLVITE-FE TAB	-	NC
OVEEZA CAP	-	NC
PUREFOLIX TAB	-	NC
IRON		
ACCRUFER CAP	-	NC
ferrous sulfate elixir	OTC	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
FERROUS SULFATE LIQUID	OTC	NC
ferrous sulfate soln	OTC	NC
STEM CELL MOBILIZERS		
MOZOBIL INJ	-	NC
plerixafor subcutaneous inj (MOZOBIL equiv)	-	NC
XOLREMDI CAP	-	NC
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
tranexamic acid tab (LYSTEDA equiv)	-	2
aminocaproic acid soln (AMICAR equiv)	-	3
aminocaproic acid tab (AMICAR equiv)	-	3
AMICAR SOLN	-	NC
AMICAR TAB	-	NC
CYKLOKAPRON INJ	-	NC
LYSTEDA TAB	-	NC
tranexamic acid inj (CYKLOKAPRON equiv)	-	NC
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	2
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	2
PHENOBARBITAL ELXIR	-	2
PHENOBARBITAL TAB	-	2
HYPNOTICS - TRICYCLIC AGENTS		
doxepin tab (SILENOR equiv)	-	NC
NON-BARBITURATE HYPNOTICS		
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	2
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	2
temazepam cap 15mg (RESTORIL equiv)	-	2
temazepam cap 30mg (RESTORIL equiv)	-	2
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	2
zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day)	QL	2
temazepam cap 22.5mg (RESTORIL equiv)	-	4
temazepam cap 7.5mg (RESTORIL equiv)	-	4
AMBIEN CR TAB	-	NC
AMBIEN TAB	-	NC
EDLUAR SL TAB	-	NC
estazolam tab (PROSOM equiv)	-	NC
FLURAZEPAM CAP	-	NC
HALCION TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
INTERMEZZO SL TAB	-	NC
LUNESTA TAB	-	NC
QUAZEPAM TAB	-	NC
RESTORIL CAP 15MG	-	NC
RESTORIL CAP 22.5MG	-	NC
RESTORIL CAP 30MG	-	NC
RESTORIL CAP 7.5MG	-	NC
triazolam tab (HALCION equiv)	-	NC
ZOLPIDEM CAP	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIMIST SPRAY	-	NC
OREXIN RECEPTOR ANTAGONISTS		
DAYVIGO TAB	-	NC
QUVIVIQ TAB	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	QL	3
HETLIOZ CAP	-	NC
HETLIOZ SUSP	-	NC
ROZEREM TAB	-	NC
tasimelteon cap (HETLIOZ equiv)	-	NC
LAXATIVES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
LAXATIVES Cont.		
LAXATIVE COMBINATIONS		
GAVILYTE-C SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	1
GOLYTELY SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; A other members covered at preferred brand copay)	QL	1
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copa	QL	1
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	1
peg 3350/electrolytes soln (NULYTELY equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	1
sodium/magnesium/potassium soln (SUPREP equiv) ($0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year)	QL	1
SUFLAVE SOLN (QL= 2 fills/365 days)	QL	3
CLENPIQ SOLN	-	NC
MOVIPREP SOLN	-	NC
PEG-PREP KIT	-	NC
PLENVU SOLN	-	NC
SUPREP BOWEL PREP PACK	-	NC
SUTAB TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
LAXATIVES Cont.		
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	2
GIALAX KIT	-	NC
lactulose oral crystal packet	-	NC
MIRALAX	OTC	NC
MIRALAX PACKET	OTC	NC
polyethylene glycol 3350 powder (MIRALAX equiv)	OTC	NC
polyethylene glycol packet (MIRALAX equiv)	OTC	NC
SALINE LAXATIVES		
OSMOPREP TAB	-	NC
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETIC COMBINATIONS		
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC
MACROLIDES		
AZITHROMYCIN		
azithromycin susp (ZITHROMAX equiv)	-	2
azithromycin tab (ZITHROMAX equiv)	-	2
ZITHROMAX POWDER PACK	-	4
ZITHROMAX SUSP	-	NC
ZITHROMAX TAB	-	NC
CLARITHROMYCIN		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MACROLIDES Cont.		
clarithromycin tab (BIAXIN equiv)	-	2
CLARITHROMYCIN SUSP	-	3
clarithromycin ER tab (BIAXIN XL equiv)	-	4
BIAXIN TAB	-	NC
ERYTHROMYCINS		
ERYTHROMYCIN CAP DR	-	3
erythromycin DR cap (ERYC equiv)	-	3
ERYTHROMYCIN EC CAP	-	3
erythromycin ethylsuccinate susp (ERYPED equiv)	-	3
erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE)	-	3
E.E.S. TAB	-	4
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	4
erythromycin tab (ERY-TAB equiv)	-	4
ERYPED SUSP	-	NC
FIDAXOMICIN		
DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3
DIFICID TAB (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3
fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
MEDICAL DEVICES		
PARENTERAL THERAPY SUPPLIES		
INPEN INSULIN INJECTION DEVICE	-	NC
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CERVICAL CAP	-	1
DIAPHRAGM	-	1
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	1
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	1
DIABETIC SUPPLIES		
ACCU-CHEK GUIDE CARE METER	OTC	1
ACCU-CHEK GUIDE ME KIT	OTC	1
FREESTYLE FREEDOM LITE METER	OTC	1
FREESTYLE LITE METER	OTC	1
FREESTYLE PRECISION NEO METER	OTC	1
PRECISION XTRA METER	OTC	1
CALIBRATION LIQUID	OTC	2
LANCET DEVICE	OTC	2
LANCET KIT	OTC	2
LANCETS	OTC	2
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
DEXCOM G6 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
DEXCOM G7 SENSOR (15-DAY) (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exceptio required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE 3-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exceptio required if member is not currently utilizing insulin)	QL-ST	3
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorizatic (exception) required if member is not currently utilizing insulin)	QL-ST	3
GLUCOCARD 01 BLOOD GLUCOSE W/DEVICE KIT	-	3
GLUCOCARD 01-MINI GLUCOSE W/DEVICE KIT	-	3
GLUCOCARD EXPRESSION MONITOR W/DEVICE KIT	-	3
GLUCOCARD SHINE CONNEX W/DEVICE KIT	-	3
GLUCOCARD SHINE EXPRESS W/DEVICE KIT	-	3
GLUCOCARD SHINE W/DEVICE KIT	-	3
GLUCOCARD VITAL MONITOR W/DEVICE KIT	-	3
GLUCOCARD X-METER W/DEVICE KIT	-	3
OMNIPOD 5 DEX G7G6 INTRO KIT (QL= 1 kit/year)	QL	3
OMNIPOD 5 DEX G7G6 PODS (QL= 10 pods/month)	QL	3
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	3
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days)	QL	3
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT (QL= 1 kit/year)	QL	3
OMNIPOD 5 LIBRE2 PLUS G6 PODS (QL= 10 pods/30 days)	QL	3
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	3
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	3
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
OMNIPOD GO KIT (QL= 10 pods/month)	QL	3
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	3
TEMPO SMART BUTTON (QL= 1 button/8 months)	QL	3
TWIIST REFILL KIT (QL= 1 kit/month)	QL	3
TWIIST STARTER KIT (QL= 1 kit/month)	QL	3
V-GO INJ KIT (QL= 1 kit/day)	QL	3
DIABETIC METER (all other diabetic meters)	OTC	NC
OMNIPOD DASH PDM KIT	-	NC
PIVOT INSULIN PUMP STARTER KIT	-	NC
PIVOT SUPPLY KIT	-	NC
MISC. DEVICES		
ALCOHOL SWABS	OTC	2
ORAL HYGIENE PRODUCTS		
HURRISEAL MIS SNAP	-	NC
PARENTERAL THERAPY SUPPLIES		
B-D INSULIN SYRINGE	--OTC	2
B-D PEN NEEDLE	OTC	2
EMBECTA INSULIN SYRINGE	--OTC	2
EMBECTA PEN NEEDLE	OTC	2
NOVOFINE PEN NEEDLE	OTC	2
NOVOTWIST PEN NEEDLE	OTC	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	2
LASIX ONYU REUSABLE UNIT (QL= 1 device/year)	QL	3
CEQUR SIMPLICITY	-	NC
INSULIN SYRINGE	OTC	NC
PEN NEEDLE	OTC	NC
RESPIRATORY THERAPY SUPPLIES		
PEAK FLOW METER	OTC	2
AEROCHAMBER	OTC	3
AEROCHAMBER SUPPLIES	-	3
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	3
QULIPTA TAB	-	NC
UBRELVY TAB	-	NC
MIGRAINE COMBINATIONS		
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB	-	4
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB 1-100MG	-	NC
MIGERGOT SUPP	-	NC
PRODRIN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
SUMANSETRON PAK	-	NC
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC
SYMBRAVO TAB	-	NC
TREXIMET TAB	-	NC
MIGRAINE PRODUCTS		
ERGOMAR SL TAB (QL= 20 tabs/28 days)	PA-QL	4
BREKIYA INJ	-	NC
D.H.E. INJ	-	NC
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC
dihydroergotamine mesylate nasal spray (MIGRANAL equiv)	-	NC
MIGRANAL SPRAY	-	NC
TRUDHESA NASAL SPRAY	-	NC
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AIMOVIG INJ	-	NC
AJOVY INJ	-	NC
EMGALITY INJ	-	NC
EMGALITY INJ 100MG/ML	-	NC
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER	-	NC
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC
ELYXYB SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
SEROTONIN AGONISTS		
eletriptan tab (RELPAX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	2
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	2
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
sumatriptan vial inj (IMITREX equiv) (QL= 10 vials/fill, 2 fills/30 days)	QL	2
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	2
frovatriptan tab (FROVA equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	3
SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	3
sumatriptan inj (IMITREX equiv) (QL= 6 inj/fill, 3 fills/30 days)	QL	3
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 3 fills/3 days)	QL	3
almotriptan tab (QL= 9 tabs/fill, 2 fills/30 days)	QL	4
FROVA TAB (QL= 9 tabs/fill, 2 fills/30 days)	QL	4
IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days)	QL	4
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days)	QL	4
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	4
ZOLMITRIPTAN SPRAY, ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days)	QL	4
AXERT TAB	-	NC
IMITREX 4MG INJ, ZEMBRACE INJ	-	NC
IMITREX INJ	-	NC
IMITREX TAB	-	NC
MAXALT MLT TAB	-	NC
MAXALT TAB	-	NC
ONZETRA XSAIL	-	NC
RELPAX TAB	-	NC
REYVOW TAB	-	NC
RIZAFILM MIS	-	NC
SUMAVEL DOSEPRO INJ	-	NC
TOSYMRA SOLN	-	NC
ZECUITY PAD	-	NC
ZOMIG TAB	-	NC
MINERALS & ELECTROLYTES		
FLUORIDE		
FLUORABON SOLN ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	1
FLUORIDE CHW 0.25MG ($0 copay for members age 5 years and younger; All oth members covered at generic copay)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
sodium fluoride soln (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1
SODIUM FLUORIDE TAB ($0 copay for members age 5 years and younger; All oth members covered at generic copay)	-	1
sodium fluoride tab (LURIDE equiv) ($0 copay for members age 5 years and younge All other members covered at generic copay)	-	1
MAGNESIUM		
MAGNESIUM SULF INJ	-	NC
magnesium sulfate inj	-	NC
PHOSPHATE		
PHOSPHA 250 NEUTRAL TAB	-	2
K-PHOS TAB	-	3
PHOSPHO-TRIN K500 TAB	-	3
K-PHOS NEUTRAL TAB 155-852-130MG	-	NC
POTASSIUM		
EFFER-K TAB	-	2
K-TAB	-	2
potassium bicarbonate effer tab (K-LYTE equiv)	-	2
potassium chloride ER cap (MICRO-K equiv)	-	2
potassium chloride ER tab (K-TAB equiv)	-	2
potassium chloride micro tab (K-DUR equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered		**generic** =small letters	**BRANDS** =CAPITAL LETTERS
INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
POTASSIUM CHLORIDE TAB ER	-	2
potassium chloride powder packet (KLOR-CON equiv)	-	3
potassium chloride soln	-	3
POKONZA ORAL SOLN	-	NC
POKONZA POWDER	-	NC
SODIUM		
SOD CHLORIDE INJ	M	6
sodium chloride inj	-	NC
TRACE MINERALS		
ZYCUBO INJ	-	NC
ZINC		
zinc gluconate tab	OTC	2
GALZIN CAP	-	NC
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
penicillamine tab (DEPEN TITRATAB equiv)	-	3
trientine cap (SYPRINE equiv)	MSP-PA	5
CUPRIMINE CAP	-	NC
CUVRIOR TAB	-	NC
DEPEN TITRATAB	-	NC
penicilliamine cap (CUPRIMINE equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
SYPRINE CAP	-	NC
TRIENTINE CAP	-	NC
IMMUNOMODULATORS		
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	2
REZUROCK TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
JOENJA TAB	-	NC
REVLIMID CAP	-	NC
RHAPSIDO TAB	-	NC
VYVGART HYTRULO INJ	-	NC
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab (ZORTRESS equiv)	PA	5
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 c PantheRx Pharmacy 855-726-8479)	LD-PA-QL	5
sirolimus soln (RAPAMUNE equiv)	-	5
ASTAGRAF XL CAP	-	NC
azathioprine tab 100mg (AZASAN equiv)	-	NC
azathioprine tab 75mg (AZASAN equiv)	-	NC
ENSPRYNG INJ	-	NC
MYHIBBIN SUSP	-	NC
PROGRAF PACKET	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
RAPAMUNE SOLN	-	NC
tacrolimus cap er (ASTAGRAF XL equiv)	-	NC
ZORTRESS TAB	-	NC
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	5
POTASSIUM REMOVING AGENTS		
LOKELMA PAK (QL= 1 packet/day)	PA-QL	3
VELTASSA POWDER 1GM (QL= 4 packets/day)	PA-QL	3
LOKELMA PAK 10GM	-	NC
LOKELMA PAK 5GM	-	NC
SPS	-	NC
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP	-	NC
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	MSP-PA-QL	5
BENLYSTA INJ (QL= 4 inj/28 day)	MSP-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
SAPHNELO INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	5
SAPHNELO PEN INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	5
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
lidocaine viscous soln (LIDOCAINE HCL (MOUTH-THROAT) equiv)	-	2
FIRST MOUTHWASH BLM	-	4
LIDOCAINE ORAL SOLN	-	NC
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	2
nystatin susp	-	2
NYSTATIN SUSP	-	NC
ORAVIG TAB	-	NC
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	2
DEBACTEROL SOLN	-	NC
PERIDEX SOLN	-	NC
DENTAL PRODUCTS		
DENTA 5000 CREAM PLUS ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
sodium fluoride cream (PREVIDENT equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	1
FLUORIDEX SENSITIVITY PASTE	-	2
SODIUM FLUORIDE GEL	-	2
SODIUM FLUORIDE PASTE	-	2
SODIUM FLUORIDE SOLN	-	2
PREVIDENT 5000 PASTE 1.1%	-	3
PREVIDENT GEL	-	3
PREVIDENT SOLN 0.2%	-	3
FRAICHE 5000 SENSITIVE GEL	-	NC
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	2
THROAT PRODUCTS - MISC.		
pilocarpine tab (SALAGEN equiv)	-	2
cevimeline cap (EVOXAC equiv)	-	3
EVOXAC CAP	-	NC
GELCLAIR GEL	-	NC
PROTHELIAL PASTE	-	NC
SALAGEN TAB	-	NC
SILATRIX GEL	-	NC
MULTIVITAMINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
B-COMPLEX VITAMINS		
EB-N3 DR CAP	-	NC
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	2
DIALYVITE/ZINC TAB	-	2
FOLBEE PLUS CZ TAB	-	2
ACTIVITE TAB	-	NC
dialyvite tab (NEPHRO-VITE equiv)	-	NC
FIBRIK CAP	-	NC
MYNEPHRON CAP	-	NC
renaphro cap (NEPHROCAP equiv)	-	NC
TERAVAX CAP	-	NC
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	NC
STROVITE TAB	-	NC
V-C FORTE CAP	-	NC
v-c forte cap (V-C FORTE equiv)	-	NC
MULTIVITAMINS		
FOLIKA-V TAB	-	NC
PED MULTI VITAMINS W/FL & FE		
ESCAVITE CHEW TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
MULTIPLE-VITAMIN/FL-FE DROPS	-	NC
pediatric multiple vitamins/fluoride/iron soln	-	NC
PED MV W/ FLUORIDE		
FLORIVA PLUS DROPS	-	NC
MULTIVITAMIN CHEW TAB	-	NC
pediatric multiple vitamins/fluoride soln	-	NC
POLY-VI-FLOR SUSP	-	NC
TRI-VITAMIN FLUORIDE DROPS	-	NC
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	NC
PRENATAL VITAMINS		
CONCEPT DHA CAP	-	2
PRENATABS RX TAB	-	2
PRENATAL 19 CHEW TAB	-	2
PRENATAL 19 TAB	-	2
PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS)	-	2
VP-PNV-DHA CAP	-	2
AZESCHEW TAB 13-1MG	-	4
MYNATAL-Z TAB	-	4
NEONATAL 19 TAB	-	4
NEONATAL FE TAB	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
PRENATAL VITAMINS (NON-PREFERRED)	-	4
VITAFOL STRIPS	-	4
AZESCO TAB	-	NC
CITRANATAL CAP MEDLEY	-	NC
JENLIVA CAP	-	NC
MATERVIA CAP	-	NC
MATRONEX TAB	-	NC
MULTI-MAC TAB	-	NC
PREGEN DHA CAP	-	NC
PREGENNA TAB	-	NC
PRENARA CAP	-	NC
PRENATE MAX TAB	-	NC
PRENATOL-M TAB 27-1.2MG	-	NC
PRENATRIX TAB	-	NC
PRENATRYL TAB	-	NC
RELEVIA TAB 27-1MG	-	NC
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
baclofen tab (BACLOFEN equiv)	-	2
carisoprodol tab (SOMA equiv)	-	2
cyclobenzaprine tab 10mg (FLEXERIL equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
cyclobenzaprine tab 5mg (FLEXERIL equiv)	-	2
methocarbamol tab (ROBAXIN equiv)	-	2
orphenadrine citrate ER tab (NORFLEX equiv)	-	2
tizanidine tab (ZANAFLEX equiv)	-	2
chlorzoxazone tab 500mg	-	3
tizanidine cap (ZANAFLEX equiv)	-	3
baclofen oral soln 10MG/5ML (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	4
BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization required for members age 9 years and older)	PA	4
baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older)	PA	4
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	4
FLEQSUVY SUSP (Prior Authorization required for members age 9 years and older	PA	4
LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older)	PA	4
AMRIX CAP	-	NC
ATMEKSI SUSP	-	NC
BACLOFEN SOLN	-	NC
baclofen susp (BACLOFEN equiv)	-	NC
baclofen tab 15mg	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
carisoprodol tab 250mg (SOMA equiv)	-	NC
chlorzoxazone tab	-	NC
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
cyclobenzaprine ER cap (AMRIX equiv)	-	NC
METAXALONE TAB	-	NC
metaxalone tab (SKELAXIN equiv)	-	NC
methocarbamol tab 1000mg (ROBAXIN equiv)	-	NC
ONTRALFY ORAL SOLN	-	NC
ROBAXIN TAB	-	NC
SKELAXIN TAB	-	NC
SOMA TAB	-	NC
SOMA TAB 250MG	-	NC
ZANAFLEX CAP	-	NC
ZANAFLEX TAB	-	NC
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	3
DANTRIUM CAP	-	NC
FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS		
SOHONOS CAP 1.5MG	-	NC
SOHONOS CAP 10MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
SOHONOS CAP 1MG	-	NC
SOHONOS CAP 2.5MG	-	NC
SOHONOS CAP 5MG	-	NC
MUSCLE RELAXANT COMBINATIONS		
CARISOPRODOL/ASPIRIN TAB	-	NC
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC
LORVATUS PHARMAPAK KIT	-	NC
NORGESIC TAB FORTE	-	NC
NORGESIC TAB, ORPHENADRINE/ASPIRIN/CAFFEINE TAB 25-385-30MG	-	NC
TIZANIDINE COMFORT KIT	-	NC
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC
AZENASE PAK	-	NC
DYMISTA SPRAY	-	NC
RYALTRIS SPRAY	-	NC
NASAL AGENTS - MISC.		
ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
NASAL ANESTHETICS		
COCAINE HCL SOLN	-	NC
NASAL ANTIALLERGY		
azelastine nasal spray 0.1% (ASTELIN equiv)	-	2
azelastine nasal spray 0.15% (ASTEPRO equiv)	-	3
olopatadine nasal spray (PATANASE equiv)	-	3
ASTELIN NASAL SPRAY, ASTEPRO NASAL SPRAY	-	NC
PATANASE NASAL SPRAY	-	NC
NASAL ANTICHOLINERGICS		
ipratropium nasal spray (ATROVENT equiv)	-	2
NASAL STEROIDS		
budesonide nasal spray (RHINOCORT AQUA equiv) (QL= 2 bottles/fill)	OTC-QL	2
flunisolide nasal soln (QL= 2 bottles/fill)	QL	2
fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill)	QL	2
mometasone nasal spray (NASONEX equiv) (QL= 2 bottles/fill)	QL	2
triamcinolone OTC nasal spray (NASACORT equiv) (QL= 2 bottles/fill)	OTC-QL	2
FLONASE SENSIMIST NASAL SPRAY	OTC	3
BECONASE AQ NASAL SPRAY (QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or mometasone)	QL-ST	4
NASACORT OTC NASAL SPRAY (QL= 2 bottles/fill)	OTC-QL	4
OMNARIS NASAL SPRAY	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
QNASL NASAL SPRAY	-	NC
XHANCE NASAL EXHALER	-	NC
SYMPATHOMIMETIC DECONGESTANTS		
ADRENALIN SOLN	-	NC
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC
NEUROMUSCULAR AGENTS		
ALS AGENTS		
riluzole tab (RILUTEK equiv)	-	3
RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accre 800-803-2523)	LD-PA-QL	5
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	5
RILUTEK TAB	-	NC
TIGLUTIK SUSP	-	NC
FRIEDRICH'S ATAXIA AGENTS		
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-430	LD-PA-QL	5
MUSCULAR DYSTROPHY AGENTS		
DUVYZAT ORAL SUSP	-	NC
RETT SYNDROME AGENTS		
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
NEUROMUSCULAR AGENTS Cont.		
DAYBUE STIX POWDER	-	NC
DAYBUE STIX POWDER 8000MG	-	NC
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOLN	-	NC
EVRYSDI TAB	-	NC
NUTRIENTS		
LIPIDS		
DOJOLVI ORAL LIQUID	-	NC
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	NC
BETA-BLOCKERS - OPHTHALMIC		
BETAXOLOL OPHTH SOLN	-	2
betaxolol ophth soln (BETOPTIC-S equiv)	-	2
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	2
LEVOBUNOLOL OPHTH SOLN	-	2
levobunolol ophth soln (BETAGAN equiv)	-	2
timolol maleate ophth soln (TIMOPTIC equiv)	-	2
BETIMOL OPHTH SOLN 0.25%	-	3
BETOPTIC-S OPHTH SOLN	-	3
brimonidine/timolol ophth soln (COMBIGAN equiv)	-	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	3
ISTALOL OPHTH SOLN	-	3
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	3
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	3
timolol ophth soln (BETIMOL equiv)	-	3
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	4
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	4
BETAGAN OPHTH SOLN	-	NC
CARTEOLOL OPHTH SOLN	-	NC
carteolol ophth soln (OCUPRESS equiv)	-	NC
COMBIGAN OPHTH SOLN	-	NC
COSOPT (PF) OPHTH SOLN	-	NC
TIMOPTIC OCUDOSE OPHTH SOLN 0.25%	-	NC
TIMOPTIC OCUDOSE OPHTH SOLN 0.5%	-	NC
TIMOPTIC OPHTH SOLN	-	NC
TIMOPTIC-XE OPHTH GEL	-	NC
CHOLINERGIC AGONISTS		
TYRVAYA NASAL SPRAY	-	NC
CYCLOPLEGIC MYDRIATICS		
ALTAFRIN OPHTH SOLN	-	2
atropine ophth oint	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ATROPINE OPHTH SOLN	-	2
atropine ophth soln (ISOPTO ATROPINE equiv)	-	2
ATROPINE SUL SOLN 1% OPHTH	-	2
ATROPINE SULFATE OPHTH OINT	-	2
cyclopentolate ophth soln (CYCLOGYL equiv)	-	2
phenylephrine ophth soln (MYDFRIN equiv)	-	2
tropicamide ophth soln (MYDRIACYL equiv)	-	2
CYCLOMYDRIL OPHTH SOLN	-	3
HOMATROPINE OPHTH SOLN	-	3
CYCLOGYL OPHTH SOLN	-	4
CYCLOGYL OPHTH SOLN	-	NC
MYDCOMBI OPHTH SOLN	-	NC
MYDRIACYL OPHTH SOLN	-	NC
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC
MIOTICS		
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	2
ISOPTO CARPINE OPHTH SOLN	-	NC
PHOSPHOLINE OPHTH SOLN	-	NC
pilocarpine hcl ophth soln 1.25% (VUITY equiv)	-	NC
QLOSI OPHTH SOLN, VUITY OPHTH SOLN	-	NC
VIZZ OPHTH SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
VUITY OPHTH SOLN 1.25%	-	NC
YUVEZZI SOLN	-	NC
OPHTHALMIC ADRENERGIC AGENTS		
brimonidine ophth soln 0.2%	-	2
APRACLONIDINE OPHTH SOLN	-	3
apraclonidine ophth soln (IOPIDINE equiv)	-	3
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	3
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	3
IOPIDINE OPHTH SOLN	-	3
ALPHAGAN P OPHTH SOLN 0.15%	-	NC
IOPIDINE OPHTH SOLN	-	NC
SIMBRINZA OPHTH SUSP	-	NC
OPHTHALMIC ANTI-INFECTIVES		
BACIT/POLYMY OPHTH OINT	-	2
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	2
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	2
ciprofloxacin ophth soln (CILOXAN equiv)	-	2
erythromycin ophth oint	-	2
GENTAK OPHTH OINT	-	2
gentamicin ophth soln (GARAMYCIN equiv)	-	2
levofloxacin ophth soln (QUIXIN equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
LEVOFLOXACIN OPHTH SOLN 0.5%	-	2
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	2
NEO/BAC/POLY OPHTH OINT	-	2
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	2
ofloxacin ophth soln (OCUFLOX equiv)	-	2
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	2
SULFACETAMIDE SOD OPHTH SOLN	-	2
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	2
tobramycin ophth soln (TOBREX equiv)	-	2
AZASITE SOLN	-	3
BACITRACIN OPHTH OINT	-	3
ZIRGAN OPHTH GEL	-	3
CILOXAN OPHTH OINT	-	4
gatifloxacin ophth soln (ZYMAXID equiv)	-	4
TOBREX OPHTH OINT	-	4
BESIFLOXACIN OPHTH SUSP, BESIVANCE OPHTH SUSP	-	NC
BLEPH-10 OPHTH SOLN	-	NC
CILOXAN OPHTH SOLN	-	NC
ERYTHROMYCIN OPHTH OINT	-	NC
LEVOFLOXACIN OPHTH SOLN	-	NC
MOXEZA OPHTH SOLN 0.5%	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOL	-	NC
MOXIFLOXACIN SOLN	-	NC
NATACYN OPHTH SUSP	-	NC
NEOSPORIN OPHTH SOLN	-	NC
OCUFLOX OPHTH SOLN	-	NC
POLYTRIM OPHTH SOLN	-	NC
TOBREX OPHTH SOLN	-	NC
TRIFLURIDINE OPHTH SOLN	-	NC
VIGAMOX OPHTH SOLN	-	NC
XDEMVY DROP	-	NC
ZYMAXID OPHTH SOLN	-	NC
OPHTHALMIC IMMUNOMODULATORS		
cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist)	QL-RS	2
CEQUA (PF) OPHTH SOLN, VEVYE OPHTH SOLN	-	NC
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC
RESTASIS OPHTH EMULSION	-	NC
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	-	NC
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ROCKLATAN OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	2
tetracaine hcl ophth soln	-	2
TETRACAINE OPHTH SOLN	-	2
ALCAINE OPHTH SOLN	-	NC
IHEEZO GEL	-	NC
TETRACAINE OPHTH SOLN	-	NC
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE OPHTH SOLN	-	NC
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA OP KIT	-	NC
PHOTREXA VISCOUS OPHTH SOLN	-	NC
OPHTHALMIC STEROIDS		
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	2
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	2
NEO/POLY/BAC/HC OPHTH OINT	-	2
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	2
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	2
prednisolone acetate ophth susp (PRED FORTE equiv)	-	2
PREDNISOLONE OPHTH SUSP	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	2
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	2
SULFACETAMIDE/PREDNISOLONE OPHTH SOLN	-	2
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	2
ALREX OPHTH SUSP	-	3
ALREX OPHTH SUSP 0.2%	-	3
DEXAMETHASONE OPHTH SOLN	-	3
difluprednate ophth emulsion (DUREZOL equiv)	-	3
LOTEMAX OPHTH OINT	-	3
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	3
loteprednol ophth susp (LOTEMAX, ALREX equiv)	-	3
MAXIDEX OPHTH SOLN	-	3
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	3
PRED MILD OPHTH SOLN	-	3
TOBRADEX OPHTH OINT	-	3
LOTEMAX GEL	-	4
BYQLOVI OPHTH SUSP	-	NC
BYQLOVI SUSP	-	NC
DEXTENZA OPHTH INSERT	-	NC
DUREZOL OPHTH EMULSION	-	NC
EYSUVIS OPHTH SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
FLAREX OPHTH SUSP	-	NC
FML FORTE OPHTH SUSP	-	NC
FML LIQUIFLIM OPHTH SUSP	-	NC
INVELTYS OPHTH SUSP	-	NC
KLARITY-B DROPS	-	NC
KLARITY-L DROPS	-	NC
LOTEMAX OPHTH SUSP	-	NC
LOTEMAX SM GEL 0.38%	-	NC
loteprednol etabonate-tobramycin ophth susp (ZYLET equiv)	-	NC
MAXITROL OPHTH OINT	-	NC
MAXITROL OPHTH SUSP	-	NC
PRED FORTE OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC
TOBRADEX OPHTH SOLN	-	NC
TOBRADEX ST OPHTH SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ZYLET OPHTH SUSP	-	NC
OPHTHALMIC SURGICAL AIDS		
DUOVISC KIT	-	NC
OPHTHALMICS - MISC.		
azelastine ophth soln (OPTIVAR equiv)	-	2
cromolyn ophth soln (CROLOM equiv)	-	2
CROMOLYN SODIUM OPHTH SOLN	-	2
diclofenac sodium ophth soln (VOLTAREN equiv)	-	2
dorzolamide ophth soln (TRUSOPT equiv)	-	2
ketorolac ophth soln (ACULAR (LS) equiv)	-	2
KETOROLAC TROMETHAMINE OPHTH SOLN	-	2
ketotifen ophth soln (ZADITOR equiv) (OTC covered only)	OTC	2
olopatadine ophth soln (PATADAY equiv)	OTC	2
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	2
ALOCRIL OPHTH SOLN	-	3
brinzolamide ophth susp (AZOPT equiv)	-	3
bromfenac ophth soln (BROMDAY equiv)	-	3
FLURBIPROFEN OPHTH SOLN	-	3
PROLENSA OPHTH SOLN	-	3
ACUVAIL OPHTH SOLN	-	4
bepotastine ophth soln (BEPREVE equiv)	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
epinastine opthth soln (ELESTAT equiv)	-	4
ZERVIATE OPTH SOLN	-	4
CYSTADROPS SOLN (QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	5
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	5
UPNEEQ SOLN	-	EXC
ACULAR (LS) OPHTH SOLN	-	NC
ACULAR (LS) OPHTH SOLN 0.4%	-	NC
AZOPT OPHTH SUSP	-	NC
BROMSITE DROP 0.075%	-	NC
ELESTAT OPHTH SOLN	-	NC
ILEVRO OPHTH SUSP	-	NC
MIEBO OPHTH SOLN	-	NC
NEVANAC OPHTH SUSP	-	NC
OMLONTI OPHTH SOLN	-	NC
TRUSOPT OPHTH SOLN	-	NC
TRYPTYR SOLN	-	NC
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	2
bimatoprost ophth soln (QL= 2.5ml/30 days)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days)	QL	3
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv) (QL= 1 vial/day)	PA-QL	3
travoprost ophth soln (TRAVATAN Z equiv) (QL= 2.5ml/30 days)	QL	3
ZIOPTAN OPHTH SOLN (QL= 1 vial/day)	PA-QL	4
IYUZEH OPHTH DROPS	-	NC
TRAVATAN Z DROPS	-	NC
VYZULTA SOLN	-	NC
XALATAN OPHTH SOLN	-	NC
XELPROS OPHTH EMULSION	-	NC
ZOLYMBUS OPHTH GEL	-	NC
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	2
OTIC ANTIFUNGALS		
CLOTIC SOLN	-	NC
OTIC ANTI-INFECTIVES		
ofloxacin otic soln (FLOXIN equiv)	-	2
ciprofloxacin hcl otic soln (CETRAXAL equiv)	-	3
XTORO OTIC SUSP	-	NC
OTIC COMBINATIONS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
neomycin/polymixin/hydrocoritisone otic soln (CORTISPORIN equiv)	-	2
neomycin/polymixin/hydrocoritisone otic susp (CORTISPORIN equiv)	-	2
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	3
COLY-MYCIN S OTIC SUSP	-	3
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CIPRO HC OTIC SUSP	-	NC
CIPRODEX OTIC SUSP	-	NC
ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv)	-	NC
CORTANE-B OTIC SOLN	-	NC
CORTIC-ND DROPS	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	2
fluocinolone otic oil (DERMOTIC equiv)	-	3
DERMOTIC OIL	-	NC
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
MPM PAK	-	NC
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	3

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
HIZENTRA INJ	MSP-PA	5
CUVITRU INJ	-	NC
MONOCLONAL ANTIBODIES		
SYNAGIS INJ	-	NC
PASSIVE IMMUNIZING AGENTS - COMBINATIONS		
HYQVIA INJ	-	NC
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
IMMUNE SERUMS		
HIZENTRA INJ	MSP-PA	5
CUTAQUIG INJ	-	NC
XEMBIFY INJ	-	NC
MONOCLONAL ANTIBODIES		
BEYFORTUS INJ	VAC	1
ENFLONSIA INJ	VAC	1
PENICILLINS		
AMIDINOPENICILLINS		
PIVYA TAB	-	NC
AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	2
AMOXICILLIN CHEW	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PENICILLINS Cont.		
amoxicillin susp (TRIMOX equiv)	-	2
amoxicillin tab (AMOXIL equiv)	-	2
ampicillin cap (AMPICILLIN equiv)	-	2
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC
NATURAL PENICILLINS		
penicillin vk tab (VEETIDS equiv)	-	2
PENICILLN VK SOLN	-	2
PENICILLN VK SOLN 125MG/5ML	-	NC
PENICILLN VK SOLN 250MG/5ML	-	NC
PENICILLIN COMBINATIONS		
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	2
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	2
AMOXICILLIN/CLAVULANATE CHEW TAB	-	3
amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv)	-	4
AUGMENTIN SUSP	-	4
AUGMENTIN ES-600 SUSP	-	NC
AUGMENTIN TAB	-	NC
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	2
PHARMACEUTICAL ADJUVANTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PHARMACEUTICAL ADJUVANTS Cont.		
LIQUID VEHICLES		
TRICHOSOL SOLN	-	NC
SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	3
PROGESTINS		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	2
norethindrone tab (AYGESTIN equiv)	-	2
progesterone cap (PROMETRIUM equiv)	-	2
progesterone oil inj	-	2
hydroxyprogesterone inj (MAKENA equiv)	MSP-PA	4
megestrol ES susp (MEGACE ES equiv)	-	4
MEGESTROL SUSP	-	4
AYGESTIN TAB	-	NC
MAKENA INJ	-	NC
PROMETRIUM CAP	-	NC
PROVERA TAB	-	NC
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
disulfiram tab (ANTABUSE equiv)	-	2
lofexidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days)	PA-QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	4
acamprosate calcium DR tab (CAMPRAL equiv)	-	NC
ANTABUSE TAB	-	NC
disulfiram tab 500mg	-	NC
ANTI-CATAPLECTIC AGENTS		
sodium oxybate oral soln (XYREM equiv) (QL= 540ml/30 days; Only available throu Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	2
LUMRYZ PACK (QL= 1 pack/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
LUMRYZ STARTER PACK (QL= 1 packet/day; Only available through Accredo 800-803-2523)	LD-PA-QL	5
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	5
XYREM SOLN	-	NC
XYWAV SOLN	-	NC
ANTIDEMENTIA AGENTS		
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	2
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	2
galantamine ER cap (RAZADYNE ER equiv)	-	2
galantamine tab (RAZADYNE equiv)	-	2
memantine tab (NAMENDA equiv)	-	2
MEMANTINE TITRATION PAK	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
rivastigmine cap (EXELON equiv)	-	2
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	3
GALANTAMINE SOLN	-	3
memantine ER cap (NAMENDA XR equiv)	-	3
memantine sol (NAMENDA equiv)	-	3
NAMENDA XR TITRATION PACK	-	3
rivastigmine patch (EXELON equiv)	-	3
LEQEMBI IQLIK INJ 250MG/1.25ML (QL= 8 inj/28 days; Only available through Caremed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	5
LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	5
ADLARITY PATCH	-	NC
ARICEPT TAB	-	NC
ARICEPT TAB 23MG	-	NC
EXELON PATCH	-	NC
memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv)	-	NC
NAMENDA TAB	-	NC
NAMENDA XR CAP	-	NC
NAMZARIC CAP	-	NC
NAMZARIC STARTER PACK	-	NC
RAZADYNE SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
RAZADYNE TAB	-	NC
ZUNVEYL TAB	-	NC
COMBINATION PSYCHOTHERAPEUTICS		
PERPHENAZINE/ AMITRIPTYLINE TAB	-	2
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	3
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC
DULOXICAINE PACK	-	NC
LYBALVI TAB	-	NC
SYMBYAX CAP	-	NC
FIBROMYALGIA AGENTS		
milnacipran hcl tab (SAVELLA equiv) (QL= 2 tabs/day)	QL	3
milnacipran hcl tab pak (SAVELLA equiv)	-	3
SAVELLA PAK	-	4
SAVELLA TAB (QL= 2 tabs/day)	QL	4
TONMYA SL TAB	-	NC
MOVEMENT DISORDER DRUG THERAPY		
tetrabenazine tab (XENAZINE equiv)	MSP-PA	4
AUSTEDO XR TAB (QL= 1 tab/day)	MSP-PA-QL	5
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	MSP-PA-QL	5
AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days)	MSP-PA-QL	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
INGREZZA CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416)	LD-PA-QL	5
INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416)	LD-PA-QL	5
AUSTEDO TAB	-	NC
AUSTEDO TITRATION PACK	-	NC
INGREZZA PACK 40-80MG	-	NC
XENAZINE TAB	-	NC
MULTIPLE SCLEROSIS AGENTS		
cladribine tab therapy pack (MAVENCLAD equiv) (Only available through Walgreens 888-347-3416)	LD	2
dalfampridine ER tab (AMPYRA equiv)	MSP	2
teriflunomide tab (AUBAGIO TAB equiv)	MSP	2
AVONEX INJ	MSP	5
BETASERON INJ	MSP	5
dimethyl fumarate DR cap (TECFIDERA equiv)	MSP	5
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	MSP	5
fingolimod hcl cap 0.5mg (GILENYA equiv)	MSP	5
GILENYA CAP 0.25MG	MSP	5

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
glatiramer inj (COPAXONE equiv)	MSP	5
KESIMPTA INJ	MSP	5
MAVENCLAD THERAPY PAK (Only available through Walgreens 888-347-3416)	LD	5
PLEGRIDY INJ	MSP	5
PLEGRIDY PEN INJ	MSP	5
REBIF INJ	MSP	5
AMPYRA TAB	-	NC
AUBAGIO TAB	-	NC
BAFIERTAM CAP	-	NC
COPAXONE INJ	-	NC
EXTAVIA INJ	-	NC
GILENYA CAP 0.5MG	-	NC
MAYZENT TAB	-	NC
MAYZENT TAB STARTER PACK	-	NC
PONVORY TAB	-	NC
PONVORY TAB STARTER PACK	-	NC
TASCENSO ODT TAB	-	NC
TECFIDERA CAP	-	NC
TECFIDERA STARTER PACK	-	NC
TYSABRI INJ	-	NC
VUMERITY CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
ZEPOSIA CAP	-	NC
ZEPOSIA STARTER PACK	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
gabapentin (once-daily) tab (GRALISE equiv)	-	NC
GRALISE TAB	-	NC
LIDOTIN PAK	-	NC
LYRICA CR TAB	-	NC
pregabalin ER tab (LYRICA CR equiv)	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
fluoxetine cap (SARAFEM equiv)	-	4
FLUOXETINE CAP (PMDD)	-	4
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		
dextromethorphan hbr-quinidine sulfate cap (NUEDEXTA equiv)	-	NC
NUEDEXTA CAP	-	NC
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
pimozide tab (ORAP equiv)	-	3
ERGOLOID MESYLATES TAB	-	4
AQNEURSA PACKET FOR SUSPENSION	-	NC
MIPLYFFA CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
ORAP TAB	-	NC
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	1
NICODERM PATCH (Limited to 180 days/plan year)	OTC-QL-SMKG	1
NICORETTE GUM (Limited to 180 days/plan year)	OTC-QL-SMKG	1
NICORETTE LOZENGE (Limited to 180 days/plan year)	OTC-QL-SMKG	1
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1
NICOTINE KIT (Limited to 180 days/plan year)	OTC-QL-SMKG	1
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	1
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	1
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	1
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	1
varenicline tartrate tab (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	1
varenicline tartrate tab starter pack (CHANTIX equiv) (Limited to 180 days/plan year	QL-SMKG	1
ZYBAN TAB (Limited to 180 days/plan year)	QL-SMKG	1
CHANTIX STARTER PACK	SMKG	NC
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
WAINUA INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP	-	NC
paroxetine cap (BRISDELLE equiv)	-	NC
RESPIRATORY AGENTS - MISC.		
ALPHA-PROTEINASE INHIBITOR (HUMAN)		
ARALAST/PROLASTIN/ZEMAIRA INJ	-	NC
CYSTIC FIBROSIS AGENTS		
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	3
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416	LD-PA-QL-SF	5
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5
ORKAMBI TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	5
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	5
ALYFTREK TAB	-	NC
ALYFTREK TAB 4-20-50MG	-	NC
BRONCHITOL CAP	-	NC
PULMOZYME INH SOLN	-	NC
TRIKAFTA TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
PULMONARY FIBROSIS AGENTS		
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	MSP-PA-QL	2
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	MSP-PA-QL	2
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	MSP-PA-QL	2
ESBRIET CAP	-	NC
ESBRIET TAB	-	NC
JASCAYD TAB	-	NC
nintedanib esylate cap (OFEV equiv)	-	NC
OFEV CAP	-	NC
PIRFENIDONE TAB	-	NC
RESPIRATORY AGENTS - MISC.		
BRINSUPRI TAB	-	NC
SULFONAMIDES		
SULFONAMIDES		
sulfadiazine tab	-	4
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB	-	NC
TETRACYCLINES		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	2
doxycycline hyclate tab (VIBRATAB equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
doxycycline monohydrate cap (MONODOX equiv)	-	2
doxycycline monohydrate tab (ADOXA equiv)	-	2
minocycline cap (MINOCIN equiv)	-	2
doxycycline susp (VIBRAMYCIN equiv)	-	3
minocycline tab (DYNACIN equiv)	-	3
demeclocycline tab (DECLOMYCIN equiv)	-	4
doxycycline hyclate DR tab (DORYX equiv)	-	4
tetracycline cap	-	4
ACTICLATE TAB 75MG, 150MG	-	NC
DORYX MPC TAB	-	NC
DORYX TAB	-	NC
DOXYCYCLINE HYCLATE CAP	-	NC
doxycycline hyclate tab (TARGADOX equiv)	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
DYNACIN TAB	-	NC
MINOCIN CAP	-	NC
MINOCYCLINE ER CAP	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
MINOLIRA TAB	-	NC
MONODOX CAP	-	NC
SEYSARA TAB	-	NC
SOLODYN TAB	-	NC
TETRACYCLINE TAB	-	NC
VIBRAMYCIN CAP	-	NC
VIBRAMYCIN SUSP	-	NC
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	2
propylthiouracil tab	-	2
SODIUM IODIDE I-131 SOLN	-	NC
TAPAZOLE TAB	-	NC
THYROID HORMONES		
ARMOUR THYROID TAB, NATURE THYROID TAB	-	2
levothyroxine tab (SYNTHROID equiv)	-	2
liothyronine tab (CYTOMEL equiv)	-	2
SYNTHROID TAB	-	4
CYTOMEL TAB	-	NC
ERMEZA SOLN 150 MCG/5ML	-	NC
LEVOTHYROXINE INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
THYROID AGENTS Cont.		
LEVOTHYROXINE INJ 100MCG/ML	-	NC
THYQUIDITY SOLN	-	NC
TIROSINT CAP	-	NC
TIROSINT-SOL	-	NC
TOXOIDS		
TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	1
DAPTACEL INJ, INFANRIX INJ	VAC	1
DIPTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	1
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	1
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	1
PEDIARIX INJ	VAC	1
PENTACEL INJ	VAC	1
TETANUS/DIPHTHERIA TOXOID INJ	VAC	1
VAXELIS INJ	VAC	1
ULCER DRUGS		
ANTISPASMODICS		
dicyclomine cap (BENTYL equiv)	-	2
dicyclomine tab (BENTYL equiv)	-	2
hyoscyamine sulfate CR tab (LEVBID equiv)	-	2
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	2
hyoscyamine tab (LEVSIN equiv)	-	2
BELLADONNA ALKALOID/OPIUM SUPP	-	3
dicyclomine soln (BENTYL equiv)	-	3
glycopyrrolate tab (ROBINUL equiv)	-	3
methscopolamine tab (PAMINE equiv)	-	4
atropine inj	M	6
ATROPINE SULFATE INJ	M	6
ANASPAZ ODT	-	NC
b-donna tab (DONNATAL equiv)	-	NC
BENTYL CAP	-	NC
BENTYL SYRUP	-	NC
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	NC
DONNATAL TAB	-	NC
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC
LEVSIN INJ	-	NC
LIBRAX CAP	-	NC
ROBINUL TAB	-	NC
H-2 ANTAGONISTS		
cimetidine soln (CIMETIDINE equiv)	-	2
cimetidine tab (TAGAMET equiv)	OTC	2

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
nizatidine cap (AXID equiv)	-	2
famotidine susp (PEPCID equiv)	-	3
AXID CAP	-	NC
famotidine tab (PEPCID equiv)	OTC	NC
PEPCID SUSP	-	NC
PEPCID TAB	OTC	NC
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	2
CARAFATE TAB	-	NC
PROTON PUMP INHIBITORS		
esomeprazole cap (NEXIUM equiv)	OTC	2
lansoprazole cap (PREVACID equiv)	OTC	2
omeprazole DR cap (PRILOSEC equiv)	-	2
pantoprazole EC tab (PROTONIX equiv)	-	2
rabeprazole EC tab (ACIPHEX equiv)	-	2
PREVACID CAP (RX Only)	-	4
PREVACID OTC CAP	OTC	4
ACIPHEX SPRINKLE CAP	-	NC
ACIPHEX TAB	-	NC
FIRST OMEPRAZOLE SUSP	-	NC
LANSOPRAZOLE SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
PRILOSEC CAP	-	NC
PROTONIX EC TAB	-	NC
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	2
CYTOTEC TAB	-	NC
ULCER THERAPY COMBINATIONS		
HELIDAC PACK	-	NC
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC
ZEGERID CAP	-	NC
ZEGERID POWDER PACK	-	NC
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		
HYOSCYAMINE ELXIR	-	2
HYOSCYAMINE SULFATE ER TAB	-	2
HYOSCYAMINE SULFATE SL TAB	-	2
HYOSCYAMINE TAB	-	2
CUVPOSA SOLN	-	4
glycopyrrolate oral soln (CUVPOSA equiv)	-	4
ATROPINE SUL INJ	M	6
ATROPINE SULFATE INJ	-	6

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
CHLORDIAZEPOXIDE/CLIDINIUM CAP	-	NC
DARTISLA ODT TAB	-	NC
DERMACINRX TAB	-	NC
DICYCLOMINE TAB	-	NC
DONNATAL ELXIR	-	NC
GLYCATE TAB	-	NC
HYOSCYAMINE INJ	-	NC
LEVBID ER TAB 0.375MG	-	NC
LEVSIN SL TAB 0.125MG	-	NC
LEVSIN TAB 0.125MG	-	NC
H-2 ANTAGONISTS		
NIZATIDINE CAP	-	2
RANITIDINE TAB	-	NC
MISC. ANTI-ULCER		
sucralfate susp (CARAFATE equiv)	-	3
CARAFATE SUSP	-	NC
PROTON PUMP INHIBITORS		
omeprazole tab	OTC	2
esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
lansoprazole odt (PREVACID SOLUTAB equiv) (Prior Authorization required for members age 9 years and older)	PA	4
NEXIUM 24HR TAB	OTC	4
DEXILANT DR CAP	-	NC
dexlansoprazole DR cap (DEXILANT equiv)	-	NC
FIRST PANTOPRAZOLE SUSP	-	NC
NEXIUM GRANULE PACK	-	NC
omeprazole magnesium DR tab 20mg (PRILOSEC equiv)	OTC	NC
pantoprazole sodium packet (PROTONIX PAK equiv)	-	NC
PREVACID SOLUTAB	-	NC
VOQUEZNA TAB	-	NC
ULCER THERAPY COMBINATIONS		
bismuth/metro/tetra cap (PYLERA equiv)	-	NC
KONVOMEP SUSP	-	NC
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC
LANSOPRAZOLE/AMOXICILLIN/CLARITHTHROMYCIN KIT	-	NC
PYLERA CAP	-	NC
TALICIA CAP	-	NC
VOQUEZNA DUAL PAK	-	NC
VOQUEZNA TRIP PAK	-	NC
URINARY ANTI-INFECTIVES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
URINARY ANTI-INFECTIVES Cont.		
URINARY ANTI-INFECTIVE COMBINATIONS		
PROSED DS TAB	-	NC
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
trospium chloride SR cap (SANCTURA XR equiv)	-	3
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	2
oxybutynin ER tab (DITROPAN XL equiv)	-	2
oxybutynin syrup	-	2
oxybutynin tab (DITROPAN equiv)	-	2
solifenacin tab (VESICARE equiv)	-	2
tolterodine SR cap (DETROL LA equiv)	-	2
tolterodine tab (DETROL equiv)	-	2
trospium tab (SANCTURA equiv)	-	2
darifenacin SR tab (ENABLEX equiv)	-	3
TOVIAZ TAB	-	4
DETROL LA CAP	-	NC
DETROL TAB	-	NC
DITROPAN XL TAB	-	NC
ENABLEX TAB	-	NC
GELNIQUE	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
oxybutynin tab 2.5mg	-	NC
VESICARE LS SUSP	-	NC
VESICARE TAB	-	NC
URINARY ANTISPASMODIC COMBINATIONS		
URELIEF PLUS TAB	-	NC
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
MYRBETRIQ TAB	-	3
GEMTESA TAB	-	NC
mirabegron granules for oral extended release susp (MYRBETRIQ equiv)	-	NC
mirabegron tab er (MYRBETRIQ equiv)	-	NC
MYRBETRIQ SUSP	-	NC
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	2
URECHOLINE TAB	-	NC
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
flavoxate tab (URISPAS equiv)	-	4
VACCINES		
BACTERIAL VACCINES		
ACTHIB INJ, HIBERIX INJ	VAC	1
BEXSERO INJ	VAC	1
CAPVAXIVE INJ	VAC	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VACCINES Cont.		
MENACTRA INJ	VAC	1
MENQUADFI INJ	VAC	1
MENVEO INJ	VAC	1
PEDVAXHIB INJ	VAC	1
PENBRAYA INJ	VAC	1
PENMENVY INJ	VAC	1
PNEUMOVAX INJ	VAC	1
PREVNAR 20 INJ	VAC	1
TRUMENBA INJ	VAC	1
VAXNEUVANCE INJ	VAC	1
BCG INJ	VAC	EXC
TYPHIM VI INJ	VAC	EXC
VAXCHORA SUSP	VAC	EXC
VIVOTIF CAP	VAC	EXC
VIRAL VACCINES		
ABRYSVO INJ (QL= 1 dose/lifetime)	QL-VAC	1
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	1
AREXVY INJ (QL= 1 dose/lifetime)	QL-VAC	1
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	1
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	1
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
VACCINES Cont.		
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	1
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	1
DENGVAXIA SUSP	VAC	1
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	1
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	1
FLUBLOK INJ (QL= 1 inj/28 days)	QL-VAC	1
FLUCELVAX INJ (QL= 1 inj/28 days)	QL-VAC	1
FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days)	QL-VAC	1
FLUMIST NASAL (QL= 1 dose/28 days)	QL-VAC	1
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	1
GARDASIL 9 INJ	VAC	1
HAVRIX INJ, VAQTA INJ	VAC	1
HEPLISAV-B INJ	VAC	1
IPOL INJ	VAC	1
JYNNEOS INJ	VAC	1
MFLUSIVA INJ (QL= 1 inj/28; Covered for members age 50 years and older)	QL-VAC	1
M-M-R II INJ	VAC	1
MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days)	QL-VAC	1
MRESVIA INJ (QL= 1 dose/lifetime)	QL-VAC	1
NOVAVAX INJ (QL= 1 dose/24 days)	QL-VAC	1
PREHEVBRIO SUSP	VAC	1

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VACCINES Cont.		
PRIORIX INJ	VAC	1
PROQUAD INJ	VAC	1
ROTARIX SUSP	VAC	1
ROTATEQ INJ	VAC	1
SHINGRIX INJ (Covered for members age 19 years and older)	VAC	1
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	1
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	1
TWINRIX INJ	VAC	1
VARIVAX INJ	VAC	1
IMOVAX INJ	VAC	EXC
IXCHIQ INJ	VAC	EXC
IXIARO INJ	VAC	EXC
TICOVAC INJ	VAC	EXC
VIMKUNYA INJ	VAC	EXC
YF-VAX INJ	VAC	EXC
VAGINAL AND RELATED PRODUCTS		
VAGINAL ANTI-INFECTIVES		
VANDAZOLE GEL	-	2
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	4
NUVESSA VAGINAL GEL	-	NC
XACIATO GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Category/Class

Last Updated* 9/1/2026

DrugName	Special Code	Tier
VAGINAL AND RELATED PRODUCTS Cont.		
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL (QL= 1 box/fill)	QL	1
VAGINAL PROGESTINS		
ENDOMETRIN SUPP	PA	3
progesterone vaginal insert (ENDOMETRIN equiv)	PA	3
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
FEM PH GEL	-	4
INTRAROSA SUPP	-	NC
SPERMICIDES		
CONTRACEPTIVE FILM	OTC	1
CONTRACEPTIVE GEL	OTC	1
CONTRACEPTIVE SUPP	OTC	1
TODAY SPONGE	OTC	1
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv)	QL	2
metronidazole vaginal gel (METROGEL equiv)	-	2
terconazole cream (TERAZOL equiv)	-	2
TERCONAZOLE CREAM 0.8%	-	2
terconazole supp (TERAZOL equiv)	-	2
CLEOCIN VAGINAL SUPP (QL= 3 suppositories/fill)	QL	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
GYNAZOLE CREAM	-	4
MICONAZOLE 3 SUPP 200MG	-	4
CLEOCIN VAGINAL CREAM	-	NC
METROGEL VAGINAL GEL	-	NC
TERAZOL CREAM	-	NC
VAGINAL ESTROGENS		
estradiol cream (ESTRACE equiv)	-	2
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days (1 tabs on first fill))	QL	3
ESTRING (3 copays per Rx)	-	3
PREMARIN VAGINAL CREAM	-	3
FEMRING (3 copays per Rx)	-	4
ESTRACE VAGINAL CREAM	-	NC
IMVEXXY SUPP	-	NC
VAGIFEM TAB	-	NC
VAGINAL PROGESTINS		
CRINONE GEL	PA	3
ENDOMETRIN INSERT	PA	3
PROGESTERONE SUPP	PA	4
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VASOPRESSORS Cont.		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	2
NEFFY SPRAY (QL= 2 doses/fill)	QL	3
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC
AUVI-Q INJ	-	NC
EPIPEN (JR) INJ	-	NC
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap (NORTHERA equiv)	-	NC
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	2
VITAMINS		
MISC. NUTRITIONAL FACTORS		
PRENATAL VITAMINS (NON-PREFERRED)	-	4
OIL SOLUBLE VITAMINS		
cholecalciferol cap 50000 unit	-	2
vitamin D cap (Rx covered Only)	-	2
phytonadione tab (MEPHYTON equiv)	-	3
DRISDOL CAP	-	NC
ERGOCAL CAP	-	NC
MEPHYTON TAB	-	NC
vitamin D cap 1000unit	OTC	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic** =small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VITAMINS Cont.		
vitamin D cap 400unit	OTC	NC
VITAMIN D TAB 400UNIT	OTC	NC
WATER SOLUBLE VITAMINS		
POTABA CAP	-	4

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

NC =Not Covered **generic =**small letters **BRANDS** =CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	M	Medical Benefit
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit
RS	Restricted to Specialist	SF	Limited to two 15 day fills per month fo first 3 months
SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary
Prior Authorization Drug List
Last Updated* 9/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ACTIMMUNE INJ	5
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	5
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT	5
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT	5
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	5
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	5
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT	5
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KI	5
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	5
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	5
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	5
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA 80MG/0.8ML	5
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA 40MG/0.4ML	5
adapalene cream	3
adapalene gel	3
adapalene gel 0.3%	3
ADBRY INJ	5
ALECENSA CAP	5
ALKINDI SPRINKLE CAP 0.5MG	5
ALKINDI SPRINKLE CAP 1MG	5
ALUNBRIG TAB 30MG	5
ALUNBRIG TAB 90MG, 180MG	5
ambrisentan tab	2
APRETUDE SUSP	1
ARBLI SUSP	4
ARIKAYCE SUSP	5
aripiprazole soln	4
asenapine maleate SL tab	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ATORVALIQ SUSP	4
AUGTYRO CAP	5
AUGTYRO CAP 160MG	5
AUSTEDO XR TAB	5
AUSTEDO XR TAB TITRATION KIT	5
AUSTEDO XR TITRATION PACK	5
AVTOZMA INJ	5
AYVAKIT TAB	5
baclofen oral soln 10MG/5ML	4
BACLOFEN ORAL SOLN 5 MG/5ML	4
baclofen oral soln 5mg/5ml	4
BALVERSA TAB 3MG	5
BALVERSA TAB 4MG	5
BALVERSA TAB 5MG	5
BENLYSTA AUTO-INJECTOR	5
BENLYSTA INJ	5
BERINERT INJ	5
BESREMI INJ	5
BESREMI PEN INJ	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
bexarotene cap	2
bexarotene gel	2
bosentan tab	5
bosentan tab for oral susp	2
BOSULIF CAP	5
BOSULIF TAB	5
bosutinib tab	2
BRAFTOVI CAP 75MG	5
budesonide ER tab	4
budesonide rectal foam	4
BYLVAY CAP 1200MCG	5
BYLVAY CAP 400MCG	5
BYLVAY SPRINKLE CAP 200MCG	5
BYLVAY SPRINKLE CAP 600MCG	5
CALQUENCE TAB	5
CAMZYOS CAP	5
CAPRELSA TAB	5
CAPRELSA TAB 300MG	5
CIMZIA INJ 200MG/ML	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CINRYZE INJ	5
clobazam susp	2
COPIKTRA CAP	5
CORLANOR SOLN	4
COTELLIC TAB	5
CRINONE GEL	3
dasatinib tab	2
DAYBUE SOLN	5
deferiprone tab	2
DESCOVY TAB	1
diclofenac gel	3
DIFFERIN OTC GEL 0.1%	2
DOPTELET SPRINKLE CAP	5
DOPTELET TAB	5
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALOI CREAM	4
dronabinol cap	3
eltrombopag olamine powder pack for susp	2
eltrombopag olamine tab 12.5mg, 25mg	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
eltrombopag olamine tab 50mg	2
eltrombopag olamine tab 75mg	2
enalapril maleate oral soln	3
ENBREL INJ 25MG	5
ENBREL INJ 50MG	5
ENBREL MINI INJ	5
ENBREL SURECLICK INJ 50MG	5
ENDOMETRIN INSERT	3
ENDOMETRIN SUPP	3
EPANED SOLN	4
EPIDIOLEX SOLN	5
EPRONTIA SOLN	4
ERGOMAR SL TAB	4
ERIVEDGE CAP	5
ERLEADA TAB	5
ERLEADA TAB 240MG	5
erlotinib tab	5
erlotinib tab 25mg	5
esomeprazole DR granule pack	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
everolimus tab	2
everolimus tab (ZORTRESS equiv)	5
everolimus tab 5mg	5
everolimus tab for oral susp	2
fentanyl citrate lollipop	3
FERRIPROX SOLN	5
FERRIPROX TAB 1000MG	5
FILSPARI TAB	5
FIRDAPSE TAB	5
FLEQSUVY SUSP	4
FLOLIPID SUSP	4
FRUZAQLA CAP 1MG	5
FRUZAQLA CAP 5MG	5
GAVRETO CAP	5
gefitinib tab	5
GENOTROPIN INJ	5
GENOTROPIN INJ 5MG	5
GILOTRIF TAB	5
HADLIMA INJ	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
HADLIMA INJ 40MG/0.8ML	5
HADLIMA PUSH INJ	5
HADLIMA PUSH INJ 40MG/0.8ML	5
HAEGARDA INJ	5
HEMLIBRA INJ	5
HIZENTRA INJ	5
HUMIRA INJ 10MG	5
HUMIRA INJ 20MG	5
HUMIRA INJ 40MG	5
HUMIRA INJ 80MG	5
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	5
HUMIRA INJ PEDIATRIC CROHNS STARTER PAC	5
HUMIRA INJ PEDIATRIC UC STARTER PACK	5
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	5
HUMIRA PEN INJ 40MG	5
HYCAMTIN CAP	5
hydroxyprogesterone inj	4
HYFTOR GEL	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
icatibant inj	5
ICLUSIG TAB	5
IDHIFA TAB	5
IMBRUVICA CAP 140MG	5
IMBRUVICA CAP 70MG	5
IMBRUVICA TAB 420MG	5
INGREZZA CAP	5
INGREZZA SPRINKLE CAP	5
INLYTA TAB	5
INLYTA TAB 1MG	5
INZIRQO SUSP	4
itraconazole soln	4
JAYPIRCA TAB	5
KALYDECO PAK	5
KALYDECO TAB	5
KERENDIA TAB	3
KHINDIVI SOLN	5
KISQALI PAK	5
KISQALI TAB	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
KOSELUGO CAP 10MG	5
KOSELUGO SPRINKLE CAP 5MG	5
KRAZATI TAB	5
lansoprazole odt	4
lapatinib ditosylate tab	2
LEDIPASVIR/SOFOSBUVIR TAB	3
LENVIMA CAP	5
LEQEMBI IQLIK INJ 250MG/1.25ML	5
LEQEMBI IQLK INJ	5
l-glutamine powder packet	2
LINZESS CAP	4
liraglutide soln pen-injector	3/3P
LIVMARLI SOLN	5
LIVTENCITY TAB	5
lofexidine hcl tab	4
LOKELMA PAK	3
LORBRENA TAB 100MG	5
LORBRENA TAB 25MG	5
LUCEMYRA TAB	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
LUMRYZ PACK	5
LUMRYZ STARTER PACK	5
LUPKYNIS CAP	5
LYNPARZA TAB	5
LYTGOBI THERAPY PACK	5
LYVISPAH GRANULE PACKET	4
macitentan tab	2
MEKINIST SOLN	5
MEKINIST TAB 0.5MG	5
MEKINIST TAB 2MG	5
MEKTOVI TAB	5
mercaptopurine susp	4
methyltestosterone cap	4
mifepristone tab	5
MOUNJARO INJ	3/3P
MOVANTIK TAB	3
NERLYNX TAB	5
nilotinib hcl cap	2
NINLARO CAP	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
nitazoxanide tab	3
nitrofurantoin susp	4
NORLIQVA ORAL SOLN	4
ODACTRA SL TAB	4
ODOMZO CAP	5
OJJAARA TAB	5
OMNITROPE INJ	5
OPZELURA CREAM	4
ORILISSA TAB 150MG	3
ORILISSA TAB 200MG	3
ORKAMBI GRANULES PACKET	5
ORKAMBI TAB	5
OTEZLA STARTER PACK	5
OTEZLA TAB	5
OTEZLA XR TAB	5
OTEZLA/OTEZLA XR STARTER PACK	5
OZEMPIC INJ	3/3P
OZEMPIC TAB, RYBELSUS TAB	3/3P
PALFORZIA POWDER PACK	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
PALFORZIA SPRINKLE CAP	5
pazopanib tab	2
PEMAZYRE TAB	5
PIQRAY TAB	5
pirfenidone cap	2
pirfenidone tab 267mg	2
pirfenidone tab 801mg	2
PREVYMIS PAK	5
PREVYMIS TAB	5
PROGESTERONE SUPP	4
progesterone vaginal insert	3
pyrimethamine tab	2
PYRUKYND TAB	5
PYRUKYND TAPER PACK	5
QBRELIS SOLN	4
QINLOCK TAB	5
RADICAVA ORS STARTER KIT	5
RADICAVA ORS SUSP	5
RETIN-A CREAM	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
RETIN-A GEL	2
REXULTI TAB	4
REZLIDHIA CAP	5
REZUROCK TAB	5
RINVOQ ER TAB	5
RINVOQ ORAL SOLN	5
ROZLYTREK CAP	5
RUBRACA TAB	5
RUCONEST INJ	5
rufinamide susp	3
RYDAPT CAP	5
SAPHNELO INJ	5
SAPHNELO PEN INJ	5
SCEMBLIX TAB	5
SCEMBLIX TAB 100 MG	5
sildenafil susp	3
sildenafil tab 20mg	2
SIMLANDI INJ (adalimumab-ryvk)	5
SIMLANDI KIT (adalimumab-ryvk)	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SKYCLARYS CAP	5
SKYRIZI INJ 150MG/ML	5
SKYRIZI INJ 180 MG/1.2ML	5
SKYRIZI INJ 360MG/2.4ML	5
SKYRIZI INJ 55MG/0.37ML	5
sodium oxybate oral soln	2
SODIUM OXYBATE SOLN	5
SOFOSBUVIR/VELPATASVIR TAB	3
SOGROYA INJ	4
SOLIQUA INJ	3
sorafenib tosylate tab	2
SPIRIVA HANDIHALER	4
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	4
STELARA INJ	5
STEQEYMA INJ	5
STEQEYMA INJ 90MG	5
STIVARGA TAB	5
SUBVENITE SUSP	4
sunitinib malate cap	2

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
SUNOSI TAB	3
SYMDEKO TAB	3
SYMPROIC TAB	3
TABRECTA TAB	5
tadalafil tab (PAH)	2
TADLIQ SUSP	4
TAFINLAR CAP	5
TAFINLAR TAB	5
tafluprost preservative free (pf) ophth soln	3
TAKHZYRO INJ 150MG/ML	5
TALTZ INJ	5
TALTZ INJ 20MG/0.25ML	5
TALTZ INJ 40 MG/0.5ML	5
TAVNEOS CAP	5
testosterone gel 1% 25mg	3
testosterone gel 1% 50mg	3
testosterone gel 1% pump	3
testosterone gel 1.62% 1.25gm	4
testosterone gel 1.62% 2.5gm	4

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
TESTOSTERONE GEL 20.25MG/1.25GM	4
TESTOSTERONE GEL PUMP 1%	3
testosterone gel pump 1.62%	3
testosterone soln	3
tetrabenazine tab	4
TEZSPIRE INJ	5
THALOMID CAP	5
TIBSOVO TAB	5
tiopronin tab	5
tiopronin tab delayed release	5
tiotropium bromide cap inhaler	4
TOBI PODHALER	5
tofacitinib citrate tab	2
tolvaptan tab therapy pack	2
topiramate oral soln	4
tretinoin cream	3
tretinoin gel	3
tretinoin microsphere gel	3
TRETINOIN MICROSPHERE GEL 0.04%	3

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
TRETINOIN MICROSPHERE GEL 0.1%	3
TRETINOIN MICROSPHERE GEL PUMP 0.04%	3
TRETINOIN MICROSPHERE GEL PUMP 0.1%	3
trientine cap	5
TRIKAFTA THERAPY PACK	5
TRINTELLIX TAB	4
TRULANCE TAB	3
TRULICITY INJ	3/3P
TRUQAP TAB	5
TRUQAP THERAPY PACK	5
TURALIO CAP	5
TYENNE INJ	5
TYVASO INH SOLN 0.6 MG/ML	5
UCERIS RECTAL FOAM	4
UPTRAVI TAB	5
UPTRAVI THERAPY PACK	5
VALCHLOR GEL	5
VANFLYTA TAB	5
VANFLYTA TAB 26.5MG	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
VELTASSA POWDER	3
VELTASSA POWDER 1GM	3
VEOZAH TAB	4
VERZENIO TAB	5
VICTOZA INJ	3/3P
VIJOICE GRANULES PACKET	5
VIJOICE TAB	5
VIJOICE TAB 250MG	5
VITRAKVI CAP 100MG	5
VITRAKVI CAP 25MG	5
VITRAKVI SOLN	5
VONJO CAP	5
VOWST CAP	5
VOXZOGO INJ	5
VYNDAQEL CAP	5
WELIREG TAB	5
XALKORI CAP	5
XOSPATA TAB	5
XPHOZAH TAB	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requirir prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requi

Drug Name	Tier # for Drug Copay (if prior auth is approved)
XROMI SOLN	4
XULTOPHY INJ	3
YESINTEK INJ	5
ZAVZPRET NASAL SPRAY	3
ZEJULA TAB	5
ZELSUVMI GEL	3
ZIOPTAN OPHTH SOLN	4
ZONISADE SUSP	4
ZORYVE CREAM	3
ZORYVE FOAM	3
ZTALMY SUSP	5
ZYDELIG TAB	5
ZYKADIA TAB	5

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

RxCents (Cost Savings Enabled by Tablet Splitting)

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the followir criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

	Product & Strength	Quantity	Member Copay	Annual Savings
Without Tablet Splitting	Drug A 40 mg tab	30	$15.00	
With Tablet Splitting	Drug A 80 mg tab	15	$7.50	$90

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall cost of the medication is reduced. Members may obtain tablet-splitting devices free charge by contacting Customer Service.

RxCents Program Medications

JANUVIA TAB sitagliptin phosphate tab TRINTELLIX TAB

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Last Updated* 9/1/2026

Over-the-Counter (OTC)

• The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT	ACCU-CHEK GUIDE TEST STRIP	AEROCHAMBER
ALCOHOL SWABS	aspirin chew tab 81mg	ASPIRIN EC TAB 325MG	aspirin ec tab 81mg
aspirin tab 325mg	B-D INSULIN SYRINGE	B-D PEN NEEDLE	budesonide nasal spray
CALIBRATION LIQUID	cimetidine tab	CLINISTIX TEST STRIP	CONTRACEPTIVE FILM
CONTRACEPTIVE GEL	CONTRACEPTIVE SUPP	DIFFERIN OTC GEL 0.1%	EMBECTA INSULIN SYRINGE
EMBECTA PEN NEEDLE	esomeprazole cap	FEMALE CONDOMS	FLONASE SENSIMIST NASAL SPRAY
folic acid tab 400mcg	folic acid tab 800mcg	FREESTYLE FREEDOM LITE METER	FREESTYLE INSULINX TEST STRIP
FREESTYLE LITE METER	FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP
FREESTYLE TEST STRIP	guaifenesin/codeine syrup	HUMULIN MIX INJ	HUMULIN MIX PEN INJ
HUMULIN N INJ	HUMULIN N PEN INJ	HUMULIN R INJ	KETO-DIASTIX TEST STRIP
KETOSTIX	ketotifen ophth soln	LANCET DEVICE	LANCET KIT
LANCETS	lansoprazole cap	levonorgestrel tab	MALE CONDOMS
meclizine chew tab	meclizine tab	naloxone hcl nasal spray	NARCAN NASAL SPRAY

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

NASACORT OTC NASAL SPRAY	NEXIUM 24HR TAB	NICODERM PATCH	NICORETTE GUM
NICORETTE LOZENGE	nicotine gum	NICOTINE KIT	nicotine lozenge
nicotine patch	NOVOFINE PEN NEEDLE	NOVOTWIST PEN NEEDLE	NOVOTWIST/NOVOFINE PEN NEEDLE
olopatadine ophth soln	olopatadine ophth soln 0.2%	omeprazole tab	PEAK FLOW METER
PLAN B TAB	PRECISION XTRA METER	PRECISION XTRA TEST STRIP	PREVACID OTC CAP
RIVIVE, REXTOVY SPRAY	TODAY SPONGE	triamcinolone OTC nasal spray	zinc gluconate tab

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Mandatory Specialty Pharmacy (MSP)

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

abiraterone tab 250mg	ACTIMMUNE INJ	ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT	ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT	ADALIMUMAB-FKJP AUTO-INJECTOR KIT	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML	ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML	ADBRY INJ
ALECENSA CAP	ALKINDI SPRINKLE CAP 0.5MG	ALKINDI SPRINKLE CAP 1MG	ALUNBRIG TAB 30MG
ALUNBRIG TAB 90MG, 180MG	ambrisentan tab	ARIKAYCE SUSP	AUGTYRO CAP

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

AUGTYRO CAP 160MG	AUSTEDO XR TAB	AUSTEDO XR TAB TITRATION KIT	AUSTEDO XR TITRATION PACK
AVONEX INJ	AVTOZMA INJ	AYVAKIT TAB	BALVERSA TAB 3MG
BALVERSA TAB 4MG	BALVERSA TAB 5MG	BENLYSTA AUTO-INJECTOR	BENLYSTA INJ
BERINERT INJ	BESREMI INJ	BESREMI PEN INJ	BETASERON INJ
bexarotene cap	bexarotene gel	bosentan tab	bosentan tab for oral susp
BOSULIF CAP	BOSULIF TAB	bosutinib tab	BRAFTOVI CAP 75MG
BYLVAY CAP 1200MCG	BYLVAY CAP 400MCG	BYLVAY SPRINKLE CAP 200MCG	BYLVAY SPRINKLE CAP 600MCG
CALQUENCE TAB	CAMZYOS CAP	capecitabine tab	CAPRELSA TAB
CAPRELSA TAB 300MG	CIMZIA INJ 200MG/ML	CINRYZE INJ	cladribine tab therapy pack
COPIKTRA CAP	COTELLIC TAB	CYSTADANE POWDER	CYSTADROPS SOLN
CYSTARAN OPHTH SOLN	dalfampridine ER tab	dasatinib tab	DAYBUE SOLN
deferiprone tab	dimethyl fumarate DR cap	dimethyl fumarate DR starter pack	DOPTELET SPRINKLE CAP
DOPTELET TAB	ELIGARD INJ, VABRINITY INJ	ELIGARD INJ, VABRINTY INJ	eltrombopag olamine powder pack for susp
eltrombopag olamine tab 12.5mg, 25mg	eltrombopag olamine tab 50mg	eltrombopag olamine tab 75mg	ENBREL INJ 25MG
ENBREL INJ 50MG	ENBREL MINI INJ	ENBREL SURECLICK INJ 50MG	ENBUMYST SOLN 0.5MG/0.1ML
EPIDIOLEX SOLN	ERIVEDGE CAP	ERLEADA TAB	ERLEADA TAB 240MG
erlotinib tab	erlotinib tab 25mg	ETOPOSIDE CAP	everolimus tab
everolimus tab 5mg	everolimus tab for oral susp	FERRIPROX SOLN	FERRIPROX TAB 1000MG
FILSPARI TAB	fingolimod hcl cap 0.5mg	FIRDAPSE TAB	FRUZAQLA CAP 1MG

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

FRUZAQLA CAP 5MG	FULPHILA INJ	FUROSCIX KIT	GAVRETO CAP
gefitinib tab	GENOTROPIN INJ	GENOTROPIN INJ 5MG	GILENYA CAP 0.25MG
GILOTRIF TAB	glatiramer inj	HADLIMA INJ	HADLIMA INJ 40MG/0.8ML
HADLIMA PUSH INJ	HADLIMA PUSH INJ 40MG/0.8ML	HAEGARDA INJ	HEMLIBRA INJ
HIZENTRA INJ	HUMIRA INJ 10MG	HUMIRA INJ 20MG	HUMIRA INJ 40MG
HUMIRA INJ 80MG	HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	HUMIRA INJ PEDIATRIC UC STARTER PACK
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	HUMIRA PEN INJ 40MG	HYCAMTIN CAP	hydroxyprogesterone inj
HYFTOR GEL	icatibant inj	ICLUSIG TAB	IDHIFA TAB
imatinib tab	IMBRUVICA CAP 140MG	IMBRUVICA CAP 70MG	IMBRUVICA TAB 420MG
INCRELEX INJ	INGREZZA CAP	INGREZZA SPRINKLE CAP	INLYTA TAB
INLYTA TAB 1MG	JAYPIRCA TAB	KALYDECO PAK	KALYDECO TAB
KESIMPTA INJ	KHINDIVI SOLN	KISQALI PAK	KISQALI TAB
KOSELUGO CAP 10MG	KOSELUGO SPRINKLE CAP 5MG	KRAZATI TAB	lapatinib ditosylate tab
LEDIPASVIR/SOFOSBUVIR TAB	lenalidomide cap	LENVIMA CAP	LEQEMBI IQLIK INJ 250MG/1.25ML
LEQEMBI IQLK INJ	leuprolide inj	l-glutamine powder packet	LIVMARLI SOLN
LIVTENCITY TAB	LORBRENA TAB 100MG	LORBRENA TAB 25MG	LUMRYZ PACK
LUMRYZ STARTER PACK	LUPKYNIS CAP	LUPRON DEPOT INJ	LUPRON DEPOT PED INJ

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

LUPRON DEPOT-PED INJ	LYNPARZA TAB	LYSODREN TAB	LYTGOBI THERAPY PACK
macitentan tab	MAVENCLAD THERAPY PAK	MEKINIST SOLN	MEKINIST TAB 0.5MG
MEKINIST TAB 2MG	MEKTOVI TAB	mesna tab	MESNEX TAB
mifepristone tab	MYLERAN TAB	NERLYNX TAB	nilotinib hcl cap
nilutamide tab	NINLARO CAP	NIVESTYM INJ	octreotide inj
OCTREOTIDE INJ 100MCG	ODOMZO CAP	OJJAARA TAB	OMNITROPE INJ
ORKAMBI GRANULES PACKET	ORKAMBI TAB	OTEZLA STARTER PACK	OTEZLA TAB
OTEZLA XR TAB	OTEZLA/OTEZLA XR STARTER PACK	PALFORZIA POWDER PACK	PALFORZIA SPRINKLE CAP
pazopanib tab	PEGASYS INJ	PEMAZYRE TAB	PIQRAY TAB
pirfenidone cap	pirfenidone tab 267mg	pirfenidone tab 801mg	PLEGRIDY INJ
PLEGRIDY PEN INJ	PREVYMIS PAK	PREVYMIS TAB	pyrimethamine tab
PYRUKYND TAB	PYRUKYND TAPER PACK	QINLOCK TAB	RADICAVA ORS STARTER KIT
RADICAVA ORS SUSP	REBIF INJ	REZLIDHIA CAP	REZUROCK TAB
RIBAVIRIN CAP	RIBAVIRIN TAB	RINVOQ ER TAB	RINVOQ ORAL SOLN
ROZLYTREK CAP	RUBRACA TAB	RUCONEST INJ	RYDAPT CAP
SAMSCA TAB 15MG	SAPHNELO INJ	SAPHNELO PEN INJ	sapropterin dihydrochloride powder packet
sapropterin dihydrochloride soluble tab	SCEMBLIX TAB	SCEMBLIX TAB 100 MG	SIMLANDI INJ (adalimumab-ryvk)
SIMLANDI KIT (adalimumab-ryvk)	SIRTURO TAB	SKYCLARYS CAP	SKYRIZI INJ 150MG/ML

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SKYRIZI INJ 180 MG/1.2ML	SKYRIZI INJ 360MG/2.4M	SKYRIZI INJ 55MG/0.37M	sodium oxybate oral soln
SODIUM OXYBATE SOLN	SOFOSBUVIR/VELPATASVIR TAB	SOGROYA INJ	sorafenib tosylate tab
STELARA INJ	STEQEYMA INJ	STEQEYMA INJ 90MG	STIVARGA TAB
sunitinib malate cap	SYMDEKO TAB	TABRECTA TAB	TAFINLAR CAP
TAFINLAR TAB	TAKHZYRO INJ 150MG/ML	TALTZ INJ	TALTZ INJ 20MG/0.25ML
TALTZ INJ 40 MG/0.5ML	TAVNEOS CAP	temozolomide cap	teriflunomide tab
tetrabenazine tab	TEZSPIRE INJ	THALOMID CAP	TIBSOVO TAB
tiopronin tab	tiopronin tab delayed release	TOBI PODHALER	tobramycin neb soln
tofacitinib citrate tab	tolvaptan tab	tolvaptan tab therapy pack	tretinoin cap
trientine cap	TRIKAFTA THERAPY PACK	TRUQAP TAB	TRUQAP THERAPY PACK
TURALIO CAP	TYENNE INJ	TYVASO INH SOLN 0.6 MG/ML	UPTRAVI TAB
UPTRAVI THERAPY PACK	VALCHLOR GEL	VANFLYTA TAB	VANFLYTA TAB 26.5MG
VERZENIO TAB	VIJOICE GRANULES PACKET	VIJOICE TAB	VIJOICE TAB 250MG
VITRAKVI CAP 100MG	VITRAKVI CAP 25MG	VITRAKVI SOLN	VIVITROL INJ
VONJO CAP	VOWST CAP	VOXZOGO INJ	VYNDAQEL CAP
WELIREG TAB	XALKORI CAP	XOSPATA TAB	XPHOZAH TAB
YESINTEK INJ	ZARXIO INJ	ZEJULA TAB	ZTALMY SUSP
ZYDELIG TAB	ZYKADIA TAB		

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Last Updated* 9/1/2026

Step Therapy (ST)

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
BECONASE AQ NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone triamcinolone or mometasone
buprenorphine patch	QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR (15-DAY)	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DIFICID SUSP	QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvan solution

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Step Therapy (ST)

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
DIFICID TAB	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvan solution
DISKETS TAB	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
febuxostat tab	Step Therapy requires trial of allopurinol
fentanyl patch	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
fidaxomicin tab	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvan solution
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if member not currently utilizing insulin

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
HYDROCODONE BITARTRATE ER TAB	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
hydromorphone ER tab	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
methadone soln	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
methadone tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
methadose tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary Cont.

Last Updated* 9/1/2026

Step Therapy (ST)

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
MORPHINE SULFATE ER BEAD CAP	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
morphine sulfate ER tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
NEXLETOL TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
NEXLIZET TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
NUCYNTA ER TAB	QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
REPATHA INJ	QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatir lovastatin, pravastatin, rosuvastatin, or simvastatin
risedronate DR tab	Step Therapy requires trial of alendronate
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), or BUDESONIDE/FORMOTEROL
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
tavaborole soln	QL= 10ml/30 days; Step Therapy requires trial of both ciclopirox nail sol and terbinafine tab
tramadol ER tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
TRAMADOL HCL ER TAB	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
XTAMPZA ER CAP	QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Smoking Cessation Agents

Last Updated* 9/1/2026

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	1
CHANTIX STARTER PACK	NC
NICODERM PATCH(Limited to 180 days/plan year)	1
NICORETTE GUM(Limited to 180 days/plan year)	1
NICORETTE LOZENGE(Limited to 180 days/plan year)	1
nicotine gum(Limited to 180 days/plan year)	1
NICOTINE KIT(Limited to 180 days/plan year)	1
nicotine lozenge(Limited to 180 days/plan year)	1
nicotine patch(Limited to 180 days/plan year)	1
NICOTROL INHALER(Limited to 180 days/plan year)	1
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	1
VARENICLINE TAB(Limited to 180 days/plan year)	1
varenicline tartrate tab(Limited to 180 days/plan year)	1
varenicline tartrate tab starter pack(Limited to 180 days/plan year)	1
ZYBAN TAB(Limited to 180 days/plan year)	1

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Infertility Drug List

Last Updated* 9/1/2026

Drug Name	Tier # for Drug Copay
cetrorelix acetate for inj kit	NC
CETROTIDE KIT	NC
clomiphene citrate tab	NC
FOLLISTIM AQ INJ	NC
GONAL-F RFF INJ	NC
GONAL-F RFF INJ, GONAL-F INJ	NC
leuprolide inj	5
MENOPUR INJ	NC
OVIDREL INJ	NC
PREGNYL INJ, NOVAREL INJ	6

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Community Health Choice Select Formulary

Last Updated* 9/1/2026

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ABRYSVO INJ	QL= 1 dose/lifetime
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT	QL= 1 kit/fill; 1 fill/plan year
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	QL= 2 inj/28 days
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	QL= 2 inj/28 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	QL= 2 inj/28 days
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML	QL= 2 inj/28 days; Only available through Lumicera 855-847-3553
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML	QL= 2 inj/28 days; Only available through Lumicera 855-847-3553
ADBRY INJ	QL= 2 inj/28 days
AFLURIA INJ, FLUZONE INJ	QL= 1 inj/28 days
albuterol HFA (18gm) inhaler	QL= 2 inhalers/30 days
albuterol HFA (6.7gm, 8.5gm) inhaler	QL= 2 inhalers/30 days
ALECENSA CAP	QL= 8 caps/day
ALKINDI SPRINKLE CAP 0.5MG	QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prio Authorization required for members age 9 years and older
ALKINDI SPRINKLE CAP 1MG	QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prio Authorization required for members age 9 years and older
almotriptan tab	QL= 9 tabs/fill, 2 fills/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
ambrisentan tab	QL= 1 tab/day; Only available through Lumicera 855-847-3553
ANNOVERA RING	QL= 1 ring/year
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
APRETUDE SUSP	QL= 7 inj/year
ARBLI SUSP	QL= 330mL/30 days; Prior Authorization required for members age 9 years and older
AREXVY INJ	QL= 1 dose/lifetime
ARIKAYCE SUSP	QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-604
armodafinil tab	QL= 1 tab/day
asenapine maleate SL tab	QL= 2 tabs/day
AUGTYRO CAP	QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
AUGTYRO CAP 160MG	QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
AUSTEDO XR TAB	QL= 1 tab/day
AUSTEDO XR TAB TITRATION KIT	QL= 1 pack/28 days
AUSTEDO XR TITRATION PACK	QL= 1 pack/28 days
AVTOZMA INJ	QL= 2 inj/28 days
AYVAKIT TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
BALVERSA TAB 3MG	QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767
BALVERSA TAB 4MG	QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767
BALVERSA TAB 5MG	QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
BAQSIMI NASAL POWDER	QL= 2 inhalations/fill
BAXDELA TAB	QL= 2 tabs/day; Restricted to Infectious Disease Specialist
BECONASE AQ NASAL SPRAY	QL= 2 bottles/fill; Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone or mometasone
BENLYSTA AUTO-INJECTOR	QL= 4 inj/28 day
BENLYSTA INJ	QL= 4 inj/28 day
BESREMI INJ	QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
BESREMI PEN INJ	QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
BIMATOPROST OPHTH SOLN	QL= 2.5ml/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
bosentan tab	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
bosentan tab for oral susp	QL= 4 tabs/day; Only available through Accredo 800-803-2523
BRAFTOVI CAP 75MG	QL= 6 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416
budesonide ER tab	QL=1 tab/day
budesonide nasal spray	QL= 2 bottles/fill
buprenorphine patch	QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
bupropion SR tab	Limited to 180 days/plan year
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYLVAY CAP 1200MCG	QL= 2 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY CAP 400MCG	QL= 6 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 200MCG	QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 600MCG	QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
CALQUENCE TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306, Onco360 877-662-6633, or Walgreens 888-347-3416
CAMZYOS CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
CAPRELSA TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
CAPRELSA TAB 300MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
CIMZIA INJ 200MG/ML	QL= 2 inj/28 days
CINRYZE INJ	QL= 16 vials/28 days; Only available through Accredo 800-803-2523
CLEOCIN VAGINAL SUPP	QL= 3 suppositories/fill
clindamycin vaginal cream	
CLINDESSE VAGINAL CREAM	QL= 1 applicator/fill
COMIRNATY INJ	QL= 1 dose/17 days
COMIRNATY INJ 30MCG/0.3ML	QL= 1 dose/17 days
COPIKTRA CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
COTELLIC TAB	QL= 3 tabs/day
COVID-19 VACCINE INJ 5-11Y (PFIZER)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	QL= 1 dose/24 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	QL= 1 dose/17 days
cyclosporine ophth emulsion	QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist
CYSTADROPS SOLN	QL = 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007
CYSTARAN OPHTH SOLN	QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416
dapagliflozin tab	QL= 1 tab/day
dapagliflozin-metformin er tab	QL= 1 tab/day
dapagliflozin-metformin er tab 5-1000MG	QL= 2 tabs/day
DAYBUE SOLN	QL= 8 bottles/30 days; Only available through AnovoRx 844-288-500
DELESTROGEN INJ	QL= 5ml/fill
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if memb is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if memb is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR (15-DAY)	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
diazepam rectal gel	QL= 4 doses/fill
diclofenac gel	QL= 300gm/30 days
diclofenac gel 1%	QL= 5 tubes/fill
diclofenac soln 1.5%	QL= 3 bottles/fill
DIFICID SUSP	QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
DIFICID TAB	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day
DOPTELET SPRINKLE CAP	QL= 2 caps/day; Only available through Accredo 800-803-2523

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
DOPTELET TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
eletriptan tab	QL= 9 tabs/fill, 2 fills/30 days
eltrombopag olamine powder pack for susp	QL= 1 packet/day
eltrombopag olamine tab 12.5mg, 25mg	QL= 1 tab/day
eltrombopag olamine tab 50mg	QL= 2 tabs/day
eltrombopag olamine tab 75mg	QL= 2 tabs/day
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
ENBUMYST SOLN 0.5MG/0.1ML	QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112
entecavir tab	QL= 1 tab/day
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
ERGOMAR SL TAB	QL= 20 tabs/28 days
ERIVEDGE CAP	QL= 1 cap/day
ERLEADA TAB	QL= 4 tabs/day
ERLEADA TAB 240MG	QL= 1 tab/day
erlotinib tab	QL= 1 tab/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
erlotinib tab 25mg	QL= 3 tab/day
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days (18 tabs on first fill)
estradiol valerate inj	QL= 5ml/fill
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
everolimus tab 5mg	QL= 2 tabs/day
everolimus tab for oral susp	QL= 1 tab/day
FARXIGA TAB	QL= 1 tab/day
FEMALE CONDOMS	QL= 12 condoms/fill
fentanyl citrate lollipop	QL= 120 lozenges/30 days
fidaxomicin tab	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
FILSPARI TAB	QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 Caremark/CVS Specialty 800-378-0695
FLUAD INJ	QL= 1 inj/28 days
FLUBLOK INJ	QL= 1 inj/28 days
FLUCELVAX INJ	QL= 1 inj/28 days
FLULAVAL INJ, FLUARIX INJ	QL= 1 inj/28 days
FLUMIST NASAL	QL= 1 dose/28 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
flunisolide nasal soln	QL= 2 bottles/fill
fluticasone nasal spray	QL= 2 bottles/fill
FLUZONE HIGH DOSE PF INJ	QL= 1 inj/28 days
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if memb is not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if memb is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if memb is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FROVA TAB	QL= 9 tabs/fill, 2 fills/30 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
frovatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
FRUZAQLA CAP 1MG	QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
FRUZAQLA CAP 5MG	QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
FUROSCIX KIT	QL= 8 inj/fill; Only available through Onco360 or CareMed 877-662-6633
gabapentin cap	QL= 9 caps/day
gabapentin soln	QL= 72 mls/day
gabapentin tab 600mg	QL= 6 tabs/day
gabapentin tab 800mg	QL= 4.5 tabs/day
GAVILYTE-C SOLN	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay
GAVRETO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
gefitinib tab	QL= 1 tab/day
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
glucagon (rdna) for inj kit	QL= 2 inj/fill
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON INJ KIT	QL= 2 inj/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
GLYXAMBI TAB	QL= 1 tab/day
GOLYTELY SOLN	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All othe members covered at preferred brand copay
granisetron tab	QL= 14 tabs/fill
guaifenesin/codeine syrup	QL= 240ml/fill
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HADLIMA INJ	QL= 2 inj/28 days
HADLIMA INJ 40MG/0.8ML	QL= 2 inj/28 days
HADLIMA PUSH INJ	QL= 2 inj/28 days
HADLIMA PUSH INJ 40MG/0.8ML	QL= 2 inj/28 days
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ 80MG	QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC UC STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
HYD POL/CPM SUSP	QL= 120ml/fill; 2 fills/30 days
hydrocodone bitartrate er tab	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
hydrocortisone succinate inj 1000mg	QL= 2 vials/fill
hydromorphone ER tab	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
HYFTOR GEL	QL= 10 grams/30 days; Only available through Walgreens 888-347-3416
ibandronate tab 150mg	QL= 1 tab/30 days
icosapent ethyl cap	QL= 4 caps/day
IDHIFA TAB	QL= 1 tab/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
IMBRUVICA CAP 140MG	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA CAP 70MG	QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA TAB 420MG	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
IMITREX INJ	QL= 4 inj/fill, 2 fills/30 days
INGREZZA CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416
INGREZZA SPRINKLE CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523, CVS/Caremark 800-237-2767, Orsini 800-410-8575, PantheRx 855-726-8479, or Walgreens 888-347-3416
INLYTA TAB	QL= 4 tabs/day
INLYTA TAB 1MG	QL= 8 tabs/day
ivermectin cream	QL= 45 grams/30 days
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JAYPIRCA TAB	QL= 2 tabs/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
KALYDECO PAK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
KALYDECO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KERENDIA TAB	QL= 1 tab/day
ketorolac inj 15mg/ml	QL= 20ml/5 days
ketorolac inj 30mg/ml	QL= 20ml/5 days
ketorolac inj 60mg/2ml	QL= 20ml/5 days
ketorolac tab	QL= 20 tabs/5 days
KHINDIVI SOLN	QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older
KISQALI PAK	QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828
KISQALI TAB	QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828
KOSELUGO CAP 10MG	QL= 8 caps/day; Only available through Onco360 877-662-6633
KOSELUGO SPRINKLE CAP 5MG	QL= 20 caps/day; Only available through Onco360 877-662-6633
KRAZATI TAB	QL= 6 tabs/day; Only available through Biologics 800-850-4306
LAGEVRIO CAP (EUA)	QL= 40 caps/fill
LAGEVRIO CAP 200MG	QL= 40 caps/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LASIX ONYU INJ 80MG/2.67ML	QL= 6 cartridges/fill
LASIX ONYU REUSABLE UNIT	QL= 1 device/year
latanoprost ophth soln	QL= 2.5ml/30 days
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/day
lenalidomide cap	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Onl available through Walgreens 888-347-3416
LENVIMA CAP	QL= 3 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416
LEQEMBI IQLIK INJ 250MG/1.25ML	QL= 8 inj/28 days; Only available through Caremed 877-227-3405 or Walgreens 888-347-3416
LEQEMBI IQLK INJ	QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days
l-glutamine powder packet	QL= 6 packets/day
LIDOCAINE OINT	QL= 107gm/30 days
lidocaine patch	QL= 3 patches/day
lidocaine patch 5%	QL= 3 patches/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LINZESS CAP	QL= 1 cap/day
liraglutide soln pen-injector	QL= 9ml/30 days
LIVMARLI SOLN	QL= 90ml/30 days; Only available through Eversana 866-849-4481
LIVTENCITY TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
lofexidine hcl tab	QL= 96 tabs/7 days
LOKELMA PAK	QL= 1 packet/day
LORBRENA TAB 100MG	QL= 1 tab/day
LORBRENA TAB 25MG	QL= 3 tabs/day
lubiprostone cap	QL= 2 caps/day
LUCEMYRA TAB	QL= 96 tabs/7 days
LUMIGAN OPHTH SOLN	QL= 2.5ml/30 days
LUMRYZ PACK	QL= 1 pack/day; Only available through Accredo 800-803-2523
LUMRYZ STARTER PACK	QL= 1 packet/day; Only available through Accredo 800-803-2523
LUPKYNIS CAP	QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479
LYNPARZA TAB	QL= 4 tabs/day; Only available through Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, or Optum 877-445-6874
LYTGOBI THERAPY PACK	QL= 5 tabs/day; Only available through Onco360 877-662-6633
macitentan tab	QL= 1 tab/day; Only available through Accredo 800-803-2523

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
malathion lotion	QL= 2 bottles/fill
MALE CONDOMS	QL= 12 condoms/fill
medroxyprogesterone inj	QL= 1 inj/90 days
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
MEKTOVI TAB	QL= 6 caps/day; Only available through AcariaHealth 800-511-5144, Accredo 800-803-2523, Biologics 800-850-4306, CVS/Caremark 800-237-2767, Onco360 877-662-6633, Optum 877-445-6874, or Walgreens 888-347-3416
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
MFLUSIVA INJ	QL= 1 inj/28; Covered for members age 50 years and older
mifepristone tab	QL= 4 tabs/day
milnacipran hcl tab	QL= 2 tabs/day
MNEXSPIKE INJ 10MCG/0.2ML	QL= 1 dose/24 days
modafinil tab	QL= 2 tabs/day
mometasone nasal spray	QL= 2 bottles/fill
MOTEGRITY TAB	QL= 1 tab/day
MOUNJARO INJ	QL= 4 inj/28 days
MOVANTIK TAB	QL= 1 tab/day
MRESVIA INJ	QL= 1 dose/lifetime

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NASACORT OTC NASAL SPRAY	QL= 2 bottles/fill
NATROBA SUSP	QL= 1 bottle/fill
NATROBA SUSP 0.90%	QL= 1 bottle/fill
NEFFY SPRAY	QL= 2 doses/fill
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
NEXLETOL TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
NEXLIZET TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
NICODERM PATCH	Limited to 180 days/plan year
NICORETTE GUM	Limited to 180 days/plan year
NICORETTE LOZENGE	Limited to 180 days/plan year
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	Limited to 180 days/plan year
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year
NICOTROL INHALER	Limited to 180 days/plan year

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
nitazoxanide tab	QL= 6 tabs/3 days
NOVAVAX INJ	QL= 1 dose/24 days
NUCYNTA ER TAB	QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioi naïve (Opioid ER Dependency)
ODOMZO CAP	QL= 1 cap/day
OJJAARA TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days
OMNIPOD 5 DEX G7G6 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 DEX G7G6 PODS	QL= 10 pods/month
OMNIPOD 5 G7 KIT INTRO	QL= 1 kit/year
OMNIPOD 5 G7 MIS PODS	QL= 10 pods/30 days
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 LIBRE2 PLUS G6 PODS	QL= 10 pods/30 days
OMNIPOD 5 PACK PODS	QL= 10 pods/month
OMNIPOD DASH INTRO KIT	QL= 1 kit/year
OMNIPOD DASH PODS	QL= 10 pods/month
OMNIPOD GO KIT	QL= 10 pods/month

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
OMNIPOD STARTER KIT	QL= 1 kit/year
OPZELURA CREAM	QL= 12 tubes/year
ORILISSA TAB 150MG	QL= 1 tab/day
ORILISSA TAB 200MG	QL= 2 tabs/day
ORKAMBI GRANULES PACKET	QL= 2 packets/day; Only available through Walgreens 888-347-3416
ORKAMBI TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
oseltamivir cap	QL= 10 caps/fill
oseltamivir cap 30mg	QL= 20 caps/fill
oseltamivir susp	QL= 250ml/fill
OTEZLA STARTER PACK	QL= 1 pack/28 days
OTEZLA TAB	QL= 2 tabs/day
OTEZLA XR TAB	QL= 1 tab/day
OTEZLA/OTEZLA XR STARTER PACK	QL= 1 pack/28 days
OZEMPIC INJ	QL= 1 pack/28 days
OZEMPIC TAB, RYBELSUS TAB	QL=1 tab/day
PAXLOVID PAK	QL= 11 tabs/90 days
PAXLOVID TAB 150-100MG	QL= 20 tabs/90 days
PAXLOVID TAB 300-100MG	QL= 30 tabs/90 days
pazopanib tab	QL= 4 tabs/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
peg 3350 soln (100 gram Moviprep equiv)	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All othe members covered at generic copay
peg 3350/electrolytes soln	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All othe members covered at generic copay
PEMAZYRE TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
PHEXXI GEL	QL= 1 box/fill
pirfenidone cap	QL= 9 caps/day
pirfenidone tab 267mg	QL= 9 tabs/day
pirfenidone tab 801mg	QL= 3 tabs/day
pregabalin cap	QL= 3 caps/day
pregabalin cap 225mg	QL= 2 caps/day
pregabalin cap 300mg	QL= 2 caps/day
pregabalin soln	QL= 30ml/day
PRETOMANID TAB	QL= 1 tab/day; Restricted to Infectious Disease Specialist
PREVYMIS PAK	QL= 4 packets/day; Limit 800 packets/365 days
PREVYMIS TAB	QL= 1 tab/day; Limit 200 tabs/365 days
prucalopride succinate tab	QL= 1 tab/day
pyrimethamine tab	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
PYRUKYND TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
PYRUKYND TAPER PACK	QL= 1 tab/day; Only available through Biologics 800-850-4306

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
QINLOCK TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
RADICAVA ORS STARTER KIT	QL= 70ml/365 days; Only available through Accredo 800-803-2523
RADICAVA ORS SUSP	QL= 50mL/28 days; Only available through Accredo 800-803-2523
ramelteon tab	QL= 1 tab/day
REPATHA INJ	QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
REXULTI TAB	QL= 1 tab/day
REZLIDHIA CAP	QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
REZUROCK TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
RINVOQ ER TAB	QL= 1 tab/day
RINVOQ ORAL SOLN	QL= 12ml/day
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
ROZLYTREK CAP	QL= 3 caps/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Optum 877-445-6874
RYDAPT CAP	QL= 56 caps/28 days
sacubitril-valsartan tab	QL= 2 tabs/day
SANCUSO PATCH	QL= 4 patches/fill

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SANTYL OINT	QL= 90gm/30 days
SAPHNELO INJ	QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767
SAPHNELO PEN INJ	QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767
SAVELLA TAB	QL= 2 tabs/day
SCEMBLIX TAB	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
SCEMBLIX TAB 100 MG	QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
SIMLANDI INJ (adalimumab-ryvk)	QL= 2 inj/28 days
SIMLANDI KIT (adalimumab-ryvk)	QL= 2 inj/28 days
SIRTURO TAB	QL= 4 tabs/day; Restricted to Infectious Disease Specialist
sitagliptin phosphate tab	QL= 1 tab/day
sitagliptin phosphate-metformin hcl er tab	QL= 2 tabs/day
sitagliptin phosphate-metformin hcl tab	QL= 2 tabs/day
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKYCLARYS CAP	QL= 3 caps/day; Only available through Biologics 800-850-4306
SKYRIZI INJ 150MG/ML	QL= 1 inj/84 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SKYRIZI INJ 180 MG/1.2ML	QL= 1 inj/56 days
SKYRIZI INJ 360MG/2.4ML	QL= 1 inj/56 days
SKYRIZI INJ 55MG/0.37ML	QL= 1 inj/84 days
sodium oxybate oral soln	QL= 540ml/30 days; Only available through Xyrem Certified Pharmac 1-866-997-3688
SODIUM OXYBATE SOLN	QL= 540ml/30 days; Only available through Xyrem Certified Pharmac 1-866-997-3688
sodium/magnesium/potassium soln	$0 copay for members age 45-75 years; All other members covered a generic copay; Limited to 2 fills/calendar year
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/day
SOLIQUA INJ	QL= 15ml/25 days
SOLU-CORTEF INJ	QL= 1 vial/fill
SOLU-CORTEF INJ 100MG	QL= 2 vials/fill
SPIKEVAX INJ	QL= 1 dose/24 days
SPIKEVAX INJ 50MCG/0.5ML	QL= 1 dose/24 days
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), or BUDESONIDE/FORMOTEROL
STELARA INJ	QL= 1 inj/84 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
STEQEYMA INJ	QL= 1 inj/84 days
STEQEYMA INJ 90MG	QL= 1 inj/84 days
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
SUFLAVE SOLN	QL= 2 fills/365 days
sumatriptan inj	QL= 6 inj/fill, 3 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 3 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 10 vials/fill, 2 fills/30 days
sunitinib malate cap	QL= 1 cap/day
SUNOSI TAB	QL= 1 tab/day
SYMDEKO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
SYMPROIC TAB	QL= 1 tab/day
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TABRECTA TAB	QL= 4 tabs/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab silodosin cap, or tamsulosin cap
TAFINLAR CAP	QL= 4 caps/day
tafluprost preservative free (pf) ophth soln	QL= 1 vial/day
TAKHZYRO INJ 150MG/ML	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TALTZ INJ	QL= 1 inj/28 days
TALTZ INJ 20MG/0.25ML	QL= 1 inj/28 days
TALTZ INJ 40 MG/0.5ML	QL= 1 inj/28 days
tavaborole soln	QL= 10ml/30 days; Step Therapy requires trial of both ciclopirox nail soln and terbinafine tab
TAVNEOS CAP	QL= 6 caps/day; Only available through PantheRx 855-726-8479
TEMPO SMART BUTTON	QL= 1 button/8 months
TESTOSTERONE ENANTHATE INJ 200MG/ML	QL= 5ml/fill
testosterone gel 1% 25mg	QL= 1 packet/day
testosterone gel 1% 50mg	QL= 2 packets/day
testosterone gel 1% pump	QL= 4 bottles/30 days
testosterone gel 1.62% 1.25gm	QL= 1 packet/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
testosterone gel 1.62% 2.5gm	QL= 2 packets/day
TESTOSTERONE GEL 20.25MG/1.25GM	QL= 1 packet/day
TESTOSTERONE GEL PUMP 1%	QL= 4 bottles/30 days
testosterone gel pump 1.62%	QL= 2 bottles/30 days
testosterone soln	QL= 2 bottles/30 days
TEZSPIRE INJ	QL= 1 pen/28 days
TIBSOVO TAB	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
tofacitinib citrate tab	QL= 2 tabs/day
tolvaptan tab therapy pack	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
TRADJENTA TAB	QL= 1 tab/day
travoprost ophth soln	QL= 2.5ml/30 days
triamcinolone OTC nasal spray	QL= 2 bottles/fill
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG	QL= 1 tab/day
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG	QL= 2 tabs/day
TRIKAFTA THERAPY PACK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
TRINTELLIX TAB	QL= 1 tab/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TRULANCE TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 pens/28 days
TRUQAP TAB	QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
TRUQAP THERAPY PACK	QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
TURALIO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
TWIIST REFILL KIT	QL= 1 kit/month
TWIIST STARTER KIT	QL= 1 kit/month
TYENNE INJ	QL= 2 inj/28 days
TYVASO INH SOLN 0.6 MG/ML	QL= 1 ampule/day; Only available through Accredo 800-803-2523
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
UPTRAVI THERAPY PACK	QL= 2 tabs/day; Only available through Accredo 800-803-2523
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 800-803-2523
VALTOCO NASAL SPRAY	QL= 5 doses/fill
vancomycin cap	QL= 56 caps/fill
VANFLYTA TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
VANFLYTA TAB 26.5MG	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
VARENICLINE TAB	Limited to 180 days/plan year
varenicline tartrate tab	Limited to 180 days/plan year
varenicline tartrate tab starter pack	Limited to 180 days/plan year
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VELTASSA POWDER	QL= 1 packet/day
VELTASSA POWDER 1GM	QL= 4 packets/day
VEOZAH TAB	QL= 1 tab/day
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days
VIJOICE GRANULES PACKET	QL= 1 packet/day; Only available through Biologics 800-850-4306
VIJOICE TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
VIJOICE TAB 250MG	QL= 2 tabs/day; Only available through Biologics 800-850-4306
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through Accredo 800-803-2523
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through Accredo 800-803-2523
VITRAKVI SOLN	QL= 10ml/day; Only available through Accredo 800-803-2523
VONJO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
VOWST CAP	QL= 12 caps/fill; Only available through Orsini 800-410-8575
VOXZOGO INJ	QL= 1 vial/day; Only available through Accredo 888-773-7376

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
VYNDAQEL CAP	QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
WELIREG TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
XALKORI CAP	QL= 2 caps/day
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 60 tabs/30 days
XIGDUO XR TAB 2.5-1000	QL= 2 tabs/day
XOFLUZA TAB	QL= 1 tab/fill
XOSPATA TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
XPHOZAH TAB	QL= 2 tabs/day
XTAMPZA ER CAP	QL= 120 caps/30 days; Step Therapy requires step through IR opioid opioid naïve (Opioid ER Dependency)
XULTOPHY INJ	QL= 15ml/30 days
YESINTEK INJ	QL= 1 inj/84 days
zaleplon cap	QL= 1 cap/day
ZAVZPRET NASAL SPRAY	QL= 6 units/fill; 60 units/365 days
ZEJULA TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
ZELSUVMI GEL	QL= 1 carton/fill, 2 fills/365 days

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ZIOPTAN OPHTH SOLN	QL= 1 vial/day
zolmitriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
ZOLMITRIPTAN SPRAY	QL= 6 sprays/fill, 2 fills/30 days
ZOLMITRIPTAN SPRAY, ZOMIG SPRA	QL= 6 sprays/fill, 2 fills/30 days
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem ER tab	QL= 1 tab/day
zolpidem tab	QL= 1 tab/day
ZOMIG SPRAY	QL= 6 sprays/fill, 2 fills/30 days
ZORYVE CREAM	QL= 60 grams/30 days
ZORYVE FOAM	QL= 60 grams/30 days
ZTALMY SUSP	QL= 1100ml/30 days; Only available through Orsini 800-410-8575
ZYBAN TAB	Limited to 180 days/plan year
ZYKADIA TAB	QL= 3 tabs/day

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.