Express Scripts Medicare (PDP)
2019 Formulary (List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS COVERED BY THIS PLAN

Formulary ID Number: 19058, v4

This formulary was updated on 08/24/2018. For more recent information or to price a medication, you can visit us on the Web at **express-scripts.com**. Or you can contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

Note to current members: This formulary has changed since last year. Please review this document to understand your plan's drug coverage.

When this drug list (formulary) refers to "we," "us" or "our," it means *Medco Containment Life Insurance Company* or *Medco Containment Insurance Company of New York (for employer plans domiciled in New York).* When it refers to "plan" or "our plan," it means *Express Scripts Medicare.*

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 24, 2018. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, premium and/or copayments/coinsurance may change on January 1, 2020. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call Express Scripts Medicare Customer Service at the numbers on the back of your member ID card for additional information. Customer Service is available 24 hours a day, 7 days a week.

Esta información está disponible sin cargo en otros idiomas. Llame al Servicio al cliente de Express Scripts Medicare a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio al cliente está disponible las 24 horas del día, los 7 días de la semana.

This document is available in braille. Please contact Customer Service if you need plan information in another format.

What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the "formulary." It contains a list of covered Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare's standard formulary rules. **Your specific plan may provide coverage of additional drugs that are not listed in this formulary, and your plan may have different plan rules and coverage.** For more information on your plan's specific drug coverage, please review your other plan materials, visit us on the Web at **express-scripts.com** or contact Customer Service.

Express Scripts Medicare will cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other plan rules are followed. For more information on how to fill your prescriptions, please review your other plan materials.

Can my drug coverage change?

Generally, if you are taking a drug covered by your plan in 2019, Express Scripts Medicare will not discontinue or reduce coverage of the drug during the 2019 coverage year, except when a new, less expensive generic drug becomes available or new information about the safety or effectiveness of a drug is released or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our plan's formulary, will not affect members who are currently taking the drug. It will remain available at the same copayment or coinsurance amount for those members taking it for the remainder of the coverage year.

- **New generic drugs.** We may immediately remove a brand-name drug on our formulary if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on the steps you may take to request an exception, and you can also find information in the section below entitled "How do I request an exception to the formulary?"
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy

restrictions on a drug or move a drug to a higher cost-sharing tier, if applicable, we must notify affected members of the change at least 30 days before the change becomes effective or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular, Hypertension/Lipids."

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 66. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the "Drug Name" column of the list.

What are generic drugs?

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered. These drugs are noted with "PA" next to them in the formulary.

  Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. These drugs are noted with "QL" next to them in the formulary.

- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs are noted with "ST" next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by looking in the drug list that begins on page 1. Note: This drug list includes all possible restrictions and limits on coverage. **The requirements and limits may not apply to your plan's specific coverage.** To confirm whether a particular drug is covered, visit us on the Web at **express-scripts.com** or contact Customer Service.

You can ask us to make an exception to these restrictions or limits. See the section "How do I request an exception to the formulary?" below for information about how to request an exception.

What if my drug is not on the formulary?

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

If you learn that your drug is not covered, you have two options:

- You can ask our Customer Service department for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.

- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request a formulary exception so that the plan will cover the drug you are taking.

How do I request an exception to the formulary?

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

- You can ask us to cover your drug even if it is not on our formulary. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If your drug is contained in our Non-Preferred Drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand Drug tier instead. If approved, this would lower the amount you must pay for your drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in our Specialty Drug tier.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

Generally, your request for an exception will only be approved if the alternative drugs that are included in the plan formulary, the lower-tiered drugs or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

For more information about the appeals process, you may contact Customer Service using the information provided on the front and back covers of this document.

Can I get a temporary transition supply while I wait for an exception decision?

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

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

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

Other times when we will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

Other coverage that your plan may provide

Your plan **may** also cover categories of "excluded" drugs that are not normally covered by a Medicare prescription drug plan and are not listed in the formulary. **Drugs in the following categories may be covered subject to the rules and limitations of your specific plan:**

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used to promote fertility
- Prescription drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

Please contact Customer Service for additional information about your plan's specific drug coverage and your cost-sharing amount. **Please note:** Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug yearly deductible (if applicable), total drug costs or yearly out-of-pocket expenses.

Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 66.

The "Drug Name" column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CRESTOR®) and generic drugs are listed in lowercase italics (e.g., *atorvastatin*). The information in the "Requirements/Limits" column tells you if there are any special requirements for coverage of that particular drug.

If you are not sure whether your drug is covered, please visit our website or contact Customer Service using the information provided on the front and back covers of this formulary.

Your Costs

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of four drug tiers. Each tier may have a different cost-sharing amount. The "Drug Tiers" chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

Your other plan materials have more information about your plan's coverage stages and list the specific cost-sharing amounts for each tier.

Drug Tiers

Tier	Includes	Helpful tips
Tier 1: **Generic Drugs**	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: **Preferred Brand Drugs**	This tier includes preferred brand-name drugs as well as some generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than non-preferred drugs.
Tier 3: **Non-Preferred Drugs**	This tier includes non-preferred brand-name drugs as well as some generic drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.
Tier 4: **Specialty Tier Drugs**	This tier includes very high cost brand-name and generic drugs.	To learn more about medications in this tier, you may contact a pharmacist using the information provided on the front and back covers of this formulary.

If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost-sharing amounts may be lower than your plan's standard benefit. Members who qualify for Extra Help will receive a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Low Income Rider" or "LIS Rider"). Please read it to find out what your costs are. You can also contact Customer Service with any questions using the information listed on the front and back covers of this formulary.

For more information

For more detailed information about your Medicare prescription drug coverage and your plan's specific costs, please review your other plan materials.

If you need additional information on network pharmacies or if you have any other questions, please contact our Customer Service department using the information provided on the front and back covers of this formulary.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or visit https://www.medicare.gov.

Below is a list of abbreviations that may appear on the following pages in the "Requirements/Limits" column that tells you if there are any special requirements for coverage of your drug.

Note: The following drug list includes all possible restrictions and limitations. **Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list.** To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **express-scripts.com**.

List of abbreviations

LA: Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, contact Customer Service using the information provided on the front and back covers of this formulary.

MO: Mail-Order Drug. This prescription drug is available through our home delivery service, as well as through our retail network pharmacies. Consider using home delivery for your long-term (maintenance) medications, such as high blood pressure medications. Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

PA: Prior Authorization. The plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover this drug.

QL: Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

ST: Step Therapy. In some cases, the plan requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	4	PA; MO
AMBISOME	4	PA; MO
amphotericin b	1	PA; MO
caspofungin	4	PA
clotrimazole mucous membrane	1	MO
CRESEMBA ORAL	4	MO
fluconazole	1	MO
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	1	MO
fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml	1	
flucytosine	4	MO
griseofulvin microsize	1	MO
griseofulvin ultramicrosize	1	MO
itraconazole	1	MO
ketoconazole oral	1	MO
MYCAMINE	4	MO
NOXAFIL ORAL	4	MO
nystatin oral suspension	1	MO
nystatin oral tablet	1	MO

Drug Name	Drug Tier	Requirements /Limits
SPORANOX ORAL SOLUTION	2	MO
terbinafine hcl oral	1	MO
voriconazole intravenous	1	MO
voriconazole oral	4	MO
ANTIVIRALS		
abacavir	1	MO
abacavir-lamivudine	4	MO
abacavir-lamivudine-zidovudine	4	MO
acyclovir oral capsule	1	MO
acyclovir oral suspension 200 mg/5 ml	1	MO
acyclovir oral tablet	1	MO
acyclovir sodium intravenous solution	1	PA; MO
adefovir	4	MO
amantadine hcl	1	MO
APTIVUS ORAL CAPSULE	4	MO
APTIVUS ORAL SOLUTION	4	
atazanavir oral capsule 150 mg, 200 mg	1	MO
atazanavir oral capsule 300 mg	4	MO
ATRIPLA	4	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
BARACLUDE ORAL SOLUTION	4	MO
BIKTARVY	4	MO
COMPLERA	4	MO
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	2	MO
DESCOVY	4	MO
didanosine oral capsule,delayed release(dr/ec) 200 mg, 250 mg, 400 mg	1	MO
EDURANT	4	MO
efavirenz oral capsule 200 mg	4	MO
efavirenz oral capsule 50 mg	1	MO
efavirenz oral tablet	4	MO
EMTRIVA	2	MO
entecavir	4	MO
EPCLUSA	4	PA; MO; QL (28 per 28 days)
EPIVIR HBV ORAL SOLUTION	2	MO
EVOTAZ	4	MO
famciclovir	1	MO
fosamprenavir	4	MO
FUZEON SUBCUTANEOUS RECON SOLN	4	MO
GENVOYA	4	MO
HARVONI	4	PA; MO; QL (28 per 28 days)
INTELENCE ORAL TABLET 100 MG, 200 MG	4	MO
INTELENCE ORAL TABLET 25 MG	2	MO
INVIRASE	4	MO
ISENTRESS HD	4	MO
ISENTRESS ORAL POWDER IN PACKET	4	MO
ISENTRESS ORAL TABLET	4	MO
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	4	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	2	MO
JULUCA	4	MO
KALETRA ORAL TABLET 100-25 MG	2	MO
KALETRA ORAL TABLET 200-50 MG	4	MO
lamivudine	1	MO
lamivudine-zidovudine	1	MO
LEXIVA ORAL SUSPENSION	2	MO
lopinavir-ritonavir	1	MO
moderiba	1	MO

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Drug Name	Drug Tier	Requirements /Limits
moderiba oral tablets,dose pack 200 mg (28)- 400 mg (28), 400-400 mg (28)-mg (28)	1	MO
moderiba dose pack oral tablets,dose pack 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)	4	MO
nevirapine oral tablet	1	MO
nevirapine oral tablet extended release 24 hr	1	MO
NORVIR ORAL CAPSULE	2	
NORVIR ORAL POWDER IN PACKET	2	MO
NORVIR ORAL SOLUTION	2	MO
ODEFSEY	4	MO
oseltamivir	1	MO
PREVYMIS ORAL	4	MO; QL (30 per 30 days)
PREZCOBIX	4	MO
PREZISTA ORAL SUSPENSION	4	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	2	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	4	MO
REBETOL ORAL SOLUTION	2	MO
RELENZA DISKHALER	2	MO
RESCRIPTOR	2	MO
REYATAZ ORAL POWDER IN PACKET	4	MO
ribasphere oral capsule	1	MO
ribasphere oral tablet 200 mg, 400 mg	1	MO
ribasphere oral tablet 600 mg	4	MO
ribasphere ribapak oral tablets,dose pack 200 mg (7)-400 mg (7)	1	
ribasphere ribapak oral tablets,dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)	4	MO
ribavirin oral capsule	1	MO
ribavirin oral tablet 200 mg	1	MO
rimantadine	1	MO
ritonavir	1	MO
SELZENTRY	2	MO
stavudine oral capsule	1	MO

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Drug Name	Drug Tier	Requirements /Limits
STRIBILD	4	MO
SYMFI	4	MO
SYMFI LO	4	MO
tenofovir disoproxil fumarate	4	MO
TIVICAY ORAL TABLET 10 MG	2	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	4	MO
TRIUMEQ	4	MO
TRUVADA	4	MO
valacyclovir oral tablet 1 gram	1	MO; QL (120 per 30 days)
valacyclovir oral tablet 500 mg	1	MO; QL (60 per 30 days)
valganciclovir	4	MO
VEMLIDY	4	MO
VIDEX 4 GRAM PEDIATRIC	2	MO
VIDEX EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 125 MG	3	MO
VIRACEPT ORAL TABLET	4	MO
VIRAMUNE ORAL SUSPENSION	3	MO
VIREAD ORAL POWDER	4	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4	MO
ZERIT ORAL RECON SOLN	3	MO
zidovudine	1	MO
CEPHALOSPORINS		
cefaclor oral capsule	1	MO
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	1	MO
cefaclor oral suspension for reconstitution 375 mg/5 ml	1	
cefaclor oral tablet extended release 12 hr	1	MO
cefadroxil oral capsule	1	MO
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	1	MO
cefadroxil oral tablet	1	MO
cefazolin injection recon soln 1 gram, 500 mg	1	MO
cefazolin injection recon soln 10 gram	1	
cefdinir	1	MO
cefepime	1	MO
cefixime	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
cefotaxime injection recon soln 1 gram, 2 gram, 500 mg	1	
cefotetan injection	1	
cefoxitin intravenous recon soln 1 gram, 2 gram	1	MO
cefoxitin intravenous recon soln 10 gram	1	
cefpodoxime	1	MO
cefprozil	1	MO
ceftazidime injection recon soln 1 gram, 2 gram	1	MO
ceftazidime injection recon soln 6 gram	1	
ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg	1	MO
ceftriaxone injection recon soln 10 gram	1	
cefuroxime axetil oral tablet	1	MO
cefuroxime sodium injection recon soln 750 mg	1	MO
cefuroxime sodium intravenous recon soln 1.5 gram	1	MO
cefuroxime sodium intravenous recon soln 7.5 gram	1	
cephalexin	1	MO
SUPRAX ORAL CAPSULE	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	3	
SUPRAX ORAL TABLET,CHEWABLE	3	MO
TEFLARO	4	MO
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin	1	MO
clarithromycin	1	MO
e.e.s. 400 oral tablet	1	MO
ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg	1	MO
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	2	MO
erythrocin (as stearate) oral tablet 250 mg	1	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	MO
erythromycin ethylsuccinate oral suspension for reconstitution	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
erythromycin ethylsuccinate oral tablet	1	MO
erythromycin oral capsule,delayed release(dr/ec)	1	MO
erythromycin oral tablet	1	MO
MISCELLANEOUS ANTIINFECTIVES		
ALBENZA	4	MO
ALINIA ORAL SUSPENSION FOR RECONSTITUTIO N	2	MO
ALINIA ORAL TABLET	4	MO
amikacin injection solution 500 mg/2 ml	1	MO
atovaquone	4	MO
atovaquone-proguanil	1	MO
aztreonam injection recon soln 1 gram	1	MO
BENZNIDAZOLE	2	
BETHKIS	4	PA; MO; QL (224 per 28 days)
CAYSTON	4	MO; LA; QL (84 per 28 days)
chloroquine phosphate	1	MO
clindamycin hcl	1	MO
clindamycin in 5 % dextrose	1	MO
clindamycin palmitate hcl	1	MO
clindamycin phosphate injection	1	MO
clindamycin phosphate intravenous solution 600 mg/4 ml	1	
COARTEM	2	MO
colistin (colistimethate na)	1	MO
dapsone oral	1	MO
daptomycin intravenous recon soln 500 mg	4	MO
DARAPRIM	4	PA; MO
EMVERM	4	MO
ethambutol	1	MO
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml	1	MO
gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml	1	
gentamicin injection solution 40 mg/ml	1	MO
hydroxychloroquine	1	MO
imipenem-cilastatin	1	MO

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Drug Name	Drug Tier	Requirements /Limits
INVANZ INJECTION	3	MO
isoniazid oral	1	MO
ivermectin	1	MO
linezolid	4	MO
linezolid in dextrose 5%	4	
mefloquine	1	MO
meropenem	1	MO
metronidazole in nacl (iso-os)	1	MO
metronidazole oral	1	MO
NEBUPENT	2	PA; MO; QL (1 per 28 days)
neomycin	1	MO
paromomycin	1	MO
PASER	2	MO
PENTAM	3	MO
polymyxin b sulfate	1	MO
PRIFTIN	2	MO
PRIMAQUINE	2	MO
pyrazinamide	1	MO
quinine sulfate	1	MO
rifabutin	1	MO
rifampin	1	MO
SIRTURO	4	MO; LA
STREPTOMYCIN	2	MO
tigecycline	4	
tinidazole	1	MO

Drug Name	Drug Tier	Requirements /Limits
TOBI PODHALER INHALATION CAPSULE	4	QL (224 per 28 days)
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	4	MO; QL (224 per 28 days)
tobramycin in 0.225 % nacl	4	PA; MO; QL (280 per 28 days)
tobramycin sulfate injection solution	1	MO
TRECATOR	2	MO
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg	1	MO
vancomycin oral capsule 125 mg	1	MO
vancomycin oral capsule 250 mg	4	MO
XIFAXAN ORAL TABLET 200 MG	4	MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	MO; QL (60 per 30 days)
PENICILLINS		
amoxicillin oral capsule	1	MO
amoxicillin oral suspension for reconstitution	1	MO
amoxicillin oral tablet	1	MO

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Drug Name	Drug Tier	Requirements /Limits
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	MO
amoxicillin-pot clavulanate	1	MO
ampicillin oral capsule 500 mg	1	MO
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	1	MO
ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram	1	MO
ampicillin-sulbactam injection recon soln 15 gram	1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	MO
BICILLIN C-R	2	MO
BICILLIN L-A	2	MO
dicloxacillin	1	MO
nafcillin injection recon soln 1 gram	1	MO
nafcillin injection recon soln 10 gram	4	MO
oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml	1	
oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml	1	MO
oxacillin injection recon soln 1 gram	1	
oxacillin injection recon soln 10 gram	4	
oxacillin injection recon soln 2 gram	1	MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML	2	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 3 MILLION UNIT/50 ML	2	MO
penicillin g potassium injection recon soln 20 million unit	1	MO
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	1	MO
penicillin g sodium	1	MO
penicillin v potassium	1	MO

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Drug Name	Drug Tier	Requirements /Limits
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	1	MO
QUINOLONES		
ciprofloxacin	1	
ciprofloxacin (mixture)	1	MO
ciprofloxacin hcl oral	1	MO
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	1	MO
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	1	MO
levofloxacin intravenous	1	MO
levofloxacin oral	1	MO
moxifloxacin oral	1	MO
ofloxacin oral tablet 300 mg	1	
ofloxacin oral tablet 400 mg	1	MO
SULFA'S / RELATED AGENTS		
sulfadiazine	1	MO
sulfamethoxazole-trimethoprim oral	1	MO
TETRACYCLINES		
demeclocycline	1	MO
doxy-100	1	MO
doxycycline hyclate oral capsule	1	MO
doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg	1	MO
doxycycline monohydrate oral capsule	1	MO
doxycycline monohydrate oral suspension for reconstitution	1	MO
doxycycline monohydrate oral tablet	1	MO
minocycline oral capsule	1	MO
minocycline oral tablet	1	MO
morgidox oral capsule 50 mg	1	MO
tetracycline	1	MO
VIBRAMYCIN ORAL SYRUP	2	MO
URINARY TRACT AGENTS		
methenamine hippurate	1	MO
nitrofurantoin	1	MO
nitrofurantoin macrocrystal	1	MO
nitrofurantoin monohyd/m-cryst	1	MO
trimethoprim	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
leucovorin calcium oral	1	MO
MESNEX ORAL	4	MO
XGEVA	4	PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
AFINITOR	4	PA; MO; QL (30 per 30 days)
AFINITOR DISPERZ	4	PA; MO
ALECENSA	4	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	4	PA; MO; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	4	PA; MO; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	4	PA; MO; QL (30 per 30 days)
anastrozole	1	MO
azathioprine	1	PA; MO
bexarotene	4	PA; MO
bicalutamide	1	MO
BOSULIF ORAL TABLET 100 MG	4	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	4	PA; MO; QL (30 per 30 days)
CABOMETYX	4	PA; MO; LA
CALQUENCE	4	PA; MO; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	4	PA; MO; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	4	PA; MO; LA; QL (30 per 30 days)
COMETRIQ	4	PA; MO
COTELLIC	4	PA; MO; LA; QL (63 per 28 days)
cyclophosphamide oral capsule	1	PA; MO
cyclosporine modified	1	PA; MO
cyclosporine oral capsule	1	PA; MO
DROXIA	2	MO
EMCYT	4	MO
ERIVEDGE	4	PA; MO; QL (30 per 30 days)
ERLEADA	4	PA; MO
exemestane	1	MO
FARESTON	4	MO
FARYDAK ORAL CAPSULE 10 MG	4	PA; MO; QL (12 per 21 days)

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Drug Name	Drug Tier	Requirements /Limits
FARYDAK ORAL CAPSULE 15 MG, 20 MG	4	PA; MO; QL (6 per 21 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	4	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	2	PA; MO
flutamide	1	MO
gengraf oral capsule 100 mg, 25 mg	1	PA; MO
gengraf oral solution	1	PA; MO
GILOTRIF	4	PA; MO; QL (30 per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	2	MO
HEXALEN	4	MO
hydroxyurea	1	MO
IBRANCE	4	PA; MO; QL (21 per 28 days)
ICLUSIG ORAL TABLET 15 MG	4	PA; MO; QL (60 per 30 days)
ICLUSIG ORAL TABLET 45 MG	4	PA; MO; QL (30 per 30 days)
IDHIFA	4	PA; MO; LA; QL (30 per 30 days)
imatinib oral tablet 100 mg	4	PA; MO; QL (180 per 30 days)
imatinib oral tablet 400 mg	4	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	4	PA; MO; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	4	PA; MO; QL (30 per 30 days)
IMBRUVICA ORAL TABLET	4	PA; MO; QL (30 per 30 days)
INLYTA ORAL TABLET 1 MG	4	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	4	PA; MO; QL (120 per 30 days)
IRESSA	4	PA; MO; QL (30 per 30 days)
JAKAFI	4	PA; MO; QL (60 per 30 days)
KISQALI	4	PA; MO
KISQALI FEMARA CO-PACK	4	PA; MO
LENVIMA	4	PA; MO
letrozole	1	MO
LEUKERAN	2	MO

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Drug Name	Drug Tier	Requirements /Limits
leuprolide subcutaneous kit	4	MO
LONSURF	4	PA; MO
LUPRON DEPOT	4	PA; MO
LUPRON DEPOT (3 MONTH)	4	PA; MO
LUPRON DEPOT (4 MONTH)	4	PA; MO
LUPRON DEPOT (6 MONTH)	4	PA; MO
LYNPARZA ORAL CAPSULE	4	PA; MO; QL (480 per 30 days)
LYNPARZA ORAL TABLET	4	PA; MO; QL (120 per 30 days)
LYSODREN	2	MO
MATULANE	4	MO
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	1	PA; MO
megestrol oral tablet	1	PA; MO
MEKINIST ORAL TABLET 0.5 MG	4	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	4	PA; MO; QL (30 per 30 days)
mercaptopurine	1	MO
methotrexate sodium	1	PA; MO
methotrexate sodium (pf) injection solution	1	PA; MO
mycophenolate mofetil oral capsule	1	PA; MO
mycophenolate mofetil oral suspension for reconstitution	4	PA; MO
mycophenolate mofetil oral tablet	1	PA; MO
mycophenolate sodium	1	PA; MO
NERLYNX	4	PA; MO; LA
NEXAVAR	4	PA; MO; LA; QL (120 per 30 days)
nilutamide	4	MO
NINLARO ORAL CAPSULE 2.3 MG	4	PA; MO; QL (6 per 28 days)
NINLARO ORAL CAPSULE 3 MG	4	PA; MO; QL (4 per 28 days)
NINLARO ORAL CAPSULE 4 MG	4	PA; MO; QL (3 per 28 days)
octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml	4	MO
octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	1	MO
ODOMZO	4	PA; MO; LA; QL (30 per 30 days)
POMALYST	4	PA; MO; LA
PURIXAN	4	MO

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Drug Name	Drug Tier	Requirements /Limits
RAPAMUNE ORAL SOLUTION	4	PA; MO
REVLIMID	4	PA; MO; LA; QL (28 per 28 days)
RUBRACA	4	PA; MO; LA; QL (120 per 30 days)
RYDAPT	4	PA; MO
SANDIMMUNE ORAL SOLUTION	2	PA; MO
SIGNIFOR	4	MO
sirolimus oral tablet 0.5 mg, 1 mg	1	PA; MO
sirolimus oral tablet 2 mg	4	PA; MO
SOLTAMOX	2	MO
SOMATULINE DEPOT	4	MO
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	4	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG	4	PA; MO; QL (90 per 30 days)
SPRYCEL ORAL TABLET 70 MG	4	PA; MO; QL (60 per 30 days)
STIVARGA	4	PA; MO; QL (84 per 28 days)
SUTENT	4	PA; MO; QL (30 per 30 days)
SYNRIBO	4	PA; MO
TABLOID	2	MO
tacrolimus oral	1	PA; MO
TAFINLAR	4	PA; MO; QL (120 per 30 days)
TAGRISSO	4	PA; MO; LA; QL (30 per 30 days)
tamoxifen	1	MO
TARCEVA ORAL TABLET 100 MG, 150 MG	4	PA; MO; QL (30 per 30 days)
TARCEVA ORAL TABLET 25 MG	4	PA; MO; QL (60 per 30 days)
TARGRETIN TOPICAL	4	PA; MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	4	PA; MO; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
THALOMID	4	PA; MO
TRELSTAR	4	PA; MO
tretinoin (chemotherapy)	4	MO
TYKERB	4	PA; MO; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 10 MG, 50 MG	2	PA; MO; LA

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Drug Name	Drug Tier	Requirements /Limits
VENCLEXTA ORAL TABLET 100 MG	4	PA; MO; LA
VENCLEXTA STARTING PACK	4	PA; MO; LA; QL (42 per 180 days)
VERZENIO	4	PA; MO; LA; QL (60 per 30 days)
VOTRIENT	4	PA; MO; QL (120 per 30 days)
XALKORI	4	PA; MO; QL (60 per 30 days)
XATMEP	4	PA; MO
XERMELO	4	PA; MO; LA; QL (90 per 30 days)
XTANDI	4	PA; MO; QL (120 per 30 days)
YONSA	4	PA; QL (120 per 30 days)
ZEJULA	4	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	4	PA; MO; QL (240 per 30 days)
ZOLINZA	4	MO
ZORTRESS	4	PA; MO
ZYDELIG	4	PA; MO; QL (60 per 30 days)
ZYKADIA	4	PA; MO; QL (150 per 30 days)
ZYTIGA ORAL TABLET 250 MG	4	PA; MO; QL (120 per 30 days)
ZYTIGA ORAL TABLET 500 MG	4	PA; MO; QL (60 per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	3	MO
APTIOM ORAL TABLET 600 MG	4	MO
BANZEL	4	MO
BRIVIACT INTRAVENOUS	3	
BRIVIACT ORAL	4	MO
carbamazepine oral capsule, er multiphase 12 hr	1	MO
carbamazepine oral suspension 100 mg/5 ml	1	MO
carbamazepine oral tablet	1	MO
carbamazepine oral tablet extended release 12 hr	1	MO
carbamazepine oral tablet,chewable	1	MO

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Drug Name	Drug Tier	Requirements /Limits
CELONTIN ORAL CAPSULE 300 MG	2	MO
clonazepam oral tablet 0.5 mg, 1 mg	1	PA; MO; QL (90 per 30 days)
clonazepam oral tablet 2 mg	1	PA; MO; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	PA; MO; QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg	1	PA; MO; QL (300 per 30 days)
DIASTAT	3	MO
DIASTAT ACUDIAL	3	MO
DILANTIN 30 MG	2	MO
divalproex	1	MO
epitol	1	MO
ethosuximide	1	MO
felbamate oral suspension	4	MO
felbamate oral tablet	1	MO
FYCOMPA ORAL SUSPENSION	4	MO
FYCOMPA ORAL TABLET	2	MO
gabapentin oral capsule 100 mg	1	PA; MO; QL (1080 per 30 days)
gabapentin oral capsule 300 mg	1	PA; MO; QL (360 per 30 days)
gabapentin oral capsule 400 mg	1	PA; MO; QL (270 per 30 days)
gabapentin oral solution 250 mg/5 ml	1	PA; MO; QL (2160 per 30 days)
gabapentin oral tablet 600 mg	1	PA; MO; QL (180 per 30 days)
gabapentin oral tablet 800 mg	1	PA; MO; QL (120 per 30 days)
GRALISE 30-DAY STARTER PACK	2	PA; MO; QL (78 per 180 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	PA; MO; QL (30 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	2	PA; MO; QL (90 per 30 days)
lamotrigine oral tablet	1	MO
lamotrigine oral tablet extended release 24hr	1	MO
lamotrigine oral tablet, chewable dispersible	1	MO
lamotrigine oral tablet,disintegrating	1	MO
lamotrigine oral tablets,dose pack	1	MO

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Drug Name	Drug Tier	Requirements /Limits
levetiracetam oral solution 100 mg/ml	1	MO
levetiracetam oral tablet	1	MO
levetiracetam oral tablet extended release 24 hr	1	MO
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	2	PA; MO; QL (90 per 30 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	2	PA; MO; QL (60 per 30 days)
LYRICA ORAL SOLUTION	2	PA; MO; QL (900 per 30 days)
ONFI ORAL SUSPENSION	4	PA; MO; QL (480 per 30 days)
ONFI ORAL TABLET 10 MG, 20 MG	4	PA; MO; QL (60 per 30 days)
oxcarbazepine	1	MO
PEGANONE	2	MO
phenobarbital	1	PA; MO
phenytoin oral suspension 125 mg/5 ml	1	MO
phenytoin oral tablet,chewable	1	MO
phenytoin sodium extended	1	MO
primidone	1	MO

Drug Name	Drug Tier	Requirements /Limits
roweepra	1	MO
roweepra xr	1	
SABRIL ORAL TABLET	4	MO; LA
SPRITAM	3	MO
tiagabine	1	MO
topiramate oral capsule, sprinkle	1	PA; MO
topiramate oral tablet	1	PA; MO
valproic acid	1	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	MO
vigabatrin	4	MO; LA
VIMPAT ORAL SOLUTION	2	MO
VIMPAT ORAL TABLET	2	MO
zonisamide	1	PA; MO
ANTIPARKINSONISM AGENTS		
APOKYN	4	MO; LA
benztropine oral	1	PA; MO
bromocriptine	1	MO
carbidopa	1	MO
carbidopa-levodopa	1	MO
carbidopa-levodopa-entacapone	1	MO
entacapone	1	MO
NEUPRO	2	MO
pramipexole	1	MO

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Drug Name	Drug Tier	Requirements /Limits
rasagiline	1	MO
ropinirole	1	MO
selegiline hcl	1	MO
tolcapone	4	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
dihydroergotamine nasal	1	MO; QL (8 per 28 days)
eletriptan	1	MO; QL (18 per 28 days)
ergotamine-caffeine	1	MO
migergot	1	MO
naratriptan	1	MO; QL (18 per 28 days)
rizatriptan	1	MO; QL (36 per 28 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation	1	MO; QL (18 per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	1	MO; QL (36 per 28 days)
sumatriptan succinate oral	1	MO; QL (18 per 28 days)
sumatriptan succinate subcutaneous cartridge	1	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous pen injector	1	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous solution	1	MO; QL (8 per 28 days)
sumatriptan-naproxen	1	MO; QL (18 per 28 days)
zolmitriptan	1	MO; QL (18 per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AMPYRA	4	PA; MO; LA
AUBAGIO	4	PA; MO
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	4	PA; MO; QL (12 per 28 days)
donepezil	1	MO
galantamine	1	MO
GILENYA ORAL CAPSULE 0.5 MG	4	PA; MO
glatiramer subcutaneous syringe 20 mg/ml	4	PA; MO; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	4	PA; MO; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	4	PA; MO; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml	4	PA; MO; QL (12 per 28 days)
memantine oral capsule,sprinkle,er 24hr	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
memantine oral solution	1	PA; MO
memantine oral tablet	1	PA; MO
NAMZARIC	2	PA; MO
NUEDEXTA	2	PA; MO
rivastigmine	1	MO
rivastigmine tartrate	1	MO
TECFIDERA	4	PA; MO; LA
tetrabenazine oral tablet 12.5 mg	4	PA; MO; QL (240 per 30 days)
tetrabenazine oral tablet 25 mg	4	PA; MO; QL (120 per 30 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen oral tablet 10 mg, 20 mg	1	MO
cyclobenzaprine oral tablet	1	PA; MO
dantrolene	1	MO
MESTINON ORAL SYRUP	4	MO
pyridostigmine bromide	1	MO
tizanidine	1	MO
NARCOTIC ANALGESICS		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	MO; QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	MO; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	MO; QL (180 per 30 days)
buprenorphine hcl sublingual	1	MO
duramorph (pf) injection solution 0.5 mg/ml	1	MO; QL (4000 per 30 days)
duramorph (pf) injection solution 1 mg/ml	1	QL (2000 per 30 days)
endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
fentanyl citrate	4	PA; MO; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr	1	PA; MO; QL (10 per 30 days)
fentanyl transdermal patch 72 hour 87.5 mcg/hour	4	PA; MO; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	1	MO; QL (5550 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	1	MO; QL (390 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	1	MO; QL (50 per 30 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	1	MO; QL (240 per 30 days)
hydromorphone injection syringe 2 mg/ml	1	QL (1200 per 30 days)
hydromorphone oral liquid	1	MO; QL (2400 per 30 days)
hydromorphone oral tablet	1	MO; QL (180 per 30 days)
hydromorphone oral tablet extended release 24 hr 12 mg, 8 mg	1	PA; MO; QL (60 per 30 days)
hydromorphone oral tablet extended release 24 hr 16 mg, 32 mg	4	PA; MO; QL (60 per 30 days)
ibuprofen-oxycodone	1	MO; QL (28 per 30 days)
levorphanol tartrate	1	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
lorcet (hydrocodone)	1	MO; QL (360 per 30 days)
lorcet hd	1	MO; QL (360 per 30 days)
lorcet plus oral tablet 7.5-325 mg	1	MO; QL (360 per 30 days)
methadone oral solution 10 mg/5 ml	1	PA; MO; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	1	PA; MO; QL (1200 per 30 days)
methadone oral tablet 10 mg	1	PA; MO; QL (120 per 30 days)
methadone oral tablet 5 mg	1	PA; MO; QL (240 per 30 days)
morphine concentrate oral solution	1	MO; QL (900 per 30 days)
morphine injection syringe 10 mg/ml	1	MO; QL (200 per 30 days)
morphine injection syringe 2 mg/ml	1	MO; QL (1000 per 30 days)
morphine injection syringe 4 mg/ml	1	MO; QL (500 per 30 days)
morphine injection syringe 5 mg/ml	1	QL (400 per 30 days)
morphine injection syringe 8 mg/ml	1	QL (250 per 30 days)
morphine oral capsule, er multiphase 24 hr	1	PA; MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
morphine oral capsule,extend.release pellets	1	PA; MO; QL (90 per 30 days)
morphine oral solution	1	MO; QL (900 per 30 days)
morphine oral tablet	1	MO; QL (180 per 30 days)
morphine oral tablet extended release 100 mg	1	PA; MO; QL (60 per 30 days)
morphine oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg	1	PA; MO; QL (120 per 30 days)
oxycodone oral capsule	1	MO; QL (360 per 30 days)
oxycodone oral concentrate	1	MO; QL (180 per 30 days)
oxycodone oral solution	1	MO; QL (1200 per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg	1	MO; QL (180 per 30 days)
oxycodone oral tablet 5 mg	1	MO; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
oxycodone-aspirin	1	MO; QL (360 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	2	PA; MO; QL (90 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	4	PA; MO; QL (60 per 30 days)
oxymorphone oral tablet 10 mg	1	MO; QL (360 per 30 days)
oxymorphone oral tablet 5 mg	1	MO; QL (180 per 30 days)
vicodin	1	MO; QL (390 per 30 days)
vicodin es	1	MO; QL (390 per 30 days)
vicodin hp	1	MO; QL (390 per 30 days)
NON-NARCOTIC ANALGESICS		
buprenorphine-naloxone sublingual tablet 2-0.5 mg	1	MO; QL (360 per 30 days)
buprenorphine-naloxone sublingual tablet 8-2 mg	1	MO; QL (90 per 30 days)
butorphanol tartrate nasal	1	MO; QL (10 per 28 days)
celecoxib	1	MO
diclofenac potassium	1	MO
diclofenac sodium oral	1	MO

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Drug Name	Drug Tier	Requirements /Limits
diclofenac sodium topical drops	1	MO; QL (300 per 28 days)
diclofenac sodium topical gel 1 %	1	MO; QL (1000 per 28 days)
diclofenac-misoprostol	1	MO
diflunisal	1	MO
etodolac	1	MO
fenoprofen oral tablet	1	MO
FLECTOR	3	PA; MO; QL (60 per 30 days)
flurbiprofen	1	MO
ibu oral tablet 600 mg, 800 mg	1	MO
ibuprofen oral suspension	1	MO
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	MO
ketoprofen oral capsule 75 mg	1	MO
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	1	MO
meclofenamate	1	MO
mefenamic acid	1	MO
meloxicam oral tablet 15 mg	1	MO
meloxicam oral tablet 7.5 mg	1	MO; QL (30 per 30 days)
nabumetone	1	MO
naloxone	1	MO
naltrexone	1	MO
naproxen	1	MO
naproxen sodium oral tablet 275 mg, 550 mg	1	MO
naproxen sodium oral tablet, er multiphase 24 hr	1	MO
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	2	MO; QL (2 per 28 days)
oxaprozin	1	MO
piroxicam	1	MO
profeno	1	
SUBOXONE SUBLINGUAL FILM 12-3 MG	2	MO; QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	2	MO; QL (360 per 30 days)
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	2	MO; QL (90 per 30 days)
sulindac	1	MO
tolmetin oral capsule	1	MO
tolmetin oral tablet 600 mg	1	MO
tramadol oral tablet	1	MO; QL (240 per 30 days)
tramadol-acetaminophen	1	MO; QL (240 per 30 days)
PSYCHOTHERAPEUTIC DRUGS		

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Drug Name	Drug Tier	Requirements /Limits
ABILIFY MAINTENA	4	MO
amitriptyline	1	PA; MO
amoxapine	1	PA; MO
aripiprazole oral solution	4	MO
aripiprazole oral tablet	1	MO; QL (30 per 30 days)
aripiprazole oral tablet,disintegrating	4	MO; QL (60 per 30 days)
ARISTADA	4	MO
armodafinil	1	PA; MO
atomoxetine	1	MO
bupropion hcl oral tablet	1	MO
bupropion hcl oral tablet extended release 12 hr	1	MO; QL (60 per 30 days)
bupropion hcl oral tablet extended release 24 hr 150 mg	1	MO; QL (90 per 30 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	1	MO; QL (30 per 30 days)
buspirone	1	MO
chlorpromazine oral	1	MO
citalopram oral solution	1	MO
citalopram oral tablet	1	MO; QL (30 per 30 days)
clomipramine	1	PA; MO
clonidine hcl oral tablet extended release 12 hr	1	MO
clorazepate dipotassium oral tablet 15 mg	1	PA; MO; QL (180 per 30 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	1	PA; MO; QL (90 per 30 days)
clozapine oral tablet	1	MO
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	1	
desipramine	1	PA; MO
desvenlafaxine succinate	1	MO; QL (30 per 30 days)
dextroamphetamine-amphetamine	1	MO
diazepam intensol	1	PA; MO; QL (240 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	1	PA; MO; QL (1200 per 30 days)
diazepam oral tablet	1	PA; MO; QL (120 per 30 days)
doxepin oral	1	PA; MO
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	MO; QL (60 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 40 mg	1	MO; QL (90 per 30 days)
EMSAM	4	MO
ergoloid	1	MO

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Drug Name	Drug Tier	Requirements /Limits
escitalopram oxalate oral solution	1	MO
escitalopram oxalate oral tablet	1	MO; QL (30 per 30 days)
eszopiclone	1	ST; MO; QL (30 per 30 days)
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	3	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	4	MO; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	3	MO; QL (8 per 28 days)
FAZACLO ORAL TABLET,DISINTEGRATING 150 MG, 200 MG	3	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	2	MO; QL (28 per 28 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	2	MO; QL (30 per 30 days)
fluoxetine oral capsule 10 mg	1	MO; QL (30 per 30 days)
fluoxetine oral capsule 20 mg	1	MO
fluoxetine oral capsule 40 mg	1	MO; QL (60 per 30 days)
fluoxetine oral capsule,delayed release(dr/ec)	1	MO; QL (4 per 28 days)
fluoxetine oral solution	1	MO
fluoxetine oral tablet 10 mg	1	MO; QL (30 per 30 days)
fluoxetine oral tablet 20 mg, 60 mg	1	MO
fluphenazine decanoate	1	MO
fluphenazine hcl	1	MO
fluvoxamine oral capsule,extended release 24hr	1	MO; QL (60 per 30 days)
fluvoxamine oral tablet 100 mg	1	MO; QL (90 per 30 days)
fluvoxamine oral tablet 25 mg	1	MO; QL (30 per 30 days)
fluvoxamine oral tablet 50 mg	1	MO; QL (60 per 30 days)
FORFIVO XL	3	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	3	MO
guanidine	1	MO
haloperidol	1	MO
haloperidol decanoate	1	MO
haloperidol lactate injection	1	MO
haloperidol lactate intramuscular	1	
haloperidol lactate oral	1	MO

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Drug Name	Drug Tier	Requirements /Limits
HETLIOZ	4	PA; MO; QL (30 per 30 days)
imipramine hcl	1	PA; MO
imipramine pamoate	1	PA; MO
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	4	MO
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	MO
INVEGA TRINZA	4	MO
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	4	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	4	MO; QL (60 per 30 days)
lithium carbonate	1	MO
lithium citrate oral solution 8 meq/5 ml	1	MO
lorazepam oral concentrate	1	PA; MO; QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	PA; MO; QL (90 per 30 days)
lorazepam oral tablet 2 mg	1	PA; MO; QL (150 per 30 days)
loxapine succinate	1	MO
maprotiline	1	MO
MARPLAN	2	MO
metadate er	1	MO
methylphenidate hcl oral capsule,er biphasic 50-50	1	MO
methylphenidate hcl oral solution	1	MO
methylphenidate hcl oral tablet	1	MO
methylphenidate hcl oral tablet extended release	1	MO
methylphenidate hcl oral tablet,chewable	1	MO
mirtazapine	1	MO
modafinil	1	PA; MO
nefazodone	1	MO
nortriptyline	1	PA; MO
NUPLAZID ORAL TABLET 17 MG	4	PA; MO
olanzapine intramuscular	1	MO
olanzapine oral	1	MO; QL (30 per 30 days)
olanzapine-fluoxetine	1	MO
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
paliperidone oral tablet extended release 24hr 6 mg	1	MO; QL (60 per 30 days)
paliperidone oral tablet extended release 24hr 9 mg	4	MO; QL (30 per 30 days)
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	1	MO; QL (30 per 30 days)
paroxetine hcl oral tablet 30 mg	1	MO; QL (60 per 30 days)
paroxetine hcl oral tablet extended release 24 hr	1	MO; QL (60 per 30 days)
paroxetine mesylate(menop.sym)	1	MO; QL (30 per 30 days)
PAXIL ORAL SUSPENSION	3	MO
perphenazine	1	MO
phenelzine	1	MO
pimozide	1	MO
procentra	1	MO
protriptyline	1	MO
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	MO; QL (90 per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	MO; QL (60 per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	MO; QL (30 per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	MO; QL (60 per 30 days)
REXULTI	4	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML	2	MO
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 37.5 MG/2 ML, 50 MG/2 ML	4	MO
risperidone oral solution	1	MO
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet 4 mg	1	MO; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	MO; QL (120 per 30 days)
ROZEREM	2	MO; QL (30 per 30 days)
SAPHRIS (BLACK CHERRY)	2	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
sertraline oral concentrate	1	MO
sertraline oral tablet 100 mg, 50 mg	1	MO; QL (60 per 30 days)
sertraline oral tablet 25 mg	1	MO; QL (30 per 30 days)
thioridazine	1	MO
thiothixene	1	MO
tranylcypromine	1	MO
trazodone	1	MO
trifluoperazine	1	MO
trimipramine	1	PA; MO
TRINTELLIX	2	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	1	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	MO; QL (90 per 30 days)
venlafaxine oral tablet	1	MO; QL (90 per 30 days)
VERSACLOZ	4	
VIIBRYD ORAL TABLET	2	MO; QL (30 per 30 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 180 days)
VRAYLAR ORAL CAPSULE	4	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	3	MO; QL (7 per 30 days)
XYREM	4	PA; MO; LA
zaleplon oral capsule 10 mg	1	ST; MO; QL (60 per 30 days)
zaleplon oral capsule 5 mg	1	ST; MO; QL (30 per 30 days)
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	3	MO
ziprasidone hcl	1	MO; QL (60 per 30 days)
zolpidem oral tablet	1	ST; MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	2	MO
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
amiodarone oral	1	MO
dofetilide	1	MO
flecainide	1	MO
mexiletine	1	MO

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Drug Name	Drug Tier	Requirements /Limits
pacerone oral tablet 100 mg, 200 mg, 400 mg	1	MO
propafenone	1	MO
quinidine gluconate oral	1	MO
quinidine sulfate oral tablet	1	MO
sorine oral tablet 120 mg, 160 mg, 80 mg	1	MO
sorine oral tablet 240 mg	1	
sotalol af oral tablet 120 mg	1	MO
sotalol oral tablet 160 mg, 240 mg, 80 mg	1	MO
SOTYLIZE	2	MO
ANTIHYPERTENSIVE THERAPY		
acebutolol	1	MO
afeditab cr	1	MO
amiloride	1	MO
amiloride-hydrochlorothiazide	1	MO
amlodipine	1	MO
amlodipine-benazepril	1	MO
amlodipine-olmesartan	1	MO
amlodipine-valsartan	1	MO
amlodipine-valsartan-hcthiazid	1	MO
atenolol	1	MO
atenolol-chlorthalidone	1	MO
benazepril	1	MO
benazepril-hydrochlorothiazide	1	MO
betaxolol oral	1	MO
BIDIL	2	MO
bisoprolol fumarate	1	MO
bisoprolol-hydrochlorothiazide	1	MO
bumetanide	1	MO
BYSTOLIC	2	MO
BYVALSON	2	MO
candesartan	1	MO
candesartan-hydrochlorothiazid	1	MO
captopril	1	MO
captopril-hydrochlorothiazide	1	MO
cartia xt	1	MO
carvedilol	1	MO
carvedilol phosphate	1	MO
chlorothiazide	1	MO
chlorthalidone oral tablet 25 mg, 50 mg	1	MO
clonidine	1	MO; QL (4 per 28 days)
clonidine hcl oral tablet	1	MO
DEMSER	4	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
diltiazem hcl oral capsule,extended release 12 hr	1	MO
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	1	MO
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	1	MO
diltiazem hcl oral tablet	1	MO
dilt-xr	1	MO
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	MO; QL (30 per 30 days)
doxazosin oral tablet 8 mg	1	MO; QL (60 per 30 days)
EDARBI	2	MO
EDARBYCLOR	2	MO
enalapril maleate	1	MO
enalapril-hydrochlorothiazide	1	MO
eplerenone	1	MO
eprosartan	1	MO
ethacrynic acid	4	MO
felodipine	1	MO
fosinopril	1	MO
fosinopril-hydrochlorothiazide	1	MO
furosemide injection	1	MO
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	MO
furosemide oral tablet	1	MO
hydralazine oral	1	MO
hydrochlorothiazide	1	MO
indapamide	1	MO
irbesartan	1	MO
irbesartan-hydrochlorothiazide	1	MO
isradipine	1	MO
labetalol oral	1	MO
lisinopril	1	MO
lisinopril-hydrochlorothiazide	1	MO
losartan	1	MO
losartan-hydrochlorothiazide	1	MO
matzim la	1	MO
methyclothiazide	1	MO
methyldopa	1	MO
metolazone	1	MO
metoprolol succinate	1	MO
metoprolol ta-hydrochlorothiaz	1	MO
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	MO
minoxidil oral	1	MO
moexipril	1	MO

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Drug Name	Drug Tier	Requirements /Limits
moexipril-hydrochlorothiazide	1	MO
nadolol	1	MO
nadolol-bendroflumethiazide	1	MO
nicardipine oral	1	MO
nifedipine oral tablet extended release	1	MO
nifedipine oral tablet extended release 24hr	1	MO
nimodipine	1	MO
nisoldipine	1	MO
olmesartan	1	MO
olmesartan-amlodipin-hcthiazid	1	MO
olmesartan-hydrochlorothiazide	1	MO
perindopril erbumine	1	MO
phenoxybenzamine	4	PA; MO
pindolol	1	MO
prazosin	1	MO
propranolol oral	1	MO
propranolol-hydrochlorothiazid	1	MO
quinapril	1	MO
quinapril-hydrochlorothiazide	1	MO
ramipril	1	MO
spironolactone	1	MO
spironolacton-hydrochlorothiaz	1	MO
taztia xt	1	MO
TEKTURNA	2	MO
TEKTURNA HCT	2	MO
telmisartan	1	MO
telmisartan-amlodipine	1	MO
telmisartan-hydrochlorothiazid	1	MO
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	MO; QL (30 per 30 days)
terazosin oral capsule 10 mg	1	MO; QL (60 per 30 days)
timolol maleate oral	1	MO
torsemide oral	1	MO
trandolapril	1	MO
trandolapril-verapamil	1	MO
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	1	MO
triamterene-hydrochlorothiazid oral tablet	1	MO
UPTRAVI	4	PA; MO; LA
valsartan	1	MO
valsartan-hydrochlorothiazide	1	MO
verapamil oral	1	MO
COAGULATION THERAPY		

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Drug Name	Drug Tier	Requirements /Limits
aspirin-dipyridamole	1	MO
BRILINTA	2	MO
cilostazol	1	MO
clopidogrel oral tablet 75 mg	1	MO
dipyridamole oral	1	MO
DOPTELET	4	PA; MO; LA
ELIQUIS	2	MO
enoxaparin subcutaneous syringe	1	MO
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	4	MO
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	1	MO
heparin (porcine) injection solution	1	MO
jantoven	1	MO
pentoxifylline	1	MO
PRADAXA	3	MO
prasugrel	1	MO
PROMACTA	4	PA; MO; LA
warfarin	1	MO
XARELTO	2	MO
ZONTIVITY	2	MO
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine-atorvastatin	1	MO; QL (30 per 30 days)
atorvastatin	1	MO; QL (30 per 30 days)
cholestyramine (with sugar) oral powder in packet	1	MO
cholestyramine light oral powder	1	MO
colesevelam oral tablet	1	MO
colestipol oral packet	1	MO
colestipol oral tablet	1	MO
ezetimibe	1	MO
ezetimibe-simvastatin	1	MO; QL (30 per 30 days)
fenofibrate micronized	1	MO
fenofibrate nanocrystallized	1	MO
fenofibrate oral tablet	1	MO
fenofibric acid	1	MO
fenofibric acid (choline)	1	MO
fluvastatin oral capsule 20 mg	1	MO; QL (30 per 30 days)
fluvastatin oral capsule 40 mg	1	MO; QL (60 per 30 days)
fluvastatin oral tablet extended release 24 hr	1	MO; QL (30 per 30 days)
gemfibrozil	1	MO

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Drug Name	Drug Tier	Requirements /Limits
JUXTAPID	4	PA; MO; LA
LIVALO	2	MO; QL (30 per 30 days)
lovastatin oral tablet 10 mg	1	MO; QL (30 per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	MO; QL (60 per 30 days)
niacin oral tablet extended release 24 hr	1	MO
PRALUENT SUBCUTANEOUS PEN INJECTOR 150 MG/ML	4	PA; MO; QL (2 per 28 days)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 75 MG/ML	4	PA; MO; QL (4 per 28 days)
pravastatin	1	MO; QL (30 per 30 days)
prevalite oral powder in packet	1	MO
REPATHA	4	PA; MO; QL (3 per 28 days)
REPATHA PUSHTRONEX	4	PA; MO; QL (3.5 per 28 days)
REPATHA SURECLICK	4	PA; MO; QL (3 per 28 days)
rosuvastatin	1	MO; QL (30 per 30 days)
simvastatin	1	MO; QL (30 per 30 days)
VASCEPA	2	MO

Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR	2	PA; MO
digitek	1	MO
digox	1	MO
digoxin oral solution 50 mcg/ml	1	MO
digoxin oral tablet	1	MO
ENTRESTO	2	MO; QL (60 per 30 days)
LANOXIN ORAL TABLET 187.5 MCG, 62.5 MCG	2	MO
RANEXA	2	MO
VECAMYL	4	
NITRATES		
isosorbide dinitrate oral tablet	1	MO
isosorbide dinitrate oral tablet extended release	1	
isosorbide mononitrate	1	MO
nitro-bid	1	MO
nitroglycerin sublingual	1	MO
nitroglycerin transdermal patch 24 hour	1	MO
nitroglycerin translingual spray,non-aerosol	1	MO

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Drug Name	Drug Tier	Requirements /Limits
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin oral capsule 10 mg	1	MO
acitretin oral capsule 17.5 mg, 25 mg	4	MO
calcipotriene	1	MO; QL (120 per 30 days)
calcipotriene-betamethasone	1	MO; QL (400 per 30 days)
calcitriol topical	1	MO
COSENTYX	4	PA; MO
COSENTYX (2 SYRINGES)	4	PA; MO
COSENTYX PEN	4	PA; MO
COSENTYX PEN (2 PENS)	4	PA; MO
selenium sulfide topical lotion	1	MO
STELARA SUBCUTANEOUS	4	PA; MO
MISCELLANEOUS DERMATOLOGICALS		
ammonium lactate	1	MO
CARAC	4	MO
CONDYLOX TOPICAL GEL	2	MO
diclofenac sodium topical gel 3 %	4	PA; MO; QL (100 per 28 days)
doxepin topical	4	MO; QL (45 per 30 days)
DUPIXENT	4	PA; MO
FLUOROURACIL TOPICAL CREAM 0.5 %	4	ST; MO
fluorouracil topical cream 5 %	1	MO
fluorouracil topical solution	1	MO
imiquimod	1	MO
lidocaine hcl mucous membrane jelly	1	MO; QL (60 per 30 days)
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	1	MO
lidocaine topical adhesive patch,medicated	1	PA; MO; QL (90 per 30 days)
lidocaine topical ointment	1	MO; QL (36 per 30 days)
lidocaine viscous	1	MO
lidocaine-prilocaine topical cream	1	MO; QL (30 per 30 days)
methoxsalen	4	MO
PANRETIN	4	MO
PICATO	4	MO
podofilox	1	MO
prudoxin	1	MO; QL (45 per 30 days)
REGRANEX	4	MO
SANTYL	2	MO
silver sulfadiazine	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ssd	1	MO
tacrolimus topical	1	PA; MO; QL (100 per 30 days)
TOLAK	3	MO
VALCHLOR	4	MO
ZYCLARA	4	ST; MO
THERAPY FOR ACNE		
amnesteem	1	MO
claravis	1	MO
clindamycin phosphate topical gel	1	MO
clindamycin phosphate topical lotion	1	MO
clindamycin phosphate topical solution	1	MO
dapsone topical	1	MO
erythromycin with ethanol topical solution	1	MO
isotretinoin	1	
metronidazole topical cream	1	MO
metronidazole topical gel	1	MO
metronidazole topical lotion	1	MO
myorisan oral capsule 10 mg, 20 mg, 40 mg	1	MO
myorisan oral capsule 30 mg	1	
tazarotene	1	PA; MO
TAZORAC TOPICAL CREAM 0.05 %	2	PA; MO
TAZORAC TOPICAL GEL	2	PA; MO
tretinoin topical	1	PA; MO
zenatane	1	MO
TOPICAL ANTIBACTERIALS		
gentamicin topical	1	MO
mupirocin	1	MO
mupirocin calcium	1	MO
sulfacetamide sodium (acne)	1	MO
SULFAMYLON TOPICAL CREAM	2	MO
SULFAMYLON TOPICAL PACKET	4	MO
TOPICAL ANTIFUNGALS		
ciclopirox topical cream	1	MO; QL (90 per 28 days)
ciclopirox topical gel	1	MO; QL (45 per 28 days)
ciclopirox topical shampoo	1	MO; QL (120 per 28 days)
ciclopirox topical solution	1	MO
ciclopirox topical suspension	1	MO; QL (60 per 28 days)
clotrimazole topical cream	1	MO; QL (45 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
clotrimazole topical solution	1	MO; QL (30 per 28 days)
clotrimazole-betamethasone topical cream	1	MO; QL (45 per 28 days)
clotrimazole-betamethasone topical lotion	1	MO; QL (60 per 28 days)
econazole	1	MO; QL (85 per 28 days)
KERYDIN	3	MO
ketoconazole topical cream	1	MO; QL (60 per 28 days)
ketoconazole topical foam	1	MO; QL (100 per 28 days)
ketoconazole topical shampoo	1	MO; QL (120 per 28 days)
naftifine	1	MO; QL (60 per 28 days)
NAFTIN TOPICAL GEL	2	MO; QL (60 per 28 days)
nyamyc	1	MO
nystatin topical cream	1	MO; QL (30 per 28 days)
nystatin topical ointment	1	MO; QL (30 per 28 days)
nystatin topical powder	1	MO
nystatin-triamcinolone	1	MO; QL (60 per 28 days)
nystop	1	MO
oxiconazole	1	MO; QL (60 per 28 days)
TOPICAL ANTIVIRALS		
acyclovir topical	1	PA; MO; QL (30 per 30 days)
DENAVIR	2	MO
XERESE	3	MO
ZOVIRAX TOPICAL CREAM	4	PA; MO; QL (5 per 30 days)
TOPICAL CORTICOSTEROIDS		
ala-cort topical cream	1	MO
alclometasone	1	MO
betamethasone dipropionate	1	MO
betamethasone valerate	1	MO
betamethasone, augmented	1	MO
CAPEX	2	MO
clobetasol topical cream	1	MO; QL (120 per 28 days)
clobetasol topical foam	1	MO; QL (100 per 28 days)
clobetasol topical gel	1	MO; QL (120 per 28 days)
clobetasol topical lotion	1	MO; QL (118 per 28 days)
clobetasol topical ointment	1	MO; QL (120 per 28 days)
clobetasol topical shampoo	1	MO; QL (236 per 28 days)
clobetasol topical spray,non-aerosol	1	MO; QL (125 per 28 days)
clobetasol-emollient topical cream	1	MO; QL (120 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
desonide	1	MO
fluocinolone and shower cap	1	MO
fluocinolone topical cream	1	MO
fluocinolone topical ointment	1	MO
fluocinolone topical solution	1	MO
fluocinonide topical cream 0.1 %	1	MO; QL (120 per 30 days)
fluocinonide topical gel	1	MO; QL (120 per 30 days)
fluocinonide topical ointment	1	MO; QL (120 per 30 days)
fluocinonide topical solution	1	MO; QL (120 per 30 days)
fluocinonide-e	1	MO; QL (120 per 30 days)
halobetasol propionate	1	MO
hydrocortisone topical cream 1 %, 2.5 %	1	MO
hydrocortisone topical lotion 2.5 %	1	MO
hydrocortisone topical ointment 1 %, 2.5 %	1	MO
mometasone topical	1	MO
nolix topical cream	1	
prednicarbate	1	MO
triamcinolone acetonide topical aerosol	1	MO
triamcinolone acetonide topical cream	1	MO
triamcinolone acetonide topical lotion	1	MO
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	MO
trianex	1	MO
triderm topical cream 0.1 %	1	MO
TOPICAL SCABICIDES / PEDICULICIDES		
lindane topical shampoo	1	MO
malathion	1	MO
permethrin topical cream	1	MO
SKLICE	2	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
acamprosate	1	MO
alendronate oral tablet 40 mg	1	MO; QL (30 per 30 days)
anagrelide	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	4	MO; LA
CARBAGLU	4	MO; LA
cevimeline	1	MO
CHEMET	2	PA; MO
CLINIMIX 4.25%/D5W SULFIT FREE	2	PA
d10 %-0.45 % sodium chloride	1	
d2.5 %-0.45 % sodium chloride	1	
d5 % and 0.9 % sodium chloride	1	MO
d5 %-0.45 % sodium chloride	1	MO
dextrose 10 % and 0.2 % nacl	1	
dextrose 10 % in water (d10w)	1	MO
dextrose 5 % in water (d5w) intravenous parenteral solution	1	MO
dextrose 5%-0.2 % sod chloride	1	
dextrose 5%-0.3 % sod.chloride	1	
dextrose with sodium chloride	1	
disulfiram	1	MO
etidronate disodium oral tablet 400 mg	1	MO
EXJADE	4	PA; MO; LA
FERRIPROX ORAL SOLUTION	4	PA
FERRIPROX ORAL TABLET	4	PA; MO
INCRELEX	4	MO; LA
kionex (with sorbitol)	1	MO
lanthanum	1	MO
levocarnitine (with sugar)	1	MO
levocarnitine oral tablet	1	MO
midodrine	1	MO
NORTHERA	4	PA; MO
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG	4	LA
ORFADIN ORAL CAPSULE 20 MG	4	MO; LA
ORFADIN ORAL SUSPENSION	4	MO; LA
pilocarpine hcl oral	1	MO
PROLASTIN-C INTRAVENOUS RECON SOLN	4	LA
PROLASTIN-C INTRAVENOUS SOLUTION	4	MO; LA
RAVICTI	4	MO
riluzole	1	MO
risedronate oral tablet 30 mg	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
sevelamer carbonate oral powder in packet	4	MO
sevelamer carbonate oral tablet	1	MO
sodium chloride 0.9 % intravenous parenteral solution	1	MO
sodium chloride irrigation	1	MO
sodium phenylbutyrate	4	MO
sodium polystyrene sulfonate oral powder	1	MO
sps (with sorbitol) oral	1	MO
THIOLA	4	MO
trientine	4	PA; MO
VELTASSA	2	MO
XURIDEN	4	MO
SMOKING DETERRENTS		
bupropion hcl (smoking deter)	1	MO
CHANTIX	2	MO
CHANTIX CONTINUING MONTH BOX	2	MO
CHANTIX STARTING MONTH BOX	2	MO
NICOTROL	3	MO
NICOTROL NS	3	MO

Drug Name	Drug Tier	Requirements /Limits
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal	1	MO; QL (60 per 30 days)
BACTROBAN NASAL	2	
chlorhexidine gluconate mucous membrane	1	MO
ipratropium bromide nasal	1	MO; QL (30 per 30 days)
olopatadine nasal	1	MO; QL (30.5 per 30 days)
periogard	1	MO
triamcinolone acetonide dental	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid otic (ear)	1	MO
ciprofloxacin hcl otic (ear)	1	MO
floxin otic (ear) drops	1	
fluocinolone acetonide oil	1	MO
hydrocortisone-acetic acid	1	MO
ofloxacin otic (ear)	1	MO
OTIC STEROID / ANTIBIOTIC		
CIPRODEX	2	MO

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Drug Name	Drug Tier	Requirements /Limits
neomycin-polymyxin-hc otic (ear)	1	MO
OTOVEL	2	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
cortisone	1	MO
dexamethasone intensol	1	MO
dexamethasone oral elixir	1	MO
dexamethasone oral tablet	1	MO
fludrocortisone	1	MO
hydrocortisone oral	1	MO
methylprednisolone oral tablet	1	PA; MO
methylprednisolone oral tablets,dose pack	1	MO
millipred oral tablet	1	PA; MO
prednisolone oral solution 15 mg/5 ml	1	MO
prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	MO
prednisolone sodium phosphate oral tablet,disintegrating	1	PA; MO
prednisone intensol	1	PA; MO
prednisone oral solution	1	MO
prednisone oral tablet	1	PA; MO
prednisone oral tablets,dose pack	1	MO
veripred 20	1	MO
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	MO
propylthiouracil	1	MO
DIABETES THERAPY		
acarbose oral tablet 100 mg	1	MO; QL (90 per 30 days)
acarbose oral tablet 25 mg	1	MO; QL (360 per 30 days)
acarbose oral tablet 50 mg	1	MO; QL (180 per 30 days)
ALCOHOL PADS	2	MO
APIDRA SOLOSTAR U-100 INSULIN	3	ST; MO
APIDRA U-100 INSULIN	3	ST; MO
BYDUREON	2	PA; MO; QL (4 per 28 days)
BYDUREON BCISE	2	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	2	PA; MO; QL (1.2 per 30 days)
CYCLOSET	3	MO; QL (180 per 30 days)
FARXIGA ORAL TABLET 10 MG	2	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	2	MO; QL (60 per 30 days)
GAUZE PADS 2 X 2	2	MO
glimepiride oral tablet 1 mg	1	MO; QL (240 per 30 days)
glimepiride oral tablet 2 mg	1	MO; QL (120 per 30 days)
glimepiride oral tablet 4 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	MO; QL (120 per 30 days)
glipizide oral tablet 5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	MO; QL (120 per 30 days)
glipizide-metformin oral tablet 2.5-250 mg	1	MO; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	MO; QL (120 per 30 days)
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY KIT (HUMAN)	2	MO
GLYXAMBI	2	MO; QL (30 per 30 days)
HUMALOG JUNIOR KWIKPEN U-100	2	MO
HUMALOG KWIKPEN INSULIN	2	MO
HUMALOG MIX 50-50 INSULN U-100	2	MO
HUMALOG MIX 50-50 KWIKPEN	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO
HUMALOG MIX 75-25(U-100)INSULN	2	MO
HUMALOG U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 KWIKPEN	2	MO
HUMULIN N NPH INSULIN KWIKPEN	2	MO

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Drug Name	Drug Tier	Requirements /Limits
HUMULIN N NPH U-100 INSULIN	2	MO
HUMULIN R REGULAR U-100 INSULN	2	MO
HUMULIN R U-500 (CONC) INSULIN	2	MO
HUMULIN R U-500 (CONC) KWIKPEN	2	MO
INSULIN PEN NEEDLE	2	MO
INSULIN SYRINGE (DISP) U-100 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	2	MO
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	2	MO; QL (120 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	2	MO; QL (120 per 30 days)
INVOKANA ORAL TABLET 100 MG	2	MO; QL (90 per 30 days)
INVOKANA ORAL TABLET 300 MG	2	MO; QL (30 per 30 days)
JANUMET	2	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	2	MO; QL (60 per 30 days)
JANUVIA	2	MO; QL (30 per 30 days)
JARDIANCE	2	MO; QL (30 per 30 days)
JENTADUETO	3	ST; MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	ST; MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	ST; MO; QL (30 per 30 days)
KAZANO	3	ST; MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	2	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	2	MO; QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN	2	MO
LANTUS U-100 INSULIN	2	MO
metformin oral tablet 1,000 mg	1	MO; QL (75 per 30 days)
metformin oral tablet 500 mg	1	MO; QL (150 per 30 days)
metformin oral tablet 850 mg	1	MO; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	MO; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	MO; QL (75 per 30 days)
miglitol oral tablet 100 mg	1	MO; QL (90 per 30 days)
miglitol oral tablet 25 mg	1	MO; QL (360 per 30 days)
miglitol oral tablet 50 mg	1	MO; QL (180 per 30 days)
nateglinide oral tablet 120 mg	1	MO; QL (90 per 30 days)
nateglinide oral tablet 60 mg	1	MO; QL (180 per 30 days)
NEEDLES, INSULIN DISP.,SAFETY	2	MO

Drug Name	Drug Tier	Requirements /Limits
NESINA	3	ST; MO; QL (30 per 30 days)
NOVOFINE 32	2	MO
NOVOFINE AUTOCOVER	2	MO
NOVOLOG FLEXPEN U-100 INSULIN	3	ST; MO
NOVOLOG MIX 70-30 U-100 INSULN	3	ST; MO
NOVOLOG MIX 70-30FLEXPEN U-100	3	ST; MO
NOVOLOG PENFILL U-100 INSULIN	3	ST; MO
NOVOLOG U-100 INSULIN ASPART	3	ST; MO
ONGLYZA	2	MO; QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	2	PA; MO; QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/0.75 ML (2 MG/1.5 ML)	2	PA; MO; QL (3 per 28 days)
pioglitazone	1	MO; QL (30 per 30 days)
pioglitazone-glimepiride	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
pioglitazone-metformin	1	MO; QL (90 per 30 days)
PROGLYCEM	2	MO
repaglinide oral tablet 0.5 mg	1	MO; QL (960 per 30 days)
repaglinide oral tablet 1 mg	1	MO; QL (480 per 30 days)
repaglinide oral tablet 2 mg	1	MO; QL (240 per 30 days)
repaglinide-metformin	1	MO; QL (150 per 30 days)
RIOMET	2	MO; QL (765 per 30 days)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	2	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	2	MO; QL (120 per 30 days)
SOLIQUA 100/33	2	MO
STEGLATRO	2	MO; QL (30 per 30 days)
SYMLINPEN 120	4	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	4	PA; MO; QL (6 per 30 days)
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
SYNJARDY ORAL TABLET 5-500 MG	2	MO; QL (120 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	2	MO; QL (30 per 30 days)
tolazamide oral tablet 250 mg	1	MO; QL (120 per 30 days)
tolazamide oral tablet 500 mg	1	MO; QL (60 per 30 days)
tolbutamide	1	MO; QL (180 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	2	MO
TOUJEO SOLOSTAR U-300 INSULIN	2	MO
TRADJENTA	3	ST; MO; QL (30 per 30 days)
TRULICITY	3	PA; MO; QL (2 per 28 days)
VGO 20	2	MO
VGO 30	2	MO
VGO 40	2	MO
VICTOZA 2-PAK	2	PA; MO; QL (9 per 30 days)
VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG	2	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-500 MG, 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
MISCELLANEOUS HORMONES		
ANDRODERM	2	PA; MO; QL (30 per 30 days)
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	2	PA; MO; QL (150 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM)	2	PA; MO; QL (37.5 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (40.5 MG/2.5 GRAM)	2	PA; MO; QL (150 per 30 days)
cabergoline	1	MO
calcitonin (salmon)	1	MO
calcitriol oral	1	MO
CERDELGA	4	MO
danazol	1	MO
desmopressin nasal spray,non-aerosol	1	MO
desmopressin oral	1	MO
doxercalciferol oral	1	MO
KORLYM	4	PA; MO
KUVAN	4	PA; MO
methyltestosterone oral capsule	4	MO
miglustat	4	MO; LA
MYALEPT	4	PA; MO; LA
NATPARA	4	PA; MO; LA
oxandrolone oral tablet 10 mg	4	PA; MO
oxandrolone oral tablet 2.5 mg	1	PA; MO
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	4	PA; MO; LA; QL (15 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	4	PA; MO; LA; QL (4 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	4	PA; MO; LA; QL (60 per 30 days)
paricalcitol oral	1	MO
SAMSCA	4	PA; MO
SENSIPAR ORAL TABLET 30 MG	2	MO
SENSIPAR ORAL TABLET 60 MG, 90 MG	4	MO

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Drug Name	Drug Tier	Requirements /Limits
SOMAVERT	4	MO
STIMATE	2	MO
SYNAREL	4	MO
testosterone cypionate	1	PA; MO
testosterone enanthate	1	PA; MO
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in packet	1	PA; MO; QL (300 per 30 days)
testosterone transdermal solution in metered pump w/app	1	PA; MO; QL (180 per 30 days)
THYROID HORMONES		
levothyroxine oral	1	MO
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO
liothyronine oral	1	MO
unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO

GASTROENTEROLOGY

Drug Name	Drug Tier	Requirements /Limits
ANTIDIARRHEALS / ANTISPASMODICS		
dicyclomine oral capsule	1	MO
dicyclomine oral solution	1	MO
dicyclomine oral tablet	1	MO
diphenoxylate-atropine	1	MO
glycopyrrolate oral tablet 1 mg, 2 mg	1	MO
loperamide oral capsule	1	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
alosetron	4	MO
AMITIZA	2	MO
aprepitant	1	PA; MO
APRISO	3	MO
ASACOL HD	2	MO
balsalazide	1	MO
budesonide oral	4	MO
CHENODAL	4	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	4	PA; MO
CHOLBAM ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
CIMZIA	4	PA; MO
CIMZIA POWDER FOR RECONST	4	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
CIMZIA STARTER KIT	4	PA; MO
colocort	1	MO
compro	1	MO
constulose	1	MO
CORTIFOAM	2	MO
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 - 60,000 UNIT, 24,000-76,000 - 120,000 UNIT, 3,000-9,500- 15,000 UNIT, 6,000-19,000 -30,000 UNIT	2	MO
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 36,000-114,000-180,000 UNIT	4	MO
cromolyn oral	1	MO
CYSTADANE	4	MO
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	2	MO
DIPENTUM	4	MO
dronabinol oral capsule 10 mg	4	PA; MO
dronabinol oral capsule 2.5 mg, 5 mg	1	PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	2	PA; MO
enulose	1	MO
GATTEX 30-VIAL	4	PA; MO
gavilyte-c	1	MO
gavilyte-g	1	MO
gavilyte-n	1	MO
generlac	1	MO
granisetron hcl oral	1	PA; MO
hydrocortisone rectal	1	MO
hydrocortisone-pramoxine rectal cream 1-1 %	1	MO
lactulose oral solution 10 gram/15 ml	1	MO
LINZESS	2	MO
meclizine oral tablet 12.5 mg, 25 mg	1	MO
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	1	MO
mesalamine rectal	1	MO
metoclopramide hcl oral	1	MO
MOVANTIK	2	MO
MOVIPREP	3	MO
OCALIVA	4	PA; MO; LA; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
ondansetron	1	PA; MO
ondansetron hcl oral solution	1	PA; MO
ondansetron hcl oral tablet 24 mg	1	PA
ondansetron hcl oral tablet 4 mg, 8 mg	1	PA; MO
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	1	MO
peg 3350-electrolytes oral recon soln 240-22.72-6.72 -5.84 gram	1	
peg-electrolyte	1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	2	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	4	MO
polyethylene glycol 3350 oral powder	1	MO
prochlorperazine	1	MO
prochlorperazine maleate oral	1	MO
procto-med hc	1	MO
procto-pak	1	MO
proctosol hc topical	1	MO
proctozone-hc	1	MO

Drug Name	Drug Tier	Requirements /Limits
RECTIV	2	MO
RELISTOR SUBCUTANEOUS SOLUTION	4	MO
RELISTOR SUBCUTANEOUS SYRINGE	4	MO
REMICADE	4	PA; MO
SANCUSO	4	MO
scopolamine base	1	MO
SUCRAID	4	MO
sulfasalazine	1	MO
SUPREP BOWEL PREP KIT	2	MO
SYMPROIC	2	MO
trilyte with flavor packets	1	MO
ursodiol	1	MO
VARUBI ORAL	2	PA; MO
VIBERZI	4	MO
VIOKACE	2	MO

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Drug Name	Drug Tier	Requirements /Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-51,000 - 82,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 25,000-85,000-136,000 UNIT, 3,000-10,000-16,000 UNIT, 5,000-17,000 -27,000 UNIT, 5,000-17,000- 24,000 UNIT	2	MO
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40,000-126,000-168,000 UNIT	4	MO
ULCER THERAPY		
amoxicil-clarithromy-lansopraz	1	MO; QL (112 per 30 days)
cimetidine	1	MO
cimetidine hcl oral	1	MO
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG	3	MO; QL (30 per 30 days)
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 60 MG	3	MO
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg	1	MO; QL (30 per 30 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	1	MO
famotidine oral suspension	1	MO
famotidine oral tablet 20 mg, 40 mg	1	MO
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	1	MO; QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	1	MO
misoprostol	1	MO
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	2	MO; QL (30 per 30 days)
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	2	MO
nizatidine	1	MO

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Drug Name	Drug Tier	Requirements /Limits
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	MO
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	MO
PYLERA	2	MO
ranitidine hcl oral capsule	1	MO
ranitidine hcl oral syrup	1	MO
ranitidine hcl oral tablet 150 mg, 300 mg	1	MO
sucralfate oral tablet	1	MO
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML, 60 MCG/ML	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML	3	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	3	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	4	PA; MO
ARCALYST	4	PA; MO
AVONEX (WITH ALBUMIN)	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	4	PA; MO; QL (4 per 28 days)
BETASERON SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	4	PA; MO
EXTAVIA SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)
EXTAVIA SUBCUTANEOUS RECON SOLN	4	PA; QL (15 per 28 days)
GRANIX	4	PA; MO
INTRON A INJECTION RECON SOLN	4	PA; MO
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML	2	PA; MO
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	4	PA; MO
LEUKINE INJECTION RECON SOLN	4	MO
NEULASTA SUBCUTANEOUS SYRINGE	4	PA; MO
NEUPOGEN	4	PA; MO
NORDITROPIN FLEXPRO	4	PA; MO
OMNITROPE	4	PA; MO
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	4	MO; QL (2 per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION	4	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	4	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	2	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	4	PA; MO
REBIF (WITH ALBUMIN)	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	4	PA; MO; QL (4.2 per 180 days)
REBIF TITRATION PACK	4	PA; MO; QL (4.2 per 180 days)
SYLATRON	4	MO
ZARXIO	4	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT)(PF)	2	MO
BCG VACCINE, LIVE (PF)	2	MO
BEXSERO	2	MO
BOOSTRIX TDAP	2	MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
GARDASIL 9 (PF)	2	MO
GRASTEK	2	PA; MO
HAVRIX (PF) INTRAMUSCULAR SUSPENSION	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	2	
HIBERIX (PF)	2	MO
IMOVAX RABIES VACCINE (PF)	2	MO
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	2	MO
IPOL	2	MO

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Drug Name	Drug Tier	Requirements /Limits
IXIARO (PF)	2	MO
KINRIX (PF) INTRAMUSCULAR SUSPENSION	2	
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	2	MO
MENVEO A-C-Y-W-135-DIP (PF)	2	MO
M-M-R II (PF)	2	MO
PEDIARIX (PF)	2	MO
PEDVAX HIB (PF)	2	MO
PRIVIGEN	4	PA; MO
PROQUAD (PF)	2	MO
QUADRACEL (PF)	2	MO
RABAVERT (PF)	2	MO
RAGWITEK	2	MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	2	PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	2	PA
ROTARIX	2	
ROTATEQ VACCINE	2	MO
SHINGRIX (PF)	2	MO
TENIVAC (PF) INTRAMUSCULAR SYRINGE	2	MO
TETANUS,DIPHTHERIA TOX PED(PF)	2	MO
TETANUS-DIPHTHERIA TOXOIDS-TD	2	MO
TRUMENBA	2	MO
TWINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
TYPHIM VI INTRAMUSCULAR SYRINGE	2	MO
VAQTA (PF)	2	MO
VARIVAX (PF)	2	MO
VARIZIG INTRAMUSCULAR SOLUTION	2	MO
YF-VAX (PF)	2	MO
ZOSTAVAX (PF)	2	MO

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Drug Name	Drug Tier	Requirements /Limits
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol	1	MO
COLCRYS	2	MO
MITIGARE	2	MO
probenecid	1	MO
probenecid-colchicine	1	MO
ULORIC	2	ST; MO
OSTEOPOROSIS THERAPY		
alendronate oral solution	1	MO; QL (1286 per 30 days)
alendronate oral tablet 10 mg, 5 mg	1	MO; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	MO; QL (4 per 28 days)
FORTEO	4	PA; MO; QL (2.4 per 28 days)
FOSAMAX PLUS D	3	ST; MO; QL (4 per 28 days)
ibandronate oral	1	MO; QL (1 per 30 days)
PROLIA	2	PA; MO
raloxifene	1	MO
risedronate oral tablet 150 mg	1	MO; QL (1 per 30 days)
risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)	1	MO; QL (4 per 28 days)
risedronate oral tablet 5 mg	1	MO; QL (30 per 30 days)
risedronate oral tablet,delayed release (dr/ec)	1	MO; QL (4 per 28 days)
TYMLOS	4	PA; MO; QL (1.56 per 30 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA	4	PA; MO
BENLYSTA SUBCUTANEOUS	4	PA; MO
CUPRIMINE	4	MO
DEPEN TITRATABS	4	MO
ENBREL MINI	4	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	4	PA; MO; QL (16 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	4	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	4	PA; MO; QL (8 per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	4	PA; MO; QL (6 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 80 MG/0.8 ML	4	PA; MO; QL (3 per 180 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	4	PA; MO; QL (2 per 180 days)
HUMIRA PEN	4	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	4	PA; MO; QL (6 per 180 days)
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	4	PA; MO; QL (4 per 180 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 10 MG/0.2 ML, 20 MG/0.2 ML, 20 MG/0.4 ML	4	PA; MO; QL (2 per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	4	PA; MO; QL (4 per 28 days)
leflunomide	1	MO; QL (30 per 30 days)
ORENCIA	4	PA; MO
ORENCIA (WITH MALTOSE)	4	PA; MO
ORENCIA CLICKJECT	4	PA; MO
OTEZLA	4	PA; MO
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	4	PA; MO
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	2	MO
RIDAURA	4	MO
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (55 per 30 days)
SIMPONI	4	PA; MO
XELJANZ ORAL TABLET 5 MG	4	PA; MO
XELJANZ XR	4	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
camila	1	MO
CRINONE VAGINAL GEL 4 %	3	MO
CRINONE VAGINAL GEL 8 %	3	PA; MO
deblitane	1	MO
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	2	MO
DEPO-SUBQ PROVERA 104	3	MO
DUAVEE	2	MO
errin	1	MO
estradiol oral	1	PA; MO
estradiol transdermal patch semiweekly	1	PA; MO; QL (8 per 28 days)
estradiol transdermal patch weekly	1	PA; MO; QL (4 per 28 days)
estradiol vaginal	1	MO
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	1	MO
estradiol-norethindrone acet	1	PA; MO
ESTRING	2	MO
jolivette	1	MO
lyza	1	MO
medroxyprogesterone	1	MO
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	2	PA; MO
nora-be	1	MO
norethindrone (contraceptive)	1	MO
norethindrone acetate	1	MO
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	PA; MO
norlyroc	1	
PREMARIN ORAL	2	MO
PREMARIN VAGINAL	2	MO
progesterone micronized	1	MO
sharobel	1	MO
yuvafem	1	MO
MISCELLANEOUS OB/GYN		
CLEOCIN VAGINAL SUPPOSITORY	2	MO
clindamycin phosphate vaginal	1	MO
metronidazole vaginal	1	MO
miconazole-3 vaginal suppository	1	MO
terconazole	1	MO
tranexamic acid oral	1	MO

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Drug Name	Drug Tier	Requirements /Limits
vandazole	1	MO
xulane	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
altavera (28)	1	MO
alyacen 1/35 (28)	1	MO
apri	1	MO
aranelle (28)	1	MO
aubra	1	MO
aviane	1	MO
caziant (28)	1	MO
cryselle (28)	1	MO
cyclafem 1/35 (28)	1	MO
cyclafem 7/7/7 (28)	1	MO
delyla (28)	1	
desog-e.estradiol/e.estradiol	1	MO
desogestrel-ethinyl estradiol	1	
drospirenone-ethinyl estradiol	1	MO
emoquette	1	MO
enpresse	1	MO
enskyce	1	MO
estarylla	1	MO
ethynodiol diac-eth estradiol	1	
falmina (28)	1	MO
femynor	1	MO
gianvi (28)	1	MO

Drug Name	Drug Tier	Requirements /Limits
introvale	1	MO
isibloom	1	MO
juleber	1	MO
kariva (28)	1	MO
kelnor 1/35 (28)	1	MO
kimidess (28)	1	MO
kurvelo	1	MO
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)	1	MO
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	1	
larin 1.5/30 (21)	1	MO
larin 1/20 (21)	1	MO
larin fe 1.5/30 (28)	1	MO
larin fe 1/20 (28)	1	MO
larissia	1	MO
lessina	1	MO
levonest (28)	1	MO
levonorgestrel-ethinyl estrad	1	MO
levonorg-eth estrad triphasic	1	MO
levora-28	1	MO
loryna (28)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
low-ogestrel (28)	1	MO
lutera (28)	1	MO
marlissa	1	MO
microgestin 1.5/30 (21)	1	MO
microgestin 1/20 (21)	1	MO
microgestin fe 1.5/30 (28)	1	MO
microgestin fe 1/20 (28)	1	MO
mili	1	
nikki (28)	1	MO
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	1	MO
norgestimate-ethinyl estradiol	1	MO
nortrel 0.5/35 (28)	1	MO
nortrel 1/35 (21)	1	MO
nortrel 1/35 (28)	1	MO
nortrel 7/7/7 (28)	1	MO
ogestrel (28)	1	MO
orsythia	1	MO
pimtrea (28)	1	MO
pirmella oral tablet 1-35 mg-mcg	1	MO
portia	1	MO
previfem	1	MO
quasense	1	MO
reclipsen (28)	1	MO
setlakin	1	MO
sprintec (28)	1	MO
sronyx	1	MO
tarina fe 1/20 (28)	1	MO
tri-legest fe	1	MO
tri-lo-estarylla	1	MO
tri-lo-sprintec	1	MO
trinessa (28)	1	MO
tri-previfem (28)	1	MO
tri-sprintec (28)	1	MO
trivora (28)	1	MO
velivet triphasic regimen (28)	1	MO
vestura (28)	1	MO
vienva	1	MO
zarah	1	MO
zovia 1/35e (28)	1	MO
OPHTHALMOLOGY		
ANTIBIOTICS		
AZASITE	2	MO
bacitracin ophthalmic (eye)	1	MO
bacitracin-polymyxin b ophthalmic (eye)	1	MO
BESIVANCE	2	MO
ciprofloxacin hcl ophthalmic (eye)	1	MO
erythromycin ophthalmic (eye)	1	MO
gatifloxacin	1	MO

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Drug Name	Drug Tier	Requirements /Limits
gentak ophthalmic (eye) ointment	1	MO
gentamicin ophthalmic (eye) drops	1	MO
levofloxacin ophthalmic (eye)	1	MO
moxifloxacin ophthalmic (eye)	1	MO
NATACYN	2	MO
neomycin-bacitracin-polymyxin	1	MO
neomycin-polymyxin-gramicidin	1	MO
ofloxacin ophthalmic (eye)	1	MO
polymyxin b sulf-trimethoprim	1	MO
tobramycin	1	MO
ANTIVIRALS		
trifluridine	1	MO
ZIRGAN	3	MO
BETA-BLOCKERS		
betaxolol ophthalmic (eye)	1	MO
carteolol	1	MO
levobunolol ophthalmic (eye) drops 0.5 %	1	MO
metipranolol	1	
timolol maleate ophthalmic (eye)	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
atropine ophthalmic (eye) drops	1	MO
azelastine ophthalmic (eye)	1	MO
BEPREVE	3	MO
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
cromolyn ophthalmic (eye)	1	MO
CYSTARAN	4	MO
epinastine	1	MO
LASTACAFT	3	MO
olopatadine ophthalmic (eye)	1	MO
PAZEO	2	MO
PHOSPHOLINE IODIDE	2	MO
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	1	MO
RESTASIS	2	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	2	MO; QL (5.5 per 30 days)
sulfacetamide sodium ophthalmic (eye)	1	MO
sulfacetamide-prednisolone	1	MO
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		

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Drug Name	Drug Tier	Requirements /Limits
BROMSITE	2	MO
diclofenac sodium ophthalmic (eye)	1	MO
flurbiprofen sodium	1	MO
ILEVRO	2	MO
ketorolac ophthalmic (eye)	1	MO
PROLENSA	2	MO
ORAL DRUGS FOR GLAUCOMA		
acetazolamide	1	MO
methazolamide	1	MO
OTHER GLAUCOMA DRUGS		
bimatoprost ophthalmic (eye)	1	MO
COMBIGAN	2	MO
dorzolamide	1	MO
dorzolamide-timolol	1	MO
latanoprost	1	MO
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	2	MO
RHOPRESSA	2	MO
SIMBRINZA	3	MO
TRAVATAN Z	2	MO
ZIOPTAN (PF)	3	ST; MO
STEROID-ANTIBIOTIC COMBINATIONS		
neomycin-bacitracin-poly-hc	1	MO
neomycin-polymyxin b-dexameth	1	MO
neomycin-polymyxin-hc ophthalmic (eye)	1	MO
tobramycin-dexamethasone	1	MO
ZYLET	2	MO
STEROIDS		
ALREX	3	MO
dexamethasone sodium phosphate ophthalmic (eye)	1	MO
fluorometholone	1	MO
LOTEMAX	2	MO
prednisolone acetate	1	MO
prednisolone sodium phosphate ophthalmic (eye)	1	MO
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	2	MO
apraclonidine	1	MO
brimonidine	1	MO
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	3	MO
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		

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Drug Name	Drug Tier	Requirements /Limits
cetirizine oral solution 1 mg/ml	1	MO
EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML, 0.3 MG/0.3 ML (MANUFACTURED BY MYLAN SPECIALTY)	2	MO; QL (4 per 30 days)
EPIPEN	2	MO; QL (4 per 30 days)
EPIPEN 2-PAK	2	MO; QL (4 per 30 days)
EPIPEN JR	2	MO; QL (4 per 30 days)
EPIPEN JR 2-PAK	2	MO; QL (4 per 30 days)
hydroxyzine hcl oral tablet	1	PA; MO
levocetirizine oral solution	1	MO
levocetirizine oral tablet	1	MO; QL (30 per 30 days)
promethazine oral	1	PA; MO
PULMONARY AGENTS		
acetylcysteine	1	PA; MO
ADEMPAS	4	PA; MO; LA
ADVAIR DISKUS	2	MO; QL (60 per 30 days)
ADVAIR HFA	2	MO; QL (12 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	1	PA; MO
albuterol sulfate oral	1	MO
ANORO ELLIPTA	2	MO; QL (60 per 30 days)
ARCAPTA NEOHALER	2	MO; QL (30 per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION	2	MO; QL (30 per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 50 MCG/ACTUATION	2	QL (30 per 30 days)
ASMANEX HFA	2	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	2	MO; QL (1 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (7 DOSES)	2	QL (4 per 28 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (120 DOSES)	2	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (14 DOSES)	2	QL (2 per 28 days)
ATROVENT HFA	2	MO; QL (25.8 per 30 days)
BEVESPI AEROSPHERE	2	MO; QL (10.7 per 30 days)
BREO ELLIPTA	2	MO; QL (60 per 30 days)
budesonide inhalation	1	PA; MO
CINRYZE	4	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
cromolyn inhalation	1	PA; MO
DALIRESP	3	PA; MO
DULERA	2	MO; QL (13 per 30 days)
DYMISTA	2	MO; QL (23 per 30 days)
ESBRIET ORAL CAPSULE	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 267 MG	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 801 MG	4	PA; MO; QL (90 per 30 days)
FASENRA	4	PA; MO
FIRAZYR	4	PA; MO
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)
FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)
FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	1	MO; QL (50 per 30 days)
fluticasone nasal	1	MO; QL (16 per 30 days)
HAEGARDA	4	PA; MO; LA
ipratropium bromide inhalation	1	PA; MO
ipratropium-albuterol	1	PA; MO
KALYDECO ORAL GRANULES IN PACKET	4	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	4	PA; MO; QL (60 per 30 days)
LETAIRIS	4	PA; MO; LA
levalbuterol hcl	1	PA; MO
metaproterenol	1	MO
mometasone nasal	1	MO; QL (34 per 30 days)
montelukast	1	MO
OFEV	4	PA; MO; QL (60 per 30 days)
OPSUMIT	4	PA; MO; LA
ORKAMBI ORAL TABLET	4	PA; MO; QL (112 per 28 days)
PERFOROMIST	2	PA; MO
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	2	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	2	MO; QL (1 per 30 days)
PULMOZYME	4	PA; MO
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	2	MO; QL (4.9 per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	2	MO; QL (8.7 per 30 days)
QVAR	2	MO; QL (17.4 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	2	MO; QL (21.2 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
SEREVENT DISKUS	2	MO; QL (60 per 30 days)
sildenafil (pulmonary arterial hypertension) oral tablet 20 mg	1	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT	2	MO; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	2	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)
SYMBICORT	2	MO; QL (10.2 per 30 days)
SYMDEKO	4	PA; MO; QL (56 per 28 days)
terbutaline oral	1	MO
THEO-24	2	MO
theophylline oral solution	1	MO
theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg	1	MO
theophylline oral tablet extended release 24 hr	1	MO
TRACLEER ORAL TABLET	4	PA; MO; LA
triamcinolone acetonide nasal	1	MO; QL (16.5 per 30 days)
TUDORZA PRESSAIR	2	MO; QL (1 per 30 days)
VENTOLIN HFA	2	MO; QL (36 per 30 days)
XOLAIR	4	PA; MO; LA; QL (6 per 28 days)
zafirlukast	1	MO
ZYFLO	4	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
flavoxate	1	MO
MYRBETRIQ	2	MO
oxybutynin chloride	1	MO
tolterodine	1	MO
TOVIAZ	2	MO
trospium	1	MO
VESICARE	2	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin	1	MO
dutasteride	1	MO
dutasteride-tamsulosin	1	MO
finasteride oral tablet 5 mg	1	MO
RAPAFLO	2	ST; MO
tamsulosin	1	MO
MISCELLANEOUS UROLOGICALS		
bethanechol chloride	1	MO

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Drug Name	Drug Tier	Requirements /Limits
CYSTAGON	2	MO; LA
ELMIRON	2	MO
potassium citrate	1	MO
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
calcium acetate oral capsule	1	MO
calcium acetate oral tablet 667 mg	1	MO
klor-con	1	MO
klor-con 10	1	MO
klor-con 8	1	MO
klor-con m10	1	MO
klor-con m15	1	MO
klor-con m20	1	MO
klor-con sprinkle	1	MO
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ	3	MO
k-tab oral tablet extended release 8 meq	1	MO
magnesium sulfate injection solution	1	MO
magnesium sulfate injection syringe	1	
NORMOSOL-R IN 5 % DEXTROSE	2	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 30 meq/l, 40 meq/l	1	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 20 meq/l	1	MO
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	1	MO
potassium chloride in water intravenous piggyback 10 meq/100 ml	1	MO
potassium chloride in water intravenous piggyback 20 meq/100 ml, 40 meq/100 ml	1	
potassium chloride intravenous solution	1	MO
potassium chloride oral capsule, extended release	1	MO

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Drug Name	Drug Tier	Requirements /Limits
potassium chloride oral liquid	1	MO
potassium chloride oral tablet extended release	1	MO
potassium chloride oral tablet,er particles/crystals	1	MO
potassium chloride-0.45 % nacl	1	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	1	MO
potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l	1	
potassium chloride-d5-0.9%nacl intravenous parenteral solution 20 meq/l	1	MO
potassium chloride-d5-0.9%nacl intravenous parenteral solution 40 meq/l	1	
sodium chloride 0.45 % intravenous parenteral solution	1	MO
sodium chloride 3 %	1	MO
sodium chloride 5 %	1	
sodium chloride intravenous parenteral solution 2.5 meq/ml	1	MO
sodium lactate intravenous	1	
MISCELLANEOUS NUTRITION PRODUCTS		
AMINOSYN 7 % WITH ELECTROLYTES	2	PA
AMINOSYN 8.5 %-ELECTROLYTES	2	PA
AMINOSYN II 10 %	2	PA
AMINOSYN II 15 %	2	PA
AMINOSYN II 8.5 %	2	PA
AMINOSYN II 8.5 %-ELECTROLYTES	2	PA
AMINOSYN-HBC 7%	2	PA
AMINOSYN-PF 10 %	2	PA
AMINOSYN-PF 7 % (SULFITE-FREE)	2	PA
AMINOSYN-RF 5.2 %	2	PA
CLINIMIX 5%/D15W SULFITE FREE	2	PA

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Drug Name	Drug Tier	Requirements /Limits
CLINIMIX 5%/D25W SULFITE-FREE	2	PA
CLINIMIX 2.75%/D5W SULFIT FREE	2	PA
CLINIMIX 4.25%/D10W SULF FREE	2	PA
CLINIMIX 4.25%-D20W SULF-FREE	2	PA
CLINIMIX 4.25%-D25W SULF-FREE	2	PA
CLINIMIX 5%-D20W(SULFITE-FREE)	2	PA
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intralipid intravenous emulsion 20 %	1	PA
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ISOLYTE-P IN 5 % DEXTROSE	2	
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plenamine	1	PA
premasol 10 %	1	PA; MO
PREMASOL 6 %	2	PA
travasol 10 %	1	PA; MO
TROPHAMINE 10 %	2	PA; MO
TROPHAMINE 6%	2	PA
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fluoride (sodium) oral tablet	1	MO
prenatal vitamin oral tablet	1	MO

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