

Health Options Program

Abridged Prescription Drug Formulary for the Enhanced and Basic Medicare Rx Options *(Partial List of Covered Drugs)*

2021

PLEASE READ: THIS DOCUMENT CONTAINS
INFORMATION ABOUT SOME OF THE DRUGS
WE COVER IN THESE PLANS.

This Abridged Prescription Drug Formulary for the Enhanced and Basic Medicare Rx Options (PDP) was updated on August 7, 2020. This is not a complete list of drugs covered by our plans. For a complete listing or other questions, please call the HOP Administration Unit at 1-800-773-7725, or for TTY users, 1-800-498-5428, 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, or visit www.HOPbenefits.com.

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means the Health Options Program, which is sponsored by the Pennsylvania Public School Employees' Retirement System. When it refers to “plan” or “our plan,” it means the Enhanced or Basic Medicare Rx Option.

This document includes a partial list of the drugs (formulary) for our plans, which is current as of August 7, 2020. For a complete, updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit.

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2022, and from time to time during the year.

What is the Enhanced and Basic Medicare Rx Options Abridged Formulary?

A formulary is a list of covered drugs selected by the Enhanced and Basic Medicare Rx Options 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 Enhanced and Basic Medicare Rx Options will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an OptumRx network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

This document is a partial formulary and includes only some of the drugs covered by the Enhanced and Basic Medicare Rx Options. For a complete listing of all prescription drugs covered by the Enhanced and Basic Medicare Rx Options, please visit our website at www.HOPbenefits.com or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Please note that this formulary covers the Enhanced and Basic Medicare Rx Options only. If you have coverage through the Value Medicare Rx Option or a Medicare Advantage plan through the Health Options Program, you will have to contact the HOP Administration Unit or the Medicare Advantage plan directly for a copy of the formulary for your prescription drug plan.

Can the formulary (drug list) change?

Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except when a new, less expensive 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 formulary, will not affect members who are currently taking the drug. It will remain available at the same cost sharing for those members taking it for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs. We must follow Medicare rules in making these changes. Below are changes to the drug list that will also affect members currently taking a drug:

- **New generic drugs.** We may immediately remove a brand-name drug on our drug list if we are replacing it with a new generic drug that will appear on the same or 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 drug list, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Enhanced and Basic Medicare Rx Options Formulary?"

- **Drugs removed from the market .** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier, or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section entitled "How do I request an exception to the Enhanced and Basic Medicare Rx Options Formulary?"

The enclosed formulary is current as of August 7, 2020. To get updated information about the drugs covered by the Enhanced and Basic Medicare Rx Options, please contact us. Our contact information appears on the front and back cover pages. In the event of midyear formulary changes, a revised Comprehensive Formulary for the Enhanced and Basic Medicare Rx Options will be posted to www.HOPbenefits.com.

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 Agents.” If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

- **Alphabetical listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 38. The Index provides an alphabetical list of all the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index, and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index, and find the name of your drug in the first column of the list.

What are generic drugs?

The Enhanced and Basic Medicare Rx Options cover both brand-name drugs and generic drugs. A generic drug is approved by the Food and Drug Administration (FDA) as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization (PA):** The Enhanced and Basic Medicare Rx Options require you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from the Enhanced and Basic Medicare Rx Options before you fill your prescriptions. If you don't get approval, the Enhanced and Basic Medicare Rx Options may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, the Enhanced and Basic Medicare Rx Options limit the amount of the drug that will be covered. For example, the Enhanced and Basic Medicare Rx Options cover 30 pills per 30 days for Crestor. If your prescription is for more, OptumRx will contact your doctor to determine whether more than one per day will be covered. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy (ST):** In some cases, the Enhanced and Basic Medicare Rx Options require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Enhanced and Basic Medicare Rx Options may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask the Enhanced or Basic Medicare Rx Option to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section “How do I request an exception to the Enhanced and Basic Medicare Rx Options Formulary?” on page iv, for information about how to request an exception.

What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact OptumRx and ask if your drug is covered. This document includes only a partial list of covered drugs, so the Enhanced and Basic Medicare Rx Options may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that the Enhanced and Basic Medicare Rx Options do not cover your drug, you have two options:

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

How do I request an exception to the Enhanced and Basic Medicare Rx Options Formulary?

You can ask the Enhanced and Basic Medicare Rx Options 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, this drug will be covered at a predetermined 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 this drug is not on the specialty tier). If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, the Enhanced and Basic Medicare Rx Options limit the amount of drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

You should contact us to ask for an initial coverage decision for a formulary, tiering, or utilization restriction exception. **When you request a formulary, tiering, or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.**

Generally, we must make our decision within 72 hours of getting your prescriber’s supporting statement. You can request an expedited (fast) exception if you or your doctor 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.

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

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a

formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

Emergency transitions and level-of-care changes

You may have a change in your treatment setting due to the level of care you require. Such transitions may include if you are:

- Admitted to a long-term care facility following an inpatient hospital stay.
- Discharged from a hospital or skilled nursing facility to a home setting.
- Admitted to a hospital or skilled nursing facility from a home setting.
- Transferred from one skilled nursing facility to another and the new facility is serviced by a different pharmacy.
- Discharged from a skilled nursing facility Medicare Part A stay, where payments include all pharmacy charges, and you now need to use your Part D plan benefit.
- Reverted back to standard Medicare Parts A and B coverage after giving up hospice status.

This transition policy applies to drugs that are covered under the Enhanced or Basic Medicare Rx Option and filled at a network pharmacy.

For more information

For more detailed information about the Enhanced and Basic Medicare Rx Options prescription drug coverage, please review your *Evidence of Coverage for the Enhanced and Basic Medicare Rx Options* and other plan materials. If you have questions about the Enhanced and Basic Medicare Rx Options, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or visit www.medicare.gov.

Enhanced and Basic Medicare Rx Options Abridged Prescription Drug Formulary

The abridged formulary that begins on page 1 provides coverage information about some of the drugs covered by the Enhanced and Basic Medicare Rx Options.

If you have trouble finding your drug in the list, turn to the Index that begins on page 38.

Remember: This is only a partial listing of drugs covered by the Enhanced and Basic Medicare Rx Options. If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIDODERM), and generic drugs are listed in lowercase italics (e.g., *meloxicam*).

The information in the Requirements/Limits column tells you if the Enhanced and Basic Medicare Rx Options have any special requirements for coverage of your drug.

WHAT THE ABBREVIATIONS MEAN

B/D: This prescription drug has a **Part B versus Part D administrative prior authorization requirement**. This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

NDS: Non-Extended Day Supply. This prescription drug is not available for an extended day's supply under the Enhanced or Basic Medicare Rx Option.

PA: Prior Authorization. You or your physician need to get approval from the Enhanced or Basic Medicare Rx Option before you fill this prescription. If you don't get approval, the Enhanced or Basic Medicare Rx Option may not cover the drug. See page iii for more information.

QL: Quantity Limit. The Enhanced and Basic Medicare Rx Options limit the amount of this drug that will be covered. See page iii for more information.

ST: Step Therapy. The Enhanced and Basic Medicare Rx Options require you to first try another drug to treat your medical condition before we will cover this one for that condition. See page iii for more information.

The Enhanced Medicare Rx Option

DEDUCTIBLE

- There is no annual deductible under the Enhanced Medicare Rx Option.

PREFERRED GENERIC DRUGS (TIER 1)

- In Initial Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay a maximum of \$4 for up to a 30-day supply (and a maximum of \$12 for a 31- to 90-day supply).
- In the Coverage Gap, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay the greater of \$3.70 or 5% up to \$100 for generic drugs.

NON-PREFERRED GENERIC DRUGS (TIER 2)

- In Initial Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay a maximum of \$11 for up to a 30-day supply (and a maximum of \$33 for a 31- to 90-day supply).
- In the Coverage Gap, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay the greater of \$3.70 or 5% up to \$100 for generic drugs.

PREFERRED BRAND-NAME DRUGS (TIER 3)

- In Initial Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25% to a maximum of \$150 for up to a 30-day supply and 25% to a maximum of \$300 (\$280 if you use mail order) for a 31- to 90-day supply.
- In the Coverage Gap, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25% of the cost.

- In Catastrophic Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay the greater of \$9.20 or 5% up to \$100 for brand-name drugs.

NON-PREFERRED BRAND-NAME DRUGS (TIER 4)

- In Initial Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 35% to a maximum of \$200 for up to a 30-day supply and 35% to a maximum of \$400 (\$380 if you use mail order) for a 31- to 90-day supply.
- In the Coverage Gap, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay the greater of \$9.20 or 5% up to \$100 for brand-name drugs.

SPECIALTY DRUGS (TIER 5)

- In Initial Coverage, if you are enrolled in the Enhanced Medicare Rx Option, you pay 33% of the cost.
- In the Coverage Gap, if you are enrolled in the Enhanced Medicare Rx Option, you'll pay 25%.
- In Catastrophic Coverage, if you are enrolled in the Enhanced Medicare Rx Option and you fill a **generic** specialty medication, you'll pay the greater of \$3.70 or 5% up to \$100; if you fill a **brand** specialty medication, you'll pay the greater of \$9.20 or 5% up to \$100.
- Specialty drugs are limited to a 30-day supply.

The Basic Medicare Rx Option

DEDUCTIBLE

- You must pay the annual deductible of \$100 before the Basic Medicare Rx Option pays any portion of your brand-name or specialty prescription drug costs.

PREFERRED GENERIC DRUGS (TIER 1)

- In Initial Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay a maximum of \$5 for up to a 30-day supply (and a maximum of \$15 for a 31- to 90-day supply).
- In the Coverage Gap, if you are enrolled in the Basic Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay the greater of \$3.70 or 5% up to \$250 for generic drugs.

NON-PREFERRED GENERIC DRUGS (TIER 2)

- In Initial Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay a maximum of \$12 for up to a 30-day supply (and a maximum of \$36 for a 31- to 90-day supply).
- In the Coverage Gap, if you are enrolled in the Basic Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay the greater of \$3.70 or 5% up to \$250 for generic drugs.

PREFERRED BRAND-NAME DRUGS (TIER 3)

- In Initial Coverage, if you are enrolled in the Basic Medicare Rx Option and after you satisfy the annual deductible, you'll pay 30% of the cost to a maximum of \$200 for up to a 30-day supply and 30% to a maximum of \$500 (\$450 if you use mail order) for a 31- to 90-day supply.

- In the Coverage Gap, if you are enrolled in the Basic Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay the greater of \$9.20 or 5% up to \$250 for brand-name drugs.

NON-PREFERRED BRAND-NAME DRUGS (TIER 4)

- In Initial Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay 40% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, if you are enrolled in the Basic Medicare Rx Option, you'll pay 25% of the cost.
- In Catastrophic Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay the greater of \$9.20 or 5% up to \$250 for brand-name drugs.

SPECIALTY DRUGS (TIER 5)

- In Initial Coverage, if you are enrolled in the Basic Medicare Rx Option, you'll pay 30% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, if you are enrolled in the Basic Medicare Rx Option, you'll pay 25%.
- In Catastrophic Coverage, if you are enrolled in the Basic Medicare Rx Option and you fill a **generic** specialty medication, you'll pay the greater of \$3.70 or 5% up to \$250; if you fill a **brand** specialty medication, you'll pay the greater of \$9.20 or 5% up to \$250.
- Specialty drugs are limited to a 30-day supply.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
<i>celecoxib caps</i>	2	QL (60 EA per 30 days)
<i>diclofenac sodium soln</i>	2	PA
<i>meloxicam tabs</i>	1	
Opioid Analgesics, Long-acting		
HYSINGLA ER T24A 20MG, 30MG, 40MG, 60MG	3	ST
NUCYNTA ER	3	
OXYCODONE HCL ER T12A 10MG, 15MG, 20MG, 30MG, 40MG	3	ST
OXYCODONE HCL ER T12A 60MG, 80MG	5	ST NDS
OXYCONTIN T12A 10MG, 15MG, 20MG, 30MG, 40MG	3	ST
OXYCONTIN T12A 60MG, 80MG	5	ST NDS
<i>tramadol hcl er tb24</i>	2	
XTAMPZA ER C12A 13.5MG, 18MG, 27MG, 9MG	3	
ZOHYDRO ER C12A	4	
Opioid Analgesics, Short-acting		
<i>hydrocodone bitartrate/acetaminophen soln 325mg/15ml; 7.5mg/15ml</i>	2	
<i>hydrocodone bitartrate/acetaminophen tabs 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg</i>	2	
<i>hydrocodone/acetaminophen tabs 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg</i>	2	
<i>lorcet</i>	2	
<i>lorcet hd</i>	2	
<i>lorcet plus tabs 325mg; 7.5mg</i>	2	
NORCO	4	
<i>tramadol hcl tabs</i>	1	
TRAMADOL HYDROCHLORIDE TABS 100MG	2	
Anesthetics		
Local Anesthetics		
<i>lidocaine/prilocaine crea</i>	2	QL (30 GM per 30 days) PA
<i>lidocaine oint</i>	2	QL (150 GM per 30 days) PA
<i>lidocaine ptch 5%</i>	2	PA
Anti-Addiction/Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti-craving		
<i>acamprosate calcium dr</i>	2	
ANTABUSE	4	
<i>disulfiram tabs</i>	2	
<i>naltrexone hcl tabs</i>	2	
Opioid Dependence		
<i>buprenorphine hcl/naloxone hcl subl 2mg; 0.5mg</i>	2	QL (360 EA per 30 days)
<i>buprenorphine hcl/naloxone hcl subl 8mg; 2mg</i>	2	QL (90 EA per 30 days)
<i>buprenorphine hcl subl</i>	2	
<i>buprenorphine hydrochloride/naloxone hydrochloride film 12mg; 3mg, 4mg; 1mg</i>	2	QL (60 EA per 30 days)
<i>buprenorphine hydrochloride/naloxone hydrochloride film 2mg; 0.5mg, 8mg; 2mg</i>	2	QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SUBOXONE FILM 12MG; 3MG, 4MG; 1MG	4	QL (60 EA per 30 days)
SUBOXONE FILM 2MG; 0.5MG, 8MG; 2MG	4	QL (90 EA per 30 days)
Opioid Reversal Agents		
NALOXONE HCL INJ 0.4MG/ML	2	
<i>naloxone hcl inj 2mg/2ml</i>	2	
<i>naloxone hydrochloride inj 0.4mg/ml</i>	2	
NARCAN LIQD	3	
Smoking Cessation Agents		
<i>bupropion hydrochloride er (sr) tb12 150mg</i>	2	QL (60 EA per 30 days)
CHANTIX CONTINUING MONTH PAK	3	QL (504 EA per 365 days)
CHANTIX STARTING MONTH PAK	3	QL (504 EA per 365 days)
CHANTIX TABS 0.5MG, 1MG	3	QL (504 EA per 365 days)
NICOTROL INHALER	3	QL (2688 EA per 365 days)
NICOTROL NS	3	QL (360 ML per 365 days)
Antibacterials		
Aminoglycosides		
<i>gentamicin sulfate crea, oint</i>	2	
<i>neomycin sulfate</i>	2	
Antibacterials, Other		
<i>clindamycin hcl caps 300mg, 75mg</i>	2	
<i>clindamycin hydrochloride caps 150mg</i>	2	
<i>nitrofurantoin monohydrate/macrocrystals</i>	2	
Beta-lactam, Cephalosporins		
<i>cefuroxime axetil tabs</i>	2	
CEPHALEXIN TABS	2	
<i>cephalexin caps 250mg, 500mg</i>	1	
<i>cephalexin caps 750mg</i>	2	
<i>cephalexin susr</i>	2	
SUPRAX CHEW	3	
Beta-lactam, Penicillins		
AMOXICILLIN CHEW 125MG, 250MG	1	
<i>amoxicillin caps, susr, tabs</i>	1	
<i>penicillin v potassium tabs</i>	1	
PENICILLIN V POTASSIUM SOLR 250MG/5ML	1	
PENICILLIN V POTASSIUM SOLR 125MG/5ML	2	
Carbapenems		
<i>ertapenem</i>	2	
<i>meropenem</i>	2	
Macrolides		
<i>azithromycin susr</i>	2	
<i>azithromycin inj 500mg</i>	2	
<i>azithromycin tabs 250mg, 500mg</i>	1	
<i>azithromycin tabs 600mg</i>	2	
<i>clarithromycin er</i>	2	
CLARITHROMYCIN SUSR	2	
<i>clarithromycin tabs</i>	2	
Quinolones		
CIPROFLOXACIN HCL TABS 100MG	1	

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin hcl tabs 750mg</i>	1	
<i>ciprofloxacin hydrochloride</i>	1	
<i>levofloxacin</i>	2	
Sulfonamides		
<i>sulfacetamide sodium lotn</i>	2	
<i>sulfamethoxazole/trimethoprim ds</i>	1	
<i>sulfamethoxazole/trimethoprim tabs</i>	1	
<i>sulfamethoxazole/trimethoprim susp</i>	2	
Tetracyclines		
<i>doxy 100</i>	2	
<i>doxycycline hyclate dr tbec 100mg, 150mg, 200mg, 50mg, 75mg</i>	2	
<i>doxycycline hyclate caps 100mg, 50mg</i>	2	
<i>doxycycline hyclate tabs 100mg, 150mg, 75mg</i>	2	
<i>minocycline hcl caps 75mg</i>	2	
<i>minocycline hcl tabs</i>	2	
MINOCYCLINE HYDROCHLORIDE ER TB24 55MG	5	NDS
<i>minocycline hydrochloride er tb24 105mg, 115mg, 135mg, 45mg, 65mg, 80mg, 90mg</i>	2	
<i>minocycline hydrochloride caps 100mg, 50mg</i>	2	
TARGADOX	4	
Anticonvulsants		
Anticonvulsants, Other		
BRIVIACT SOLN, TABS	5	PA NDS
EPIDIOLEX	5	PA NDS
<i>felbamate tabs</i>	2	
<i>felbamate susp</i>	5	NDS
FELBATOL TABS	5	NDS
FYCOMPA	5	NDS
KEPPRA XR	5	NDS
KEPPRA SOLN	5	NDS
KEPPRA TABS 250MG	4	
KEPPRA TABS 1000MG, 500MG, 750MG	5	NDS
LAMICTAL CHEWABLE DISPERSIBLE CHEW 5MG	4	
LAMICTAL CHEWABLE DISPERSIBLE CHEW 25MG	5	NDS
LAMICTAL ODT TBDP 25MG	4	
LAMICTAL ODT TBDP 100MG, 200MG, 50MG	5	NDS
LAMICTAL STARTER/NOT TAKING CARBAMAZEPINE	4	
LAMICTAL STARTER/TAKING CARBAMAZEPINE/NOT TAKING VALPROATE	5	NDS
LAMICTAL STARTER/TAKING VALPROATE	4	
LAMICTAL XR KIT	3	
LAMICTAL XR TB24	5	NDS
LAMICTAL TABS	5	NDS
<i>lamotrigine er</i>	2	
<i>lamotrigine odt</i>	2	
<i>lamotrigine starter kit/blue</i>	2	
<i>lamotrigine starter kit/green</i>	1	
<i>lamotrigine starter kit/orange</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>lamotrigine chew, tabs</i>	2	
<i>levetiracetam er</i>	2	
<i>levetiracetam soln</i>	2	
<i>levetiracetam tabs 500mg</i>	1	
<i>levetiracetam tabs 1000mg, 250mg, 750mg</i>	2	
NAYZILAM	5	QL (10 EA per 30 days) NDS
QUDEXY XR CS24 100MG, 25MG, 50MG	4	ST
QUDEXY XR CS24 150MG, 200MG	5	ST NDS
<i>roweepra xr</i>	2	
<i>roweepra tabs 500mg</i>	1	
<i>roweepra tabs 1000mg, 750mg</i>	2	
SPRITAM	3	
TOPAMAX SPRINKLE CPSP 15MG	4	
TOPAMAX SPRINKLE CPSP 25MG	5	NDS
TOPAMAX TABS 25MG	4	
TOPAMAX TABS 100MG, 200MG, 50MG	5	NDS
TOPIRAMATE ER	2	
<i>topiramate cpsp</i>	2	
<i>topiramate tabs 25mg, 50mg</i>	1	
<i>topiramate tabs 100mg, 200mg</i>	2	
TROKENDI XR CP24 100MG, 25MG, 50MG	3	
TROKENDI XR CP24 200MG	5	NDS
<i>valproic acid</i>	2	
Calcium Channel Modifying Agents		
CELONTIN CAPS 300MG	3	
<i>ethosuximide</i>	2	
ZARONTIN	4	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>clobazam tabs</i>	2	
<i>clobazam susp</i>	5	NDS
<i>clonazepam odt tbdp 2mg</i>	2	QL (300 EA per 30 days)
<i>clonazepam odt tbdp 0.125mg, 0.25mg, 0.5mg, 1mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam tabs 0.5mg, 1mg</i>	1	QL (90 EA per 30 days)
<i>clonazepam tabs 2mg</i>	2	QL (300 EA per 30 days)
DEPAKOTE	4	
DEPAKOTE ER	4	
DEPAKOTE SPRINKLES	4	
DIASTAT ACUDIAL	4	
DIASTAT PEDIATRIC GEL 2.5MG	4	
DIAZEPAM RECTAL GEL	2	
<i>divalproex sodium dr</i>	2	
<i>divalproex sodium er</i>	2	
<i>divalproex sodium csdr</i>	2	
<i>gabapentin caps 400mg</i>	1	QL (270 EA per 30 days)
<i>gabapentin caps 300mg</i>	1	QL (360 EA per 30 days)
<i>gabapentin caps 100mg</i>	2	QL (360 EA per 30 days)
<i>gabapentin soln</i>	2	QL (2160 ML per 30 days)
<i>gabapentin tabs 800mg</i>	2	QL (150 EA per 30 days)
<i>gabapentin tabs 600mg</i>	2	QL (180 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
GABITRIL TABS 12MG, 16MG, 2MG	4	
GABITRIL TABS 4MG	5	NDS
KLONOPIN TABS 2MG	4	QL (300 EA per 30 days)
KLONOPIN TABS 0.5MG, 1MG	4	QL (90 EA per 30 days)
LYRICA SOLN	4	QL (900 ML per 30 days)
LYRICA CAPS 300MG	4	QL (60 EA per 30 days)
LYRICA CAPS 100MG, 150MG, 200MG, 225MG, 25MG, 50MG, 75MG	4	QL (90 EA per 30 days)
MYSOLINE TABS	5	NDS
NEURONTIN SOLN	4	QL (2160 ML per 30 days)
NEURONTIN CAPS 100MG, 300MG	4	QL (360 EA per 30 days)
NEURONTIN CAPS 400MG	5	QL (270 EA per 30 days) NDS
NEURONTIN TABS 800MG	5	QL (150 EA per 30 days) NDS
NEURONTIN TABS 600MG	5	QL (180 EA per 30 days) NDS
ONFI SUSP	5	NDS
ONFI TABS 10MG, 20MG	5	NDS
<i>phenobarbital elix 20mg/5ml</i>	2	
<i>phenobarbital tabs 15mg</i>	1	
<i>phenobarbital tabs 100mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg</i>	2	
<i>pregabalin caps 300mg</i>	2	QL (60 EA per 30 days)
<i>pregabalin caps 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg</i>	2	QL (90 EA per 30 days)
<i>pregabalin soln</i>	2	QL (900 ML per 30 days)
<i>primidone tabs</i>	2	
SABRIL	5	PA NDS
SYMPAZAN	5	NDS
<i>tiagabine hydrochloride</i>	2	
VALTOCO	5	QL (10 EA per 30 days) NDS
<i>vigabatrin</i>	5	PA NDS
<i>vigadrone</i>	5	PA NDS
Sodium Channel Agents		
APTIOM	5	NDS
BANZEL	5	NDS
<i>carbamazepine er</i>	2	
<i>carbamazepine chew</i>	1	
<i>carbamazepine susp, tabs</i>	2	
CARBATROL	4	
DILANTIN INFATABS	4	
DILANTIN-125	4	
DILANTIN CAPS 30MG	3	
DILANTIN CAPS 100MG	4	
<i>epitol</i>	2	
<i>oxcarbazepine</i>	2	
OXTELLAR XR TB24 150MG, 300MG	3	
OXTELLAR XR TB24 600MG	5	NDS
PEGANONE TABS 250MG	3	
PHENYTEK	4	
<i>phenytoin sodium extended</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>phenytoin chew, susp</i>	2	
TEGRETOL-XR	4	
TEGRETOL SUSP, TABS	4	
TRILEPTAL SUSP	5	NDS
TRILEPTAL TABS 150MG	4	
TRILEPTAL TABS 300MG, 600MG	5	NDS
VIMPAT SOLN	5	NDS
VIMPAT TABS 50MG	3	
VIMPAT TABS 100MG, 150MG, 200MG	5	NDS
ZONEGRAN CAPS 100MG, 25MG	5	NDS
<i>zonisamide</i>	2	
Antidementia Agents		
<i>Antidementia Agents, Other</i>		
ERGOLOID MESYLATES TABS	2	
NAMZARIC CP24	3	QL (30 EA per 30 days) ST
NAMZARIC C4PK	3	QL (56 EA per 365 days) ST
<i>Cholinesterase Inhibitors</i>		
<i>donepezil hcl tbdp</i>	2	
<i>donepezil hcl tabs 10mg</i>	1	
<i>donepezil hcl tabs 23mg</i>	2	
<i>donepezil hydrochloride tabs 5mg</i>	1	
<i>rivastigmine transdermal system</i>	2	
<i>N-methyl-D-aspartate (NMDA) Receptor Antagonist</i>		
<i>memantine hcl titration pak</i>	2	
<i>memantine hydrochloride er</i>	2	QL (30 EA per 30 days)
<i>memantine hydrochloride soln, tabs</i>	2	
Antidepressants		
<i>Antidepressants, Other</i>		
APLENZIN	5	QL (30 EA per 30 days) ST NDS
<i>bupropion hcl tabs 100mg</i>	2	
<i>bupropion hydrochloride er (sr) tb12 200mg</i>	1	QL (60 EA per 30 days)
<i>bupropion hydrochloride er (sr) tb12 150mg</i>	2	QL (60 EA per 30 days)
<i>bupropion hydrochloride er (sr) tb12 100mg</i>	2	QL (90 EA per 30 days)
BUPROPION HYDROCHLORIDE ER (XL) TB24 450MG	3	QL (30 EA per 30 days) ST
<i>bupropion hydrochloride er (xl) tb24 300mg</i>	2	QL (30 EA per 30 days)
<i>bupropion hydrochloride er (xl) tb24 150mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hydrochloride tabs 75mg</i>	2	
CHLORDIAZEPOXIDE/AMITRIPTYLINE	2	
FORFIVO XL	3	QL (30 EA per 30 days) ST
MAPROTILINE HCL	2	
<i>mirtazapine odt</i>	2	
<i>mirtazapine tabs</i>	2	
<i>olanzapine/fluoxetine caps 25mg; 12mg, 50mg; 12mg, 50mg; 6mg</i>	2	QL (30 EA per 30 days)
<i>olanzapine/fluoxetine caps 25mg; 3mg, 25mg; 6mg</i>	2	QL (90 EA per 30 days)
PERPHENAZINE/AMITRIPTYLINE	2	
REMERON SOLTAB	4	ST
REMERON TABS 15MG, 30MG	4	ST
SYMBYAX CAPS 50MG; 12MG, 50MG; 6MG	4	QL (30 EA per 30 days) ST

Drug Name	Drug Tier	Requirements/Limits
SYMBYAX CAPS 25MG; 3MG, 25MG; 6MG	4	QL (90 EA per 30 days) ST
WELLBUTRIN SR TB12 150MG, 200MG	4	QL (60 EA per 30 days) ST
WELLBUTRIN SR TB12 100MG	4	QL (90 EA per 30 days) ST
WELLBUTRIN XL TB24 300MG	5	QL (30 EA per 30 days) ST NDS
WELLBUTRIN XL TB24 150MG	5	QL (90 EA per 30 days) ST NDS
Monoamine Oxidase Inhibitors		
EMSAM	5	QL (30 EA per 30 days) ST NDS
MARPLAN	3	ST
NARDIL	4	ST
PARNATE	5	ST NDS
<i>phenelzine sulfate</i>	2	
<i>tranylcypromine sulfate</i>	2	
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
BRISDELLE	4	QL (30 EA per 30 days) ST
CELEXA TABS	4	ST
<i>citalopram hydrobromide tabs</i>	1	
<i>citalopram hydrobromide soln</i>	2	
CYMBALTA CPEP 20MG, 60MG	4	QL (60 EA per 30 days) ST
CYMBALTA CPEP 30MG	4	QL (90 EA per 30 days) ST
DESVENLAFAXINE ER TB24 100MG	3	QL (120 EA per 30 days) ST
DESVENLAFAXINE ER TB24 50MG	3	QL (30 EA per 30 days) ST
<i>desvenlafaxine er tb24 100mg</i>	2	QL (120 EA per 30 days)
<i>desvenlafaxine er tb24 25mg, 50mg</i>	2	QL (30 EA per 30 days)
DRIZALMA SPRINKLE CSDR 20MG, 60MG	3	QL (60 EA per 30 days)
DRIZALMA SPRINKLE CSDR 30MG, 40MG	3	QL (90 EA per 30 days)
DULOXETINE HCL CPEP 40MG	2	QL (90 EA per 30 days)
<i>duloxetine hydrochloride cpep 20mg, 60mg</i>	2	QL (60 EA per 30 days)
<i>duloxetine hydrochloride cpep 30mg</i>	2	QL (90 EA per 30 days)
EFFEXOR XR	4	ST
<i>escitalopram oxalate soln</i>	2	
<i>escitalopram oxalate tabs 10mg, 20mg</i>	1	
<i>escitalopram oxalate tabs 5mg</i>	2	
FETZIMA	3	QL (30 EA per 30 days) ST
FETZIMA TITRATION PACK	3	QL (56 EA per 365 days) ST
FLUOXETINE DR	2	QL (4 EA per 28 days)
<i>fluoxetine hcl caps 20mg</i>	1	
<i>fluoxetine hydrochloride caps 10mg</i>	1	
<i>fluoxetine hydrochloride caps 40mg</i>	2	
<i>fluoxetine hydrochloride soln, tabs</i>	2	
<i>fluvoxamine maleate</i>	2	
<i>fluvoxamine maleate er</i>	2	QL (60 EA per 30 days)
LEXAPRO TABS	4	ST
NEFAZODONE HCL TABS 100MG, 150MG	2	
NEFAZODONE HYDROCHLORIDE TABS 200MG, 250MG, 50MG	2	
<i>paroxetine</i>	2	QL (30 EA per 30 days)
<i>paroxetine hcl er</i>	2	
<i>paroxetine hcl tabs 30mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>paroxetine hcl tabs 40mg</i>	2	
<i>paroxetine hydrochloride tabs 10mg</i>	1	
<i>paroxetine hydrochloride tabs 20mg</i>	2	
PAXIL CR	4	ST
PAXIL SUSP	3	ST
PAXIL TABS	4	ST
PEXEVA TABS 10MG, 20MG, 40MG	3	QL (30 EA per 30 days) ST
PEXEVA TABS 30MG	3	QL (60 EA per 30 days) ST
PRISTIQ TB24 100MG	4	QL (120 EA per 30 days) ST
PRISTIQ TB24 25MG, 50MG	4	QL (30 EA per 30 days) ST
PROZAC CAPS 10MG, 20MG	4	ST
PROZAC CAPS 40MG	5	ST NDS
SARAFEM TABS 10MG	4	ST
SARAFEM TABS 20MG	5	ST NDS
<i>sertraline hcl tabs 25mg, 50mg</i>	1	
<i>sertraline hydrochloride conc</i>	2	
<i>sertraline hydrochloride tabs 100mg</i>	1	
<i>trazodone hydrochloride</i>	2	
TRINTELLIX	3	QL (30 EA per 30 days) ST
<i>venlafaxine hcl</i>	2	
<i>venlafaxine hcl er cp24 150mg, 37.5mg</i>	2	
<i>venlafaxine hcl er tb24 37.5mg</i>	2	
<i>venlafaxine hydrochloride er cp24</i>	2	
<i>venlafaxine hydrochloride er tb24 150mg, 225mg, 75mg</i>	2	
VIIBRYD STARTER PACK	3	QL (60 EA per 365 days) ST
VIIBRYD TABS	3	QL (30 EA per 30 days) ST
ZOLOFT	4	ST
Tricyclics		
<i>amitriptyline hcl tabs 25mg</i>	1	
<i>amitriptyline hcl tabs 100mg, 150mg, 75mg</i>	2	
<i>amitriptyline hydrochloride tabs 10mg</i>	1	
<i>amitriptyline hydrochloride tabs 50mg</i>	2	
AMOXAPINE	2	
ANAFRANIL	5	NDS
<i>clomipramine hcl caps</i>	2	
<i>desipramine hcl tabs</i>	2	
DOXEPIN HCL CAPS 150MG	2	
<i>doxepin hcl caps 100mg, 10mg, 50mg, 75mg</i>	2	
<i>doxepin hcl conc</i>	1	
<i>doxepin hydrochloride caps 25mg</i>	2	
<i>imipramine hcl tabs 25mg, 50mg</i>	2	
<i>imipramine hydrochloride tabs 10mg</i>	1	
<i>imipramine pamoate</i>	2	
NORPRAMIN TABS 10MG, 25MG	4	ST
NORTRIPTYLINE HCL SOLN	2	
<i>nortriptyline hcl caps 25mg, 75mg</i>	2	
<i>nortriptyline hydrochloride caps 10mg</i>	1	
<i>nortriptyline hydrochloride caps 50mg</i>	2	
PAMELOR CAPS	5	ST NDS

Drug Name	Drug Tier	Requirements/Limits
<i>protriptyline hcl</i>	2	
<i>trimipramine maleate caps</i>	2	
Antiemetics		
Antiemetics, Other		
<i>meclizine hcl tabs 12.5mg</i>	1	
<i>meclizine hcl tabs 25mg</i>	2	
<i>prochlorperazine maleate tabs</i>	1	
Emetogenic Therapy Adjuncts		
<i>dronabinol caps 2.5mg, 5mg</i>	1	QL (60 EA per 30 days) PA
<i>dronabinol caps 10mg</i>	2	QL (60 EA per 30 days) PA
<i>ondansetron hcl soln</i>	2	QL (450 ML per 30 days) B/D
ONDANSETRON HCL TABS 24MG	2	QL (14 EA per 28 days) B/D
<i>ondansetron hydrochloride tabs</i>	1	B/D
Antifungals		
Antifungals		
<i>fluconazole susr, tabs</i>	2	
JUBLIA	3	
<i>ketoconazole crea, foam, sham</i>	2	
<i>ketodan</i>	2	
Antigout Agents		
Antigout Agents		
<i>allopurinol tabs</i>	1	
COLCHICINE CAPS	3	
<i>colchicine tabs 0.6mg</i>	2	
MITIGARE	3	
Antimigraine Agents		
Ergot Alkaloids		
CAFERGOT TABS	4	
<i>dihydroergotamine mesylate soln</i>	5	QL (8 ML per 30 days) PA NDS
<i>ergotamine tartrate/caffeine</i>	2	
MIGERGOT	5	NDS
Prophylactic		
AIMOVIG INJ 140MG/ML	3	QL (1 ML per 30 days) PA
AIMOVIG INJ 70MG/ML	3	QL (2 ML per 30 days) PA
AJOVY	3	QL (4.5 ML per 90 days) PA
EMGALITY INJ 120MG/ML	3	QL (1 ML per 30 days) PA
EMGALITY INJ 100MG/ML	3	QL (3 ML per 30 days) PA
Serotonin (5-HT) Receptor Agonist		
<i>rizatriptan benzoate</i>	2	QL (18 EA per 30 days)
<i>rizatriptan benzoate odt</i>	2	QL (18 EA per 30 days)
<i>sumatriptan succinate refill inj 4mg/0.5ml</i>	2	QL (5 ML per 30 days)
SUMATRIPTAN SUCCINATE INJ 6MG/0.5ML	2	QL (5 ML per 30 days)
<i>sumatriptan succinate inj 4mg/0.5ml, 6mg/0.5ml</i>	2	QL (5 ML per 30 days)
<i>sumatriptan succinate tabs 25mg, 50mg</i>	1	QL (9 EA per 30 days)
<i>sumatriptan succinate tabs 100mg</i>	2	QL (9 EA per 30 days)
Antimyasthenic Agents		
Parasympathomimetics		
GUANIDINE HCL	3	
<i>pyridostigmine bromide er</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>pyridostigmine bromide soln</i>	5	NDS
PYRIDOSTIGMINE BROMIDE TABS 30MG	2	
<i>pyridostigmine bromide tabs 60mg</i>	2	
Antimycobacterials		
<i>Antimycobacterials, Other</i>		
<i>dapsone tabs</i>	2	
<i>rifabutin</i>	2	
<i>Antituberculars</i>		
<i>ethambutol hcl tabs 100mg</i>	2	
<i>ethambutol hydrochloride tabs 400mg</i>	2	
<i>rifampin caps, inj</i>	2	
Antineoplastics		
<i>Alkylating Agents</i>		
<i>cyclophosphamide caps</i>	2	B/D
LEUKERAN	5	NDS
MATULANE	5	NDS
VALCHLOR	5	PA NDS
<i>Antiandrogens</i>		
<i>abiraterone acetate</i>	5	PA NDS
<i>bicalutamide</i>	2	
CASODEX	4	
ERLEADA	5	PA NDS
<i>flutamide</i>	2	
NILANDRON TABS 150MG	5	NDS
<i>nilutamide</i>	5	NDS
NUBEQA	5	PA NDS
XTANDI	5	PA NDS
YONSA	5	PA NDS
ZYTIGA	5	PA NDS
<i>Antiangiogenic Agents</i>		
POMALYST	5	PA NDS
REVLIMID	5	PA NDS
THALOMID	5	PA NDS
<i>Antiestrogens/Modifiers</i>		
EMCYT	5	NDS
FARESTON	5	NDS
SOLTAMOX	5	NDS
<i>tamoxifen citrate tabs</i>	2	
<i>toremifene citrate</i>	5	NDS
<i>Antimetabolites</i>		
DROXIA	3	
HYDREA	4	
<i>hydroxyurea caps</i>	2	
<i>mercaptopurine tabs</i>	2	
PURIXAN	5	NDS
SIKLOS TABS 100MG	3	PA
SIKLOS TABS 1000MG	5	PA NDS
TABLOID	3	
<i>Antineoplastics, Other</i>		

Drug Name	Drug Tier	Requirements/Limits
IBRANCE TABS 100MG, 125MG, 75MG	5	PA NDS
IDHIFA	5	QL (30 EA per 30 days) PA NDS
INREBIC	5	PA NDS
KISQALI FEMARA 200 DOSE	5	PA NDS
KISQALI FEMARA 400 DOSE	5	PA NDS
KISQALI FEMARA 600 DOSE	5	PA NDS
LEUCOVORIN CALCIUM TABS 10MG, 15MG	2	
<i>leucovorin calcium tabs 25mg, 5mg</i>	2	
LONSURF	5	PA NDS
NINLARO	5	PA NDS
PEMAZYRE	5	QL (30 EA per 30 days) PA NDS
SYNRIBO	5	PA NDS
TAZVERIK	5	PA NDS
XPOVIO 100 MG ONCE WEEKLY	5	PA NDS
XPOVIO 60 MG ONCE WEEKLY	5	PA NDS
XPOVIO 80 MG ONCE WEEKLY	5	PA NDS
XPOVIO 80 MG TWICE WEEKLY	5	PA NDS
ZOLINZA	5	PA NDS
Aromatase Inhibitors, 3rd Generation		
<i>anastrozole tabs</i>	1	
ARIMIDEX	4	
AROMASIN	5	NDS
<i>exemestane</i>	2	
FEMARA	5	NDS
<i>letrozole</i>	2	
Molecular Target Inhibitors		
AFINITOR	5	QL (30 EA per 30 days) PA NDS
AFINITOR DISPERZ	5	PA NDS
ALECENSA	5	PA NDS
ALUNBRIG TBPK	5	QL (60 EA per 365 days) PA NDS
ALUNBRIG TABS 30MG	5	QL (120 EA per 30 days) PA NDS
ALUNBRIG TABS 180MG, 90MG	5	QL (30 EA per 30 days) PA NDS
AYVAKIT	5	QL (30 EA per 30 days) PA NDS
BALVERSA	5	PA NDS
BOSULIF	5	PA NDS
BRAFTOVI CAPS 75MG	5	PA NDS
BRUKINSA	5	PA NDS
CABOMETYX	5	PA NDS
CALQUENCE	5	PA NDS
CAPRELSA TABS 300MG	5	PA NDS
CAPRELSA TABS 100MG	5	QL (60 EA per 30 days) PA NDS
COMETRIQ	5	PA NDS
COPIKTRA	5	PA NDS
COTELLIC	5	PA NDS
DAURISMO	5	PA NDS
ERIVEDGE	5	PA NDS
<i>erlotinib hydrochloride</i>	5	PA NDS
<i>everolimus tabs 2.5mg, 5mg, 7.5mg</i>	5	QL (30 EA per 30 days) PA NDS
FARYDAK CAPS 10MG, 20MG	5	PA NDS

Drug Name	Drug Tier	Requirements/Limits
GILOTRIF	5	QL (30 EA per 30 days) PA NDS
GLEEVEC TABS	5	PA NDS
IBRANCE CAPS 100MG, 125MG, 75MG	5	PA NDS
ICLUSIG TABS 45MG	5	PA NDS
ICLUSIG TABS 15MG	5	QL (60 EA per 30 days) PA NDS
<i>imatinib mesylate</i>	5	PA NDS
IMBRUVICA	5	PA NDS
INLYTA	5	PA NDS
IRESSA	5	PA NDS
JAKAFI TABS 15MG, 20MG, 25MG, 5MG	5	PA NDS
JAKAFI TABS 10MG	5	QL (60 EA per 30 days) PA NDS
KISQALI	5	PA NDS
KOSELUGO	5	PA NDS
LENVIMA 10 MG DAILY DOSE	5	PA NDS
LENVIMA 12MG DAILY DOSE	5	PA NDS
LENVIMA 14 MG DAILY DOSE	5	PA NDS
LENVIMA 18 MG DAILY DOSE	5	PA NDS
LENVIMA 20 MG DAILY DOSE	5	PA NDS
LENVIMA 24 MG DAILY DOSE	5	PA NDS
LENVIMA 4 MG DAILY DOSE	5	PA NDS
LENVIMA 8 MG DAILY DOSE	5	PA NDS
LORBRENA	5	PA NDS
LYNPARZA TABS	5	NDS
MEKINIST	5	PA NDS
MEKTOVI	5	PA NDS
NERLYNX	5	QL (180 EA per 30 days) PA NDS
NEXAVAR	5	PA NDS
ODOMZO	5	PA NDS
PIQRAY 200MG DAILY DOSE	5	PA NDS
PIQRAY 250MG DAILY DOSE	5	PA NDS
PIQRAY 300MG DAILY DOSE	5	PA NDS
ROZLYTREK	5	PA NDS
RUBRACA	5	PA NDS
RYDAPT	5	PA NDS
SPRYCEL	5	PA NDS
STIVARGA	5	PA NDS
SUTENT	5	PA NDS
TAFINLAR	5	PA NDS
TAGRISSO TABS 80MG	5	PA NDS
TAGRISSO TABS 40MG	5	QL (30 EA per 30 days) PA NDS
TALZENNA	5	PA NDS
TARCEVA	5	PA NDS
TASIGNA	5	PA NDS
TIBSOVO	5	PA NDS
TURALIO	5	PA NDS
TYKERB	5	PA NDS
VENCLEXTA STARTING PACK	5	PA NDS
VENCLEXTA TABS 10MG	3	PA
VENCLEXTA TABS 100MG, 50MG	5	PA NDS

Drug Name	Drug Tier	Requirements/Limits
VERZENIO	5	PA NDS
VITRAKVI	5	PA NDS
VIZIMPRO	5	PA NDS
VOTRIENT	5	PA NDS
XALKORI	5	PA NDS
XOSPATA	5	PA NDS
ZEJULA	5	PA NDS
ZELBORAF	5	PA NDS
ZYDELIG	5	PA NDS
ZYKADIA TABS	5	PA NDS
Retinoids		
<i>bexarotene</i>	5	PA NDS
TARGRETIN	5	PA NDS
<i>tretinoin caps 10mg</i>	5	NDS
Treatment Adjuncts		
MESNEX TABS	5	NDS
Antiparasitics		
Anthelmintics		
<i>albendazole tabs</i>	5	NDS
<i>ivermectin tabs</i>	2	
Antiprotozoals		
<i>atovaquone/proguanil hcl</i>	2	
<i>hydroxychloroquine sulfate tabs</i>	2	
Antiparkinson Agents		
Anticholinergics		
<i>benztropine mesylate tabs 1mg</i>	1	
<i>benztropine mesylate tabs 0.5mg, 2mg</i>	2	
<i>trihexyphenidyl hcl soln</i>	2	
<i>trihexyphenidyl hydrochloride tabs 2mg</i>	1	
<i>trihexyphenidyl hydrochloride tabs 5mg</i>	2	
Antiparkinson Agents, Other		
CARBIDOPA/LEVODOPA/ENTACAPONE	2	
<i>entacapone</i>	2	
GOCOVRI	5	PA NDS
OSMOLEX ER TB24	3	PA
Dopamine Agonists		
NEUPRO PT24 1MG/24HR, 2MG/24HR, 3MG/24HR, 4MG/24HR, 6MG/24HR	3	
<i>pramipexole dihydrochloride</i>	2	
<i>pramipexole dihydrochloride er</i>	2	
<i>ropinirole er</i>	2	
<i>ropinirole hcl tabs 0.5mg, 1mg, 2mg, 4mg, 5mg</i>	2	
<i>ropinirole hydrochloride tabs 0.25mg, 3mg</i>	2	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
<i>carbidopa/levodopa</i>	2	
<i>carbidopa/levodopa er</i>	2	
<i>carbidopa/levodopa odt</i>	2	
INBRIJA	5	PA NDS

Drug Name	Drug Tier	Requirements/Limits
RYTARY	3	
Monoamine Oxidase B (MAO-B) Inhibitors		
<i>rasagiline mesylate tabs</i>	2	
SELEGILINE HCL TABS	2	
<i>selegiline hcl caps</i>	2	
Antipsychotics		
1st Generation/Typical		
<i>chlorpromazine hcl tabs</i>	2	
<i>fluphenazine decanoate inj</i>	2	
FLUPHENAZINE HCL CONC, INJ	2	
<i>fluphenazine hcl tabs</i>	2	
FLUPHENAZINE HYDROCHLORIDE	2	
HALDOL DECANOATE 100	4	
HALDOL DECANOATE 50	4	
HALDOL INJ	4	
<i>haloperidol decanoate inj</i>	2	
<i>haloperidol lactate</i>	2	
<i>haloperidol conc, tabs</i>	2	
<i>loxapine succinate caps 25mg, 50mg, 5mg</i>	2	
<i>loxapine caps 10mg</i>	2	
<i>molindone hydrochloride</i>	2	
<i>perphenazine tabs</i>	2	
PIMOZIDE	2	
<i>thioridazine hcl tabs 100mg, 10mg, 25mg, 50mg</i>	2	
<i>thiothixene caps 10mg, 1mg, 2mg, 5mg</i>	2	
<i>trifluoperazine hcl tabs 10mg, 2mg, 5mg</i>	2	
<i>trifluoperazine hydrochloride tabs 1mg</i>	2	
2nd Generation/Atypical		
ABILIFY MAINTENA	5	NDS
ABILIFY MYCITE	5	QL (30 EA per 30 days) ST NDS
ABILIFY TABS	5	QL (30 EA per 30 days) NDS
<i>aripiprazole odt</i>	5	QL (60 EA per 30 days) NDS
<i>aripiprazole tabs</i>	2	QL (30 EA per 30 days)
<i>aripiprazole soln</i>	2	QL (750 ML per 30 days)
ARISTADA	5	NDS
ARISTADA INITIO	5	NDS
CAPLYTA	5	QL (30 EA per 30 days) ST NDS
FANAPT TITRATION PACK	3	QL (8 EA per 180 days) ST
FANAPT TABS 1MG, 2MG, 4MG	3	QL (60 EA per 30 days) ST
FANAPT TABS 10MG, 12MG, 6MG, 8MG	5	QL (60 EA per 30 days) ST NDS
GEODON INJ	3	QL (60 EA per 30 days)
GEODON CAPS	5	QL (60 EA per 30 days) ST NDS
INVEGA SUSTENNA INJ 39MG/0.25ML	3	
INVEGA SUSTENNA INJ 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	5	NDS
INVEGA TRINZA	5	ST NDS
INVEGA TB24 1.5MG, 3MG, 9MG	5	QL (30 EA per 30 days) ST NDS
INVEGA TB24 6MG	5	QL (60 EA per 30 days) ST NDS
LATUDA TABS 120MG, 20MG, 40MG, 60MG	5	QL (30 EA per 30 days) NDS

Drug Name	Drug Tier	Requirements/Limits
LATUDA TABS 80MG	5	QL (60 EA per 30 days) NDS
NUPLAZID CAPS	5	PA NDS
NUPLAZID TABS 10MG	5	PA NDS
<i>olanzapine odt</i>	2	QL (30 EA per 30 days)
<i>olanzapine inj</i>	2	
<i>olanzapine tabs 7.5mg</i>	1	QL (30 EA per 30 days)
<i>olanzapine tabs 10mg, 15mg, 2.5mg, 20mg, 5mg</i>	2	QL (30 EA per 30 days)
<i>paliperidone er tb24 1.5mg, 3mg</i>	2	QL (30 EA per 30 days)
<i>paliperidone er tb24 6mg</i>	2	QL (60 EA per 30 days)
<i>paliperidone er tb24 9mg</i>	5	QL (30 EA per 30 days) NDS
PERSERIS	5	NDS
<i>quetiapine fumarate er tb24 150mg, 300mg, 400mg, 50mg</i>	2	QL (60 EA per 30 days)
<i>quetiapine fumarate er tb24 200mg</i>	2	QL (90 EA per 30 days)
<i>quetiapine fumarate tabs 300mg, 400mg</i>	2	QL (60 EA per 30 days)
<i>quetiapine fumarate tabs 100mg, 200mg, 25mg, 50mg</i>	2	QL (90 EA per 30 days)
REXULTI	5	QL (30 EA per 30 days) NDS
RISPERDAL CONSTA INJ 12.5MG, 25MG	3	
RISPERDAL CONSTA INJ 37.5MG, 50MG	5	NDS
RISPERDAL SOLN	5	QL (240 ML per 30 days) NDS
RISPERDAL TABS 0.5MG, 1MG	4	QL (60 EA per 30 days)
RISPERDAL TABS 2MG, 3MG, 4MG	5	QL (60 EA per 30 days) NDS
RISPERIDONE ODT TBDP 0.25MG	2	QL (60 EA per 30 days)
<i>risperidone odt tbdp 0.5mg, 1mg, 2mg, 3mg, 4mg</i>	2	QL (60 EA per 30 days)
<i>risperidone soln</i>	2	QL (240 ML per 30 days)
<i>risperidone tabs 1mg</i>	1	QL (60 EA per 30 days)
<i>risperidone tabs 0.25mg, 0.5mg, 2mg, 3mg, 4mg</i>	2	QL (60 EA per 30 days)
SAPHRIS	5	QL (60 EA per 30 days) NDS
SECUADO	5	QL (30 EA per 30 days) PA NDS
SEROQUEL XR TB24 150MG, 300MG, 50MG	4	QL (60 EA per 30 days)
SEROQUEL XR TB24 200MG	4	QL (90 EA per 30 days)
SEROQUEL XR TB24 400MG	5	QL (60 EA per 30 days) NDS
SEROQUEL TABS 100MG, 200MG, 25MG, 50MG	4	QL (90 EA per 30 days)
SEROQUEL TABS 300MG, 400MG	5	QL (60 EA per 30 days) NDS
VRAYLAR CPPK	3	QL (14 EA per 365 days) ST
VRAYLAR CAPS	5	QL (30 EA per 30 days) ST NDS
<i>ziprasidone hcl</i>	2	QL (60 EA per 30 days)
ZYPREXA RELPREVV INJ 210MG	3	
ZYPREXA ZYDIS TBDP 10MG, 5MG	4	QL (30 EA per 30 days)
ZYPREXA ZYDIS TBDP 15MG, 20MG	5	QL (30 EA per 30 days) NDS
ZYPREXA INJ	4	
ZYPREXA TABS 10MG, 2.5MG, 5MG, 7.5MG	4	QL (30 EA per 30 days)
ZYPREXA TABS 15MG, 20MG	5	QL (30 EA per 30 days) NDS
Treatment-Resistant		
CLOZAPINE ODT TBDP 12.5MG	2	QL (90 EA per 30 days)
CLOZAPINE ODT TBDP 200MG	5	QL (120 EA per 30 days) NDS
CLOZAPINE ODT TBDP 150MG	5	QL (180 EA per 30 days) NDS
<i>clozapine odt tbdp 100mg, 25mg</i>	2	QL (270 EA per 30 days)
<i>clozapine tabs 200mg</i>	2	QL (120 EA per 30 days)
<i>clozapine tabs 50mg</i>	2	QL (180 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clozapine tabs 100mg, 25mg</i>	2	QL (270 EA per 30 days)
CLOZARIL TABS 25MG	4	QL (270 EA per 30 days)
CLOZARIL TABS 200MG	5	QL (120 EA per 30 days) NDS
CLOZARIL TABS 50MG	5	QL (180 EA per 30 days) NDS
CLOZARIL TABS 100MG	5	QL (270 EA per 30 days) NDS
VERSACLOZ	5	QL (540 ML per 30 days) NDS
Antispasticity Agents		
<i>Antispasticity Agents</i>		
<i>baclofen tabs</i>	2	
<i>tizanidine hcl caps</i>	2	
<i>tizanidine hcl tabs 2mg</i>	2	
<i>tizanidine hydrochloride tabs 4mg</i>	2	
Antivirals		
<i>Anti-cytomegalovirus (CMV) Agents</i>		
PREVYMIS TABS	5	NDS
<i>valganciclovir</i>	5	NDS
<i>valganciclovir hydrochloride</i>	5	NDS
<i>Anti-hepatitis B (HBV) Agents</i>		
<i>entecavir</i>	2	QL (30 EA per 30 days)
<i>lamivudine tabs 100mg</i>	2	
<i>Anti-hepatitis C (HCV) Agents</i>		
EPCLUSA	5	QL (84 EA per 365 days) PA NDS
HARVONI TABS 90MG; 400MG	5	QL (168 EA per 365 days) PA NDS
LEDIPASVIR/SOFOSBUVIR	5	QL (168 EA per 365 days) PA NDS
MAVYRET	5	QL (336 EA per 365 days) PA NDS
<i>ribavirin caps</i>	2	
<i>ribavirin tabs 200mg</i>	2	
SOFOSBUVIR/VELPATASVIR	5	QL (84 EA per 365 days) PA NDS
VOSEVI	5	QL (84 EA per 365 days) PA NDS
<i>Anti-HIV Agents, Integrase Inhibitors (INSTI)</i>		
BIKTARVY	5	QL (30 EA per 30 days) NDS
DOVATO	5	QL (30 EA per 30 days) NDS
GENVOYA	5	QL (30 EA per 30 days) NDS
ISENTRESS HD	5	NDS
ISENTRESS PACK, TABS	5	NDS
ISENTRESS CHEW 25MG	3	
ISENTRESS CHEW 100MG	5	NDS
JULUCA	5	QL (30 EA per 30 days) NDS
STRIBILD	5	QL (30 EA per 30 days) NDS
TIVICAY TABS 10MG	3	
TIVICAY TABS 25MG, 50MG	5	NDS
<i>Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)</i>		
ATRIPLA	5	QL (30 EA per 30 days) NDS
COMPLERA	5	QL (30 EA per 30 days) NDS
DELSTRIGO	5	QL (30 EA per 30 days) NDS
EDURANT	5	NDS
<i>efavirenz caps 50mg</i>	2	
<i>efavirenz caps 200mg</i>	5	NDS

Drug Name	Drug Tier	Requirements/Limits
<i>efavirenz tabs</i>	5	NDS
INTELENCE TABS 25MG	3	
INTELENCE TABS 100MG, 200MG	5	NDS
<i>nevirapine</i>	2	
<i>nevirapine er</i>	2	
PIFELTRO	5	NDS
SUSTIVA TABS	5	NDS
SUSTIVA CAPS 50MG	4	
SUSTIVA CAPS 200MG	5	NDS
SYMFI	5	QL (30 EA per 30 days) NDS
SYMFI LO	5	QL (30 EA per 30 days) NDS
VIRAMUNE	5	NDS
VIRAMUNE XR TB24 400MG	5	NDS
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
<i>abacavir</i>	2	
<i>abacavir sulfate/lamivudine</i>	2	QL (30 EA per 30 days)
<i>abacavir sulfate/lamivudine/zidovudine</i>	5	QL (60 EA per 30 days) NDS
CIMDUO	5	QL (30 EA per 30 days) NDS
COMBIVIR	5	QL (60 EA per 30 days) NDS
DESCOVY	5	QL (30 EA per 30 days) NDS
DIDANOSINE CPDR 250MG, 400MG	2	
EMTRIVA	3	
EPIVIR	4	
EPZICOM	5	QL (30 EA per 30 days) NDS
<i>lamivudine/zidovudine</i>	2	QL (60 EA per 30 days)
<i>lamivudine soln 10mg/ml</i>	2	
<i>lamivudine tabs 150mg, 300mg</i>	2	
ODEFSEY	5	QL (30 EA per 30 days) NDS
RETROVIR CAPS, SYRP	4	
<i>stavudine caps</i>	2	
<i>tenofovir disoproxil fumarate</i>	2	
TRIUMEQ	5	QL (30 EA per 30 days) NDS
TRIZIVIR	5	QL (60 EA per 30 days) NDS
TRUVADA	5	QL (30 EA per 30 days) NDS
VIREAD	5	NDS
ZIAGEN	4	
<i>zidovudine</i>	2	
Anti-HIV Agents, Other		
FUZEON	5	NDS
SELZENTRY SOLN	5	NDS
SELZENTRY TABS 25MG	3	
SELZENTRY TABS 150MG, 300MG, 75MG	5	NDS
TYBOST	3	
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS	5	NDS
<i>atazanavir</i>	2	
<i>atazanavir sulfate caps 300mg</i>	2	
CRIXIVAN CAPS 200MG, 400MG	3	

Drug Name	Drug Tier	Requirements/Limits
EVOTAZ	5	QL (30 EA per 30 days) NDS
<i>fosamprenavir calcium</i>	5	NDS
INVIRASE TABS	5	NDS
KALETRA SOLN	5	NDS
KALETRA TABS 100MG; 25MG	3	
KALETRA TABS 200MG; 50MG	5	NDS
LEXIVA SUSP	3	
LEXIVA TABS	5	NDS
<i>lopinavir/ritonavir</i>	5	NDS
NORVIR PACK, SOLN	3	
NORVIR TABS	4	
PREZCOBIX	5	QL (30 EA per 30 days) NDS
PREZISTA SUSP	5	NDS
PREZISTA TABS 75MG	3	
PREZISTA TABS 150MG, 600MG, 800MG	5	NDS
REYATAZ	5	NDS
<i>ritonavir</i>	2	
SYMTUZA	5	QL (30 EA per 30 days) NDS
VIRACEPT	5	NDS
Anti-influenza Agents		
<i>amantadine hcl caps, syrp, tabs</i>	2	
<i>oseltamivir phosphate caps 75mg</i>	2	QL (110 EA per 365 days)
<i>oseltamivir phosphate caps 30mg</i>	2	QL (168 EA per 365 days)
<i>oseltamivir phosphate caps 45mg</i>	2	QL (84 EA per 365 days)
<i>oseltamivir phosphate susr</i>	2	QL (1080 ML per 365 days)
Antiherpetic Agents		
<i>acyclovir caps</i>	1	
<i>acyclovir susp</i>	2	
<i>acyclovir tabs 800mg</i>	1	
<i>acyclovir tabs 400mg</i>	2	
<i>valacyclovir hcl tabs 1gm</i>	2	QL (120 EA per 30 days)
<i>valacyclovir hydrochloride tabs 500mg</i>	2	QL (120 EA per 30 days)
Anxiolytics		
Anxiolytics, Other		
<i>bupirone hcl tabs 30mg</i>	1	
<i>bupirone hcl tabs 15mg</i>	2	
<i>bupirone hydrochloride tabs 10mg, 7.5mg</i>	1	
<i>bupirone hydrochloride tabs 5mg</i>	2	
<i>meprobamate</i>	2	
Benzodiazepines		
<i>alprazolam er tb24 2mg</i>	2	QL (150 EA per 30 days)
<i>alprazolam er tb24 0.5mg, 1mg</i>	2	QL (30 EA per 30 days)
<i>alprazolam er tb24 3mg</i>	2	QL (90 EA per 30 days)
ALPRAZOLAM INTENSOL	2	
<i>alprazolam odt tbdp 0.25mg, 0.5mg, 1mg</i>	2	QL (120 EA per 30 days)
<i>alprazolam odt tbdp 2mg</i>	2	QL (150 EA per 30 days)
<i>alprazolam tabs 0.25mg, 0.5mg, 1mg</i>	1	QL (120 EA per 30 days)
<i>alprazolam tabs 2mg</i>	1	QL (150 EA per 30 days)
ATIVAN TABS 2MG	5	QL (150 EA per 30 days) NDS

Drug Name	Drug Tier	Requirements/Limits
ATIVAN TABS 0.5MG, 1MG	5	QL (90 EA per 30 days) NDS
<i>chlordiazepoxide hcl caps 10mg</i>	1	QL (900 EA per 30 days)
<i>chlordiazepoxide hcl caps 5mg</i>	2	QL (120 EA per 30 days)
<i>chlordiazepoxide hydrochloride</i>	1	QL (360 EA per 30 days)
<i>clorazepate dipotassium tabs 15mg</i>	2	QL (180 EA per 30 days)
<i>clorazepate dipotassium tabs 7.5mg</i>	2	QL (360 EA per 30 days)
<i>clorazepate dipotassium tabs 3.75mg</i>	2	QL (720 EA per 30 days)
DIAZEPAM SOLN	2	
<i>diazepam conc</i>	2	
<i>diazepam tabs 10mg</i>	1	QL (120 EA per 30 days)
<i>diazepam tabs 5mg</i>	1	QL (240 EA per 30 days)
<i>diazepam tabs 2mg</i>	1	QL (300 EA per 30 days)
<i>lorazepam intensol</i>	2	
<i>lorazepam tabs 2mg</i>	1	QL (150 EA per 30 days)
<i>lorazepam tabs 0.5mg, 1mg</i>	1	QL (90 EA per 30 days)
OXAZEPAM	2	QL (120 EA per 30 days)
TRANXENE T TABS 7.5MG	4	QL (360 EA per 30 days)
VALIUM TABS 10MG	4	QL (120 EA per 30 days)
VALIUM TABS 5MG	4	QL (240 EA per 30 days)
VALIUM TABS 2MG	4	QL (300 EA per 30 days)
XANAX XR TB24 2MG	4	QL (150 EA per 30 days)
XANAX XR TB24 0.5MG, 1MG	4	QL (30 EA per 30 days)
XANAX XR TB24 3MG	4	QL (90 EA per 30 days)
XANAX TABS 0.25MG, 0.5MG, 1MG	4	QL (120 EA per 30 days)
XANAX TABS 2MG	5	QL (150 EA per 30 days) NDS
Bipolar Agents		
<i>Mood Stabilizers</i>		
EQUETRO	3	
LITHIUM	2	
<i>lithium carbonate er</i>	2	
LITHIUM CARBONATE CAPS 600MG	2	
<i>lithium carbonate caps 150mg, 300mg</i>	1	
<i>lithium carbonate tabs</i>	1	
LITHOBID	4	
Blood Glucose Regulators		
<i>Antidiabetic Agents</i>		
BYDUREON BCISE	4	QL (3.4 ML per 28 days) ST
BYDUREON PEN	4	QL (4 EA per 28 days) ST
BYETTA INJ 10MCG/0.04ML	4	QL (2.4 ML per 28 days) ST
BYETTA INJ 5MCG/0.02ML	4	QL (4.8 ML per 28 days) ST
FARXIGA	3	ST
<i>glimepiride</i>	1	
GLYXAMBI	3	ST
INVOKAMET	3	ST
INVOKAMET XR	3	ST
INVOKANA	3	ST
JANUMET	3	ST
JANUMET XR	3	ST
JANUVIA	3	ST

Drug Name	Drug Tier	Requirements/Limits
JARDIANCE	3	ST
JENTADUETO	3	ST
JENTADUETO XR	3	ST
KOMBIGLYZE XR	3	ST
<i>metformin hydrochloride er tb24 500mg, 750mg</i>	1	
<i>metformin hydrochloride er tb24 1000mg, 500mg</i>	2	
<i>metformin hydrochloride er tb24 1000mg, 500mg</i>	5	PA NDS
<i>metformin hydrochloride tabs</i>	1	
<i>metformin hydrochloride soln</i>	2	
ONGLYZA	3	ST
OZEMPIC INJ 2MG/1.5ML	3	QL (1.5 ML per 28 days) ST NDS
OZEMPIC INJ 2MG/1.5ML	3	QL (3 ML per 28 days) ST
QTERN	3	ST
RYBELSUS TABS 14MG, 7MG	3	QL (30 EA per 30 days)
RYBELSUS TABS 3MG	3	QL (60 EA per 365 days)
SEGLUROMET	3	ST
SOLIQUA 100/33	3	ST
STEGLATRO	3	ST
STEGLUJAN	3	ST
SYNJARDY	3	ST
SYNJARDY XR	3	ST
TRADJENTA	3	ST
TRIJARDY XR	3	ST
TRULICITY	3	QL (2 ML per 28 days) ST
XIGDUO XR	3	ST
XULTOPHY 100/3.6	5	ST NDS
Glycemic Agents		
BAQSIMI TWO PACK	3	
<i>diazoxide susp</i>	5	NDS
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
GVOKE PFS	3	
PROGLYCEM	5	NDS
Insulins		
ADMELOG	4	ST
ADMELOG SOLOSTAR	4	ST
AFREZZA POWD 0, 12UNIT, 4UNIT, 8UNIT	3	PA
AFREZZA POWD 0	5	PA NDS
APIDRA	3	
APIDRA SOLOSTAR	3	
BASAGLAR KWIKPEN	3	ST
FIASP	3	ST
FIASP FLEXTOUCH	3	ST
FIASP PENFILL	3	ST
HUMALOG	3	
HUMALOG JUNIOR KWIKPEN	3	
HUMALOG KWIKPEN	3	
HUMALOG MIX 50/50	3	
HUMALOG MIX 50/50 KWIKPEN	3	

Drug Name	Drug Tier	Requirements/Limits
HUMALOG MIX 75/25	3	
HUMALOG MIX 75/25 KWIKPEN	3	
HUMULIN 70/30	3	
HUMULIN 70/30 KWIKPEN	3	
HUMULIN N	3	
HUMULIN N KWIKPEN	3	
HUMULIN R	3	
HUMULIN R U-500 (CONCENTRATED)	5	NDS
HUMULIN R U-500 KWIKPEN	5	NDS
INSULIN ASPART	3	
INSULIN ASPART FLEXPEN	3	
INSULIN ASPART PENFILL	3	
INSULIN ASPART PROTAMINE/INSULIN ASPART	3	
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	3	
INSULIN LISPRO	3	
INSULIN LISPRO JUNIOR KWIKPEN	3	
INSULIN LISPRO KWIKPEN	3	
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN	3	
LANTUS	3	
LANTUS SOLOSTAR	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70/30	3	
NOVOLIN N	3	
NOVOLIN N FLEXPEN	3	
NOVOLIN R	3	
NOVOLIN R FLEXPEN	3	
NOVOLOG	3	
NOVOLOG FLEXPEN	3	
NOVOLOG MIX 70/30	3	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	
NOVOLOG PENFILL	3	
TOUJEO MAX SOLOSTAR	3	
TOUJEO SOLOSTAR	3	
TRESIBA	3	
TRESIBA FLEXTOUCH	3	

Blood Products and Modifiers

Anticoagulants

ELIQUIS STARTER PACK	3	QL (148 EA per 365 days)
ELIQUIS TABS 2.5MG	3	QL (60 EA per 30 days)
ELIQUIS TABS 5MG	3	QL (90 EA per 30 days)
FRAGMIN INJ 2500UNIT/0.2ML	3	QL (7 ML per 90 days)
FRAGMIN INJ 7500UNIT/0.3ML	5	QL (10.5 ML per 90 days) NDS
FRAGMIN INJ 12500UNIT/0.5ML	5	QL (17.5 ML per 90 days) NDS
FRAGMIN INJ 15000UNIT/0.6ML	5	QL (21 ML per 90 days) NDS
FRAGMIN INJ 95000UNIT/3.8ML	5	QL (22.8 ML per 90 days) NDS
FRAGMIN INJ 18000UNT/0.72ML	5	QL (25.3 ML per 90 days) NDS

Drug Name	Drug Tier	Requirements/Limits
FRAGMIN INJ 10000UNIT/ML	5	QL (35 ML per 90 days) NDS
FRAGMIN INJ 5000UNIT/0.2ML	5	QL (7 ML per 90 days) NDS
<i>jantoven tabs 10mg, 2.5mg, 2mg, 3mg, 4mg, 5mg, 6mg</i>	1	
<i>jantoven tabs 1mg, 7.5mg</i>	2	
PRADAXA	4	QL (60 EA per 30 days)
<i>warfarin sodium tabs 10mg, 2.5mg, 2mg, 3mg, 4mg, 5mg, 6mg</i>	1	
<i>warfarin sodium tabs 1mg, 7.5mg</i>	2	
XARELTO STARTER PACK	3	QL (102 EA per 365 days)
XARELTO TABS 10MG, 20MG	3	QL (30 EA per 30 days)
XARELTO TABS 15MG, 2.5MG	3	QL (60 EA per 30 days)
Blood Products and Modifiers, Other		
<i>anagrelide hydrochloride</i>	2	
ARANESP ALBUMIN FREE INJ 10MCG/0.4ML, 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML	3	PA
ARANESP ALBUMIN FREE INJ 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 300MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML	5	PA NDS
EPOGEN INJ 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
EPOGEN INJ 20000UNIT/ML	5	PA NDS
NEULASTA	5	PA NDS
NEUPOGEN	5	ST NDS
PROCRIT INJ 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
PROCRIT INJ 20000UNIT/ML, 40000UNIT/ML	5	PA NDS
PROMACTA TABS	5	PA NDS
PROMACTA PACK 12.5MG	5	PA NDS
RETACRIT INJ 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
RETACRIT INJ 40000UNIT/ML	5	PA NDS
UDENYCA	5	PA NDS
ZARXIO	5	NDS
Hemostasis Agents		
LYSTEDA	4	
<i>tranexamic acid tabs</i>	2	
Platelet Modifying Agents		
BRILINTA	3	
<i>clopidogrel tabs 75mg</i>	2	
TAVALISSE	5	PA NDS
Cardiovascular Agents		
Alpha-adrenergic Agonists		
<i>clonidine hcl tabs 0.1mg, 0.3mg</i>	1	
<i>clonidine hydrochloride tabs 0.2mg</i>	1	
<i>midodrine hcl</i>	2	
Alpha-adrenergic Blocking Agents		
<i>phenoxybenzamine hydrochloride</i>	5	NDS
<i>prazosin hcl caps 1mg, 5mg</i>	2	
<i>prazosin hydrochloride caps 2mg</i>	2	

Drug Name	Drug Tier	Requirements/Limits
Angiotensin II Receptor Antagonists		
EDARBI	3	
<i>irbesartan tabs 300mg</i>	1	
<i>losartan potassium tabs</i>	1	
<i>valsartan</i>	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
<i>lisinopril tabs</i>	1	
<i>ramipril caps 10mg, 2.5mg, 5mg</i>	1	
<i>ramipril caps 1.25mg</i>	2	
Antiarrhythmics		
<i>amiodarone hcl tabs 200mg, 400mg</i>	2	
<i>amiodarone hydrochloride tabs 100mg</i>	2	
<i>digitek</i>	2	
<i>digox</i>	2	
DIGOXIN SOLN	2	
<i>digoxin tabs 125mcg, 250mcg</i>	2	
<i>flecainide acetate</i>	2	
MULTAQ	3	
<i>pacerone tabs 200mg</i>	2	
<i>pacerone tabs 100mg, 400mg</i>	4	
Beta-adrenergic Blocking Agents		
BYSTOLIC	3	
<i>carvedilol</i>	1	
<i>metoprolol succinate er</i>	2	
Calcium Channel Blocking Agents, Dihydropyridines		
<i>amlodipine besylate tabs</i>	1	
<i>nifedipine er</i>	2	
<i>nifedipine caps</i>	2	
Calcium Channel Blocking Agents, Nondihydropyridines		
<i>cartia xt</i>	2	
<i>diltiazem hydrochloride er cp24 120mg, 180mg, 240mg, 300mg</i>	2	
<i>matzim la</i>	2	
<i>verapamil hcl er tbc</i>	2	
<i>verapamil hcl sr cp24 120mg, 180mg, 240mg</i>	2	
<i>verapamil hcl tabs 80mg</i>	1	
<i>verapamil hcl tabs 40mg</i>	2	
<i>verapamil hydrochloride tabs</i>	1	
Cardiovascular Agents, Other		
<i>acetazolamide tabs 250mg</i>	2	
BIDIL	3	
CORLANOR TABS	3	QL (60 EA per 30 days) PA
EDARBYCLOR	3	
ENTRESTO	3	QL (60 EA per 30 days)
<i>lisinopril/hydrochlorothiazide</i>	1	
<i>losartan potassium/hydrochlorothiazide</i>	1	
<i>ranolazine er</i>	2	
<i>triamterene/hydrochlorothiazide caps 25mg; 37.5mg</i>	2	
<i>triamterene/hydrochlorothiazide tabs</i>	1	

Drug Name	Drug Tier	Requirements/Limits
Diuretics, Loop		
<i>bumetanide inj</i>	2	
<i>bumetanide tabs 1mg</i>	1	
<i>bumetanide tabs 0.5mg, 2mg</i>	2	
<i>furosemide inj</i>	2	
FUROSEMIDE ORAL SOLN 8MG/ML	2	
<i>furosemide oral soln 10mg/ml</i>	2	
<i>furosemide tabs 40mg, 80mg</i>	1	
Diuretics, Potassium-sparing		
<i>eplerenone</i>	2	
<i>spironolactone tabs 100mg, 25mg</i>	1	
<i>spironolactone tabs 50mg</i>	2	
Diuretics, Thiazide		
<i>chlorthalidone tabs 25mg, 50mg</i>	2	
<i>hydrochlorothiazide caps, tabs</i>	1	
Dyslipidemics, Fibrin Acid Derivatives		
FENOFIBRATE CAPS 150MG, 50MG	2	
<i>fenofibrate tabs 54mg</i>	1	
<i>fenofibrate tabs 120mg, 145mg, 160mg, 40mg, 48mg</i>	2	
<i>gemfibrozil tabs</i>	2	
Dyslipidemics, HMG CoA Reductase Inhibitors		
<i>atorvastatin calcium</i>	1	
LIVALO	3	ST
<i>simvastatin tabs</i>	1	
Dyslipidemics, Other		
<i>ezetimibe</i>	2	
<i>omega-3-acid ethyl esters</i>	2	PA
PRALUENT	3	QL (2 ML per 28 days) PA
REPATHA	3	QL (3 ML per 28 days) PA
REPATHA PUSHTRONEX SYSTEM	3	QL (3.5 ML per 28 days) PA
REPATHA SURECLICK	3	QL (3 ML per 28 days) PA
VASCEPA	3	PA
Vasodilators, Direct-acting Arterial/Venous		
<i>isosorbide mononitrate</i>	2	
<i>isosorbide mononitrate er</i>	1	
<i>minitran</i>	2	
NITRO-BID	3	
<i>nitroglycerin lingual soln</i>	2	
<i>nitroglycerin transdermal</i>	2	
<i>nitroglycerin subl 0.3mg, 0.4mg, 0.6mg</i>	2	
Vasodilators, Direct-acting Arterial		
<i>hydralazine hcl tabs 10mg</i>	1	
<i>hydralazine hydrochloride tabs 25mg, 50mg</i>	1	
<i>hydralazine hydrochloride tabs 100mg</i>	2	
<i>minoxidil tabs</i>	2	
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		

Drug Name	Drug Tier	Requirements/Limits
ADDERALL TABS 1.25MG; 1.25MG; 1.25MG; 1.25MG, 1.875MG; 1.875MG; 1.875MG; 1.875MG, 5MG; 5MG; 5MG; 5MG	4	QL (90 EA per 30 days) ST
<i>amphetamine/dextroamphetamine cp24</i>	2	QL (30 EA per 30 days)
<i>amphetamine/dextroamphetamine tabs</i>	2	QL (90 EA per 30 days)
VYVANSE	3	QL (30 EA per 30 days) PA
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
<i>atomoxetine caps 100mg, 18mg, 25mg, 40mg, 60mg, 80mg</i>	2	QL (30 EA per 30 days)
<i>atomoxetine caps 10mg</i>	2	QL (60 EA per 30 days)
<i>methylphenidate hydrochloride cd cpcr 20mg, 30mg, 50mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er (la)</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er cp24 10mg, 20mg, 30mg, 40mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er cpcr 10mg, 40mg, 60mg</i>	2	QL (30 EA per 30 days)
METHYLPHENIDATE HYDROCHLORIDE ER TB24 18MG	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er tb24 27mg, 54mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er tb24 36mg</i>	2	QL (60 EA per 30 days)
METHYLPHENIDATE HYDROCHLORIDE ER TBCR 72MG	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er tbcr 10mg</i>	2	QL (180 EA per 30 days)
<i>methylphenidate hydrochloride er tbcr 18mg, 27mg, 54mg</i>	2	QL (30 EA per 30 days)
<i>methylphenidate hydrochloride er tbcr 36mg</i>	2	QL (60 EA per 30 days)
<i>methylphenidate hydrochloride er tbcr 20mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hydrochloride chew 10mg</i>	2	QL (180 EA per 30 days)
<i>methylphenidate hydrochloride chew 2.5mg, 5mg</i>	2	QL (90 EA per 30 days)
<i>methylphenidate hydrochloride soln</i>	2	
<i>methylphenidate hydrochloride tabs</i>	2	QL (90 EA per 30 days)
<i>relexxii</i>	2	QL (30 EA per 30 days)
Central Nervous System, Other		
ALLZITAL	5	NDS
AUSTEDO	5	QL (120 EA per 30 days) PA NDS
<i>bupap tabs 300mg; 50mg</i>	5	NDS
<i>butalbital/acetaminophen/caffeine caps 300mg; 50mg; 40mg</i>	2	
<i>butalbital/acetaminophen/caffeine caps 325mg; 50mg; 40mg</i>	4	
<i>butalbital/acetaminophen/caffeine tabs 325mg; 50mg; 40mg</i>	2	
BUTALBITAL/ACETAMINOPHEN CAPS	5	NDS
<i>butalbital/acetaminophen tabs 325mg; 50mg</i>	2	
<i>butalbital/aspirin/caffeine caps</i>	2	
ESGIC TABS	4	
FIORICET CAPS	4	
INGREZZA CAPS 80MG	5	QL (30 EA per 30 days) PA NDS
INGREZZA CAPS 40MG	5	QL (60 EA per 30 days) PA NDS
NUEDEXTA	3	PA
TENCON TABS 325MG; 50MG	2	
<i>vanatol lq</i>	5	NDS
<i>zebutal caps 325mg; 50mg; 40mg</i>	4	
Fibromyalgia Agents		

Drug Name	Drug Tier	Requirements/Limits
LYRICA CR TB24 330MG	3	QL (60 EA per 30 days)
LYRICA CR TB24 165MG, 82.5MG	3	QL (90 EA per 30 days)
SAVELLA	3	QL (60 EA per 30 days)
SAVELLA TITRATION PACK	3	QL (110 EA per 365 days)
Multiple Sclerosis Agents		
AMPYRA	5	QL (60 EA per 30 days) PA NDS
AUBAGIO	5	QL (30 EA per 30 days) PA NDS
AVONEX PEN	5	QL (4 EA per 28 days) PA NDS
AVONEX INJ 30MCG/0.5ML	5	QL (4 EA per 28 days) PA NDS
BETASERON	5	QL (15 EA per 30 days) PA NDS
EXTAVIA	5	QL (15 EA per 30 days) PA NDS
GILENYA CAPS 0.5MG	5	QL (30 EA per 30 days) PA NDS
<i>glatiramer acetate inj 40mg/ml</i>	5	QL (12 ML per 28 days) PA NDS
<i>glatiramer acetate inj 20mg/ml</i>	5	QL (30 ML per 30 days) PA NDS
<i>glatopa inj 40mg/ml</i>	5	QL (12 ML per 28 days) PA NDS
<i>glatopa inj 20mg/ml</i>	5	QL (30 ML per 30 days) PA NDS
MAYZENT TABS 0.25MG	5	QL (120 EA per 30 days) PA NDS
MAYZENT TABS 2MG	5	QL (30 EA per 30 days) PA NDS
REBIF	5	QL (6 ML per 28 days) PA NDS
REBIF REBIDOSE	5	QL (6 ML per 28 days) PA NDS
REBIF REBIDOSE TITRATION PACK	5	QL (8.4 ML per 365 days) PA NDS
REBIF TITRATION PACK	5	QL (8.4 ML per 365 days) PA NDS
TECFIDERA	5	QL (60 EA per 30 days) PA NDS
TECFIDERA STARTER PACK	5	QL (120 EA per 365 days) PA NDS
Dental and Oral Agents		
Dental and Oral Agents		
<i>cevimeline hydrochloride</i>	2	
<i>chlorhexidine gluconate soln</i>	1	
<i>doxycycline hyclate tabs 20mg</i>	2	
Dermatological Agents		
Acne and Rosacea Agents		
FINACEA FOAM	3	
<i>metronidazole</i>	2	
<i>tretinoin crea 0.025%, 0.05%, 0.1%</i>	2	PA
<i>tretinoin gel 0.01%, 0.025%, 0.05%</i>	2	PA
Dermatitis and Pruitus Agents		
<i>clobetasol propionate</i>	2	
<i>clodan</i>	2	
EUCRISA	3	PA
<i>triamcinolone acetonide crea 0.025%, 0.1%</i>	1	
<i>triamcinolone acetonide crea 0.5%</i>	2	
<i>triamcinolone acetonide aers, lotn</i>	2	
<i>triamcinolone acetonide oint 0.025%, 0.1%</i>	1	
<i>triamcinolone acetonide oint 0.05%, 0.5%</i>	2	
<i>trianex</i>	5	NDS
<i>triderm crea 0.1%</i>	1	
Dermatological Agents, Other		
ALDARA	4	
CARAC	5	NDS

Drug Name	Drug Tier	Requirements/Limits
<i>clotrimazole/betamethasone dipropionate crea</i>	1	
<i>clotrimazole/betamethasone dipropionate lotn</i>	2	
EFUDEX CREA	4	
FLUOROURACIL SOLN	2	
<i>fluorouracil crea 5%</i>	2	
<i>imiquimod crea</i>	2	
REGRANEX	5	PA NDS
SANTYL	3	
Pediculicides/Scabicides		
<i>permethrin crea</i>	2	
SKLICE	3	
Topical Anti-infectives		
<i>clindamycin phosphate foam, lotn, soln</i>	2	
<i>clindamycin phosphate gel</i>	3	
<i>mupirocin oint</i>	2	
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
<i>klor-con m10</i>	2	
KLOR-CON M15	3	
<i>klor-con m20</i>	2	
<i>potassium chloride cr tbcr 10meq</i>	2	
<i>potassium chloride er tbcr 20meq</i>	2	
<i>sodium chloride inj 0.45%, 0.9%, 3%</i>	2	
Electrolyte/Mineral/Metal Modifiers		
<i>deferasirox tbso</i>	5	PA NDS
<i>deferasirox tabs 360mg, 90mg</i>	5	PA NDS
<i>sodium polystyrene sulfonate powd 0</i>	2	
Phosphate Binders		
<i>calcium acetate caps</i>	2	
<i>calcium acetate tabs 667mg</i>	2	
<i>sevelamer carbonate tabs</i>	2	
<i>sevelamer carbonate pack</i>	5	NDS
VELPHORO	5	NDS
Potassium Binders		
<i>kionex</i>	2	
LOKELMA	3	QL (90 EA per 30 days)
<i>sodium polystyrene sulfonate susp 15gm/60ml</i>	2	
<i>sps</i>	2	
VELTASSA	5	NDS
Vitamins		
PRENATAL TABS 120MG; 0; 0; 200MG; 400UNIT; 2MG; 12MCG; 27MG; 1MG; 20MG; 10MG; 3MG; 1.84MG; 22MG; 4000UNIT; 25MG	2	
Gastrointestinal Agents		
Anti-Constipation Agents		
AMITIZA	3	QL (60 EA per 30 days)
<i>constulose</i>	2	
KRISTALOSE	3	ST
LACTULOSE PACK	2	

Drug Name	Drug Tier	Requirements/Limits
<i>lactulose soln</i>	2	
LINZESS	3	QL (30 EA per 30 days)
MOVANTIK	3	QL (30 EA per 30 days)
Anti-Diarrheal Agents		
DIPHENOXYLATE/ATROPINE LIQD	2	
<i>diphenoxylate/atropine tabs</i>	2	
<i>loperamide hcl caps</i>	2	
Antispasmodics, Gastrointestinal		
<i>dicyclomine hcl soln</i>	2	
<i>dicyclomine hydrochloride caps, tabs</i>	1	
<i>glycopyrrolate tabs 1mg, 2mg</i>	2	
Gastrointestinal Agents, Other		
CLENPIQ	3	
<i>gavilyte-n/ flavor pack</i>	2	
<i>metoclopramide hcl tabs 5mg</i>	1	
<i>metoclopramide hydrochloride tabs</i>	1	
METOCLOPRAMIDE ODT	2	
<i>peg-3350/nacl/na bicarbonate/kcl</i>	2	
SUPREP BOWEL PREP KIT	3	
<i>trilyte</i>	2	
XIFAXAN	5	PA NDS
Histamine2 (H2) Receptor Antagonists		
<i>cimetidine tabs</i>	2	
<i>famotidine susr</i>	2	
<i>famotidine tabs 20mg, 40mg</i>	1	
PEPCID TABS 20MG	4	
PEPCID TABS 40MG	5	NDS
Protectants		
<i>misoprostol</i>	2	
<i>sucrafate susp, tabs</i>	2	
Proton Pump Inhibitors		
DEXILANT	3	QL (30 EA per 30 days)
NEXIUM PACK	3	QL (60 EA per 30 days)
NEXIUM CPDR	4	QL (60 EA per 30 days)
<i>omeprazole dr cpdr 10mg</i>	2	QL (60 EA per 30 days)
<i>omeprazole cpdr 20mg, 40mg</i>	1	QL (60 EA per 30 days)
<i>pantoprazole sodium tbec</i>	1	QL (60 EA per 30 days)
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
CREON CPEP 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	
PANCREAZE CPEP 10850UNIT; 2600UNIT; 6200UNIT, 24600UNIT; 4200UNIT; 14200UNIT, 61500UNIT; 10500UNIT; 35500UNIT, 98400UNIT; 16800UNIT; 56800UNIT	3	ST

Drug Name	Drug Tier	Requirements/Limits
PANCREAZE CPEP 83900UNIT; 21000UNIT; 54700UNIT	5	ST NDS
PERTZYE CPEP 15125UNIT; 4000UNIT; 14375UNIT, 30250UNIT; 8000UNIT; 28750UNIT	3	ST
PERTZYE CPEP 60500UNIT; 16000UNIT; 57500UNIT	5	ST NDS
PROLASTIN-C INJ 1000MG	5	PA NDS
<i>sodium phenylbutyrate powd, tabs</i>	5	NDS
VIOKACE TABS 39150UNIT; 10440UNIT; 39150UNIT	3	ST
VIOKACE TABS 78300UNIT; 20880UNIT; 78300UNIT	5	ST NDS
VYNDAQEL	5	QL (120 EA per 30 days) PA NDS
ZENPEP CPEP 105000UNIT; 25000UNIT; 79000UNIT, 14000UNIT; 3000UNIT; 10000UNIT, 168000UNIT; 40000UNIT; 126000UNIT, 24000UNIT; 5000UNIT; 17000UNIT, 42000UNIT; 10000UNIT; 32000UNIT, 63000UNIT; 15000UNIT; 47000UNIT, 84000UNIT; 20000UNIT; 63000UNIT	3	
Genitourinary Agents		
<i>Antispasmodics, Urinary</i>		
MYRBETRIQ	3	ST
<i>oxybutynin chloride er</i>	2	
<i>oxybutynin chloride syrps, tabs</i>	2	
<i>tolterodine tartrate</i>	2	
<i>tolterodine tartrate er</i>	2	
TOVIAZ	3	ST
<i>Benign Prostatic Hypertrophy Agents</i>		
<i>finasteride tabs</i>	2	
<i>tamsulosin hydrochloride</i>	2	
<i>Genitourinary Agents, Other</i>		
<i>bethanechol chloride tabs</i>	2	
ELMIRON	5	NDS
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</i>		
<i>methylprednisolone dose pack tbpk</i>	2	
<i>methylprednisolone tabs</i>	2	
PREDNISON INTENSOL	2	
PREDNISON SOLN	2	
<i>prednisone tbpk</i>	2	
<i>prednisone tabs 10mg, 2.5mg, 50mg, 5mg</i>	1	
<i>prednisone tabs 1mg</i>	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</i>		
<i>desmopressin acetate tabs</i>	2	
GENOTROPIN	5	PA NDS
GENOTROPIN MINIQUICK INJ 0.2MG	3	PA
GENOTROPIN MINIQUICK INJ 0.4MG, 0.6MG, 0.8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 1MG, 2MG	5	PA NDS
HUMATROPE COMBO PACK	5	PA NDS
HUMATROPE INJ 12MG, 24MG, 6MG	5	PA NDS
NORDITROPIN FLEXPRO	5	PA NDS
NUTROPIN AQ NUSPIN 10	5	PA NDS

Drug Name	Drug Tier	Requirements/Limits
NUTROPIN AQ NUSPIN 20	5	PA NDS
NUTROPIN AQ NUSPIN 5	5	PA NDS
OMNITROPE	5	PA NDS
ZOMACTON INJ 5MG	3	PA
ZOMACTON INJ 10MG	5	PA NDS
Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)</i>		
KORLYM	5	QL (120 EA per 30 days) PA NDS
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
<i>Anabolic Steroids</i>		
ANADROL-50	5	PA NDS
<i>oxandrolone tabs 2.5mg</i>	2	QL (240 EA per 30 days) PA
<i>oxandrolone tabs 10mg</i>	5	QL (60 EA per 30 days) PA NDS
<i>Androgens</i>		
ANDRODERM PT24 2MG/24HR, 4MG/24HR	3	PA
<i>danazol caps</i>	2	
TESTOSTERONE PUMP GEL 1%	2	PA
<i>testosterone topical solution</i>	2	PA
<i>testosterone gel</i>	2	PA
XYOSTED	3	PA
<i>Estrogens</i>		
ESTRACE CREA	4	
<i>estradiol crea, tabs</i>	2	
IMVEXXY MAINTENANCE PACK	3	PA
IMVEXXY STARTER PACK	3	PA
MENEST TABS 0.3MG, 0.625MG, 1.25MG	3	
PREMARIN CREA	3	
PREMARIN TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	3	
PREMPHASE	3	
PREMPRO	3	
<i>yuvafem</i>	2	
<i>Progestins</i>		
DEPO-PROVERA INJ 400MG/ML	3	QL (10 ML per 28 days)
<i>medroxyprogesterone acetate tabs</i>	1	
<i>megestrol acetate susp, tabs</i>	2	PA
<i>progesterone caps</i>	2	
<i>Selective Estrogen Receptor Modifying Agents</i>		
DUAVEE	3	
OSPHENA	3	QL (30 EA per 30 days) PA
<i>raloxifene hydrochloride</i>	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</i>		
<i>levothyroxine sodium tabs</i>	2	
<i>liothyronine sodium tabs</i>	2	
Hormonal Agents, Suppressant (Adrenal)		

Drug Name	Drug Tier	Requirements/Limits
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	5	NDS
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
<i>cabergoline</i>	2	
ELIGARD INJ 30MG	3	QL (1 EA per 112 days) PA
ELIGARD INJ 45MG	3	QL (1 EA per 168 days) PA
ELIGARD INJ 7.5MG	3	QL (1 EA per 28 days) PA
ELIGARD INJ 22.5MG	3	QL (1 EA per 84 days) PA
FIRMAGON INJ 80MG	3	QL (1 EA per 28 days) PA
FIRMAGON INJ 120MG/VIAL	5	QL (4 EA per 365 days) PA NDS
<i>leuprolide acetate inj</i>	5	PA NDS
LUPRON DEPOT (1-MONTH)	5	QL (1 EA per 28 days) PA NDS
LUPRON DEPOT (3-MONTH)	5	QL (1 EA per 84 days) PA NDS
LUPRON DEPOT (4-MONTH)	5	QL (1 EA per 112 days) PA NDS
LUPRON DEPOT (6-MONTH)	5	QL (1 EA per 168 days) PA NDS
<i>octreotide acetate inj 100mcg/ml, 200mcg/ml, 50mcg/ml</i>	2	PA
<i>octreotide acetate inj 1000mcg/ml, 500mcg/ml</i>	5	PA NDS
ORLISSA TABS 150MG	5	QL (30 EA per 30 days) PA NDS
ORLISSA TABS 200MG	5	QL (60 EA per 30 days) PA NDS
SOMATULINE DEPOT INJ 120MG/0.5ML	5	PA NDS
TRELSTAR MIXJECT INJ 22.5MG	5	QL (1 EA per 168 days) PA NDS
TRELSTAR MIXJECT INJ 3.75MG	5	QL (1 EA per 28 days) PA NDS
TRELSTAR MIXJECT INJ 11.25MG	5	QL (1 EA per 84 days) PA NDS
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
<i>methimazole tabs 10mg, 5mg</i>	1	
<i>propylthiouracil tabs</i>	2	
TAPAZOLE	4	
Immunological Agents		
Angioedema Agents		
BERINERT	5	PA NDS
<i>icatibant acetate</i>	5	PA NDS
RUCONEST	5	PA NDS
TAKHZYRO	5	PA NDS
Immunoglobulins		
FLEBOGAMMA DIF INJ 5GM/50ML	5	PA NDS
GAMMAGARD LIQUID INJ 2.5GM/25ML	5	PA NDS
GAMMAGARD S/D IGA LESS THAN 1MCG/ML	5	PA NDS
GAMMAKED INJ 1GM/10ML	5	PA NDS
GAMMAPLEX INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 5GM/50ML	5	PA NDS
GAMUNEX-C INJ 1GM/10ML	5	PA NDS
OCTAGAM INJ 1GM/20ML, 2GM/20ML	5	PA NDS
PANZYGA	5	PA NDS
PRIVIGEN INJ 20GM/200ML	5	PA NDS
Immunological Agents, Other		
COSENTYX	5	PA NDS
COSENTYX SENSOREADY PEN	5	PA NDS

Drug Name	Drug Tier	Requirements/Limits
OTEZLA	5	PA NDS
SKYRIZI	5	PA NDS
XELJANZ	5	PA NDS
XELJANZ XR	5	PA NDS
Immunostimulants		
ACTIMMUNE	5	PA NDS
INTRON A	5	PA NDS
PEGASYS	5	PA NDS
PEGASYS PROCLICK INJ 180MCG/0.5ML	5	PA NDS
SYLATRON INJ 200MCG, 300MCG	5	PA NDS
Immunosuppressants		
ASTAGRAF XL CP24 0.5MG, 1MG	3	B/D
ASTAGRAF XL CP24 5MG	5	B/D NDS
AZASAN	3	B/D
<i>azathioprine tabs</i>	2	B/D
CELLCEPT	5	B/D NDS
<i>cyclosporine modified</i>	2	B/D
<i>cyclosporine caps</i>	2	B/D
ENBREL	5	PA NDS
ENBREL MINI	5	PA NDS
ENBREL SURECLICK	5	PA NDS
ENVARUSUS XR TB24 0.75MG, 1MG	3	B/D
ENVARUSUS XR TB24 4MG	5	B/D NDS
<i>everolimus tabs 0.25mg, 0.5mg, 0.75mg</i>	5	PA NDS
<i>gengraf caps 100mg, 25mg</i>	2	B/D
<i>gengraf soln</i>	2	B/D
HUMIRA	5	PA NDS
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJ 0, 80MG/0.8ML	5	PA NDS
HUMIRA PEN	5	PA NDS
HUMIRA PEN-CD/UC/HS STARTER	5	PA NDS
HUMIRA PEN-PS/UV STARTER	5	PA NDS
IMURAN TABS	4	B/D
<i>leflunomide</i>	2	
<i>methotrexate sodium inj 50mg/2ml</i>	2	
<i>methotrexate tabs</i>	2	
<i>methotrexate inj 50mg/2ml</i>	2	
<i>mycophenolate mofetil caps, tabs</i>	2	B/D
<i>mycophenolate mofetil susr</i>	5	B/D NDS
<i>mycophenolic acid dr</i>	2	B/D
MYFORTIC	5	B/D NDS
NEORAL	4	B/D
PROGRAF CAPS 0.5MG, 1MG	4	B/D
PROGRAF CAPS 5MG	5	B/D NDS
PROGRAF PACK 0.2MG	3	B/D
PROGRAF PACK 1MG	5	B/D NDS
RAPAMUNE SOLN	5	B/D NDS
RAPAMUNE TABS 0.5MG	4	B/D
RAPAMUNE TABS 1MG, 2MG	5	B/D NDS

Drug Name	Drug Tier	Requirements/Limits
RASUVO INJ 7.5MG/0.15ML	3	QL (0.6 ML per 28 days) PA
RASUVO INJ 10MG/0.2ML	3	QL (0.8 ML per 28 days) PA
RASUVO INJ 12.5MG/0.25ML	3	QL (1 ML per 28 days) PA
RASUVO INJ 15MG/0.3ML	3	QL (1.2 ML per 28 days) PA
RASUVO INJ 17.5MG/0.35ML	3	QL (1.4 ML per 28 days) PA
RASUVO INJ 20MG/0.4ML	3	QL (1.6 ML per 28 days) PA
RASUVO INJ 22.5MG/0.45ML	3	QL (1.8 ML per 28 days) PA
RASUVO INJ 25MG/0.5ML	3	QL (2 ML per 28 days) PA
RASUVO INJ 30MG/0.6ML	3	QL (2.4 ML per 28 days) PA
SANDIMMUNE SOLN	5	B/D NDS
SANDIMMUNE CAPS 25MG	4	B/D
SANDIMMUNE CAPS 100MG	5	B/D NDS
<i>sirolimus soln</i>	5	B/D NDS
<i>sirolimus tabs 0.5mg, 1mg</i>	2	B/D
<i>sirolimus tabs 2mg</i>	5	B/D NDS
<i>tacrolimus caps</i>	2	B/D
TREXALL	3	
XATMEP	3	
ZORTRESS	5	PA NDS
Vaccines		
ADACEL	3	
BOOSTRIX	3	
SHINGRIX	3	
Inflammatory Bowel Disease Agents		
Aminosalicylates		
APRISO	4	
<i>balsalazide disodium</i>	2	
COLAZAL	5	NDS
DIPENTUM	5	NDS
<i>mesalamine dr tbec</i>	2	
<i>mesalamine dr cpdr</i>	2	ST
<i>mesalamine er</i>	2	
<i>mesalamine enem</i>	2	
<i>mesalamine supp</i>	5	NDS
PENTASA CPCR 250MG	3	
PENTASA CPCR 500MG	5	NDS
<i>sulfasalazine tabs, tbec</i>	2	
Glucocorticoids		
ANUSOL-HC CREA	4	
<i>budesonide er</i>	5	ST NDS
<i>budesonide cpep</i>	2	
<i>procto-med hc</i>	2	
<i>procto-pak</i>	2	
<i>proctosol hc</i>	2	
<i>proctozone-hc</i>	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
ALENDRONATE SODIUM SOLN	2	
<i>alendronate sodium tabs 35mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>alendronate sodium tabs 70mg</i>	1	QL (4 EA per 28 days)
<i>alendronate sodium tabs 10mg</i>	2	
BINOSTO	3	QL (4 EA per 28 days)
FORTEO INJ 600MCG/2.4ML	5	PA NDS
<i>ibandronate sodium tabs</i>	2	QL (1 EA per 28 days)
PROLIA	3	QL (2 ML per 365 days)
RAYALDEE	5	NDS
SENSIPAR TABS 60MG, 90MG	5	NDS
Miscellaneous Therapeutic Agents		
<i>Miscellaneous Therapeutic Agents</i>		
ALCOHOL PREP PADS	1	
BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	1	QL (200 EA per 30 days)
Ophthalmic Agents		
<i>Ophthalmic Agents, Other</i>		
CEQUA	3	PA
COMBIGAN	3	
COSOPT	4	
COSOPT PF	4	
<i>dorzolamide hcl/timolol maleate</i>	3	
<i>dorzolamide hydrochloride/timolol maleate pf</i>	2	
<i>polymyxin b sulfate/trimethoprim sulfate</i>	1	
RESTASIS	3	
ROCKLATAN	3	QL (2.5 ML per 25 days)
SIMBRINZA	3	
TOBRADEX ST	3	
<i>tobramycin/dexamethasone</i>	2	
XIIDRA	3	QL (60 EA per 30 days) ST
ZYLET	3	
<i>Ophthalmic Anti-allergy Agents</i>		
BEPREVE	3	
<i>epinastine hcl</i>	2	
LASTACAFT	3	
<i>olopatadine hcl</i>	2	
<i>olopatadine hydrochloride soln 0.2%</i>	2	
<i>Ophthalmic Anti-Infectives</i>		
<i>erythromycin</i>	1	
<i>ofloxacin ophthalmic soln 0.3%</i>	2	
<i>tobramycin sulfate</i>	1	
ZIRGAN	3	
<i>Ophthalmic Anti-inflammatories</i>		
ALREX	3	
DUREZOL	3	
ILEVRO	3	QL (6 ML per 30 days)
INVELTYS	3	
<i>ketorolac tromethamine</i>	2	
LOTEMAX SM	3	QL (20 GM per 365 days)
LOTEMAX OINT	3	QL (14 GM per 365 days)
LOTEMAX GEL	3	QL (20 GM per 365 days)

Drug Name	Drug Tier	Requirements/Limits
NEVANAC	3	QL (6 ML per 30 days)
PREDNISOLONE ACETATE	2	
PROLENSA	3	QL (12 ML per 365 days)
Ophthalmic Beta-Adrenergic Blocking Agents		
BETIMOL	3	
LEVOBUNOLOL HCL SOLN 0.5%	2	
<i>timolol maleate ophthalmic gel forming</i>	2	
<i>timolol maleate soln 0.25%, 0.5%</i>	1	
<i>timolol maleate soln 0.5%</i>	2	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
<i>acetazolamide tabs 125mg</i>	2	
ALPHAGAN P SOLN 0.1%	3	
AZOPT	3	
<i>brimonidine tartrate</i>	2	
<i>dorzolamide hcl</i>	3	
RHOPRESSA	3	QL (2.5 ML per 25 days)
Ophthalmic Prostaglandin and Prostanoid Analogs		
<i>bimatoprost</i>	2	QL (5 ML per 30 days)
<i>latanoprost soln</i>	1	
LUMIGAN	3	QL (2.5 ML per 25 days)
VYZULTA	4	QL (5 ML per 25 days)
ZIOPTAN	4	QL (30 EA per 30 days)
Otic Agents		
Otic Agents		
CIPRODEX	3	
<i>neomycin/polymyxin/hc</i>	2	
<i>neomycin/polymyxin/hydrocortisone susp</i>	2	
<i>ofloxacin otic soln 0.3%</i>	2	
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	3	QL (30 EA per 30 days)
ASMANEX HFA AERO 100MCG/ACT, 200MCG/ACT	3	QL (13 GM per 30 days)
ASMANEX TWISTHALER 120 METERED DOSES	3	QL (1 EA per 30 days)
ASMANEX TWISTHALER 30 METERED DOSES	3	QL (1 EA per 30 days)
ASMANEX TWISTHALER 60 METERED DOSES	3	QL (1 EA per 30 days)
FLOVENT DISKUS AEPB 250MCG/BLIST	3	QL (240 EA per 30 days)
FLOVENT DISKUS AEPB 100MCG/BLIST, 50MCG/BLIST	3	QL (60 EA per 30 days)
FLOVENT HFA AERO 44MCG/ACT	3	QL (21.2 GM per 30 days)
FLOVENT HFA AERO 110MCG/ACT, 220MCG/ACT	3	QL (24 GM per 30 days)
<i>fluticasone propionate</i>	1	
<i>mometasone furoate</i>	2	QL (34 GM per 30 days)
PULMICORT FLEXHALER	3	QL (2 EA per 30 days) ST
QVAR REDHALER	3	QL (21.2 GM per 30 days) ST
Antihistamines		
<i>azelastine hcl soln 0.15%</i>	2	QL (60 ML per 30 days)
<i>azelastine hydrochloride soln 0.1%</i>	2	QL (60 ML per 30 days)
DYMISTA	3	QL (23 GM per 30 days)
<i>levocetirizine dihydrochloride soln, tabs</i>	2	
Antileukotrienes		

Drug Name	Drug Tier	Requirements/Limits
<i>montelukast sodium chew 5mg</i>	1	
<i>montelukast sodium chew 4mg</i>	2	
<i>montelukast sodium tabs</i>	1	
<i>montelukast sodium pack</i>	2	
<i>zafirlukast</i>	2	
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	QL (25.8 GM per 30 days)
INCRUSE ELLIPTA	3	QL (30 EA per 30 days)
<i>ipratropium bromide soln</i>	2	
LONHALA MAGNAIR REFILL KIT	5	QL (60 ML per 30 days) NDS
SPIRIVA HANDIHALER	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT AERS 2.5MCG/ACT	3	QL (8 GM per 28 days)
SPIRIVA RESPIMAT AERS 1.25MCG/ACT	3	QL (8 GM per 30 days)
YUPELRI	5	QL (90 ML per 30 days) B/D NDS
Bronchodilators, Sympathomimetic		
ALBUTEROL SULFATE ER	2	
ALBUTEROL SULFATE HFA AERS 108MCG/ACT	3	QL (48 GM per 30 days)
<i>albuterol sulfate hfa aers 108mcg/act</i>	2	QL (13.4 GM per 30 days)
<i>albuterol sulfate hfa aers 108mcg/act</i>	2	QL (17 GM per 30 days)
<i>albuterol sulfate syrp, tabs</i>	2	
<i>albuterol sulfate nebu 2.5mg/0.5ml</i>	2	QL (100 EA per 30 days) B/D
<i>albuterol sulfate nebu 0.63mg/3ml, 1.25mg/3ml</i>	2	QL (375 ML per 30 days) B/D
<i>albuterol sulfate nebu 0.083%</i>	2	QL (525 ML per 30 days) B/D
EPINEPHRINE INJ 0.15MG/0.15ML, 0.3MG/0.3ML	2	
<i>epinephrine inj 0.15mg/0.3ml, 0.3mg/0.3ml</i>	2	
PROAIR HFA	4	QL (17 GM per 30 days)
PROAIR RESPICLICK	3	QL (2 EA per 30 days)
SEREVENT DISKUS	3	QL (60 EA per 30 days)
VENTOLIN HFA	3	QL (48 GM per 30 days)
Cystic Fibrosis Agents		
CAYSTON	5	PA NDS
TOBI	5	B/D NDS
TOBI PODHALER	5	QL (224 EA per 56 days) NDS
<i>tobramycin</i>	5	B/D NDS
TRIKAFTA	5	QL (84 EA per 28 days) PA NDS
Mast Cell Stabilizers		
<i>cromolyn sodium nebu</i>	2	B/D
Phosphodiesterase Inhibitors, Airways Disease		
DALIRESP	3	PA
THEO-24	3	
<i>theophylline er tb24</i>	2	
THEOPHYLLINE ER TB12 300MG	2	
<i>theophylline soln</i>	2	
Pulmonary Antihypertensives		
ADCIRCA	5	QL (60 EA per 30 days) PA NDS
ADEMPAS	5	QL (90 EA per 30 days) PA NDS
LETAIRIS	5	QL (30 EA per 30 days) PA NDS
OPSUMIT	5	QL (30 EA per 30 days) PA NDS
ORENITRAM TBCR 0.125MG	3	PA

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM TBCR 0.25MG, 1MG, 2.5MG, 5MG	5	PA NDS
<i>sildenafil citrate tabs</i>	2	QL (90 EA per 30 days) PA
<i>sildenafil citrate susr</i>	5	PA NDS
UPTRAVI TBPK	5	QL (400 EA per 365 days) PA NDS
UPTRAVI TABS	5	QL (60 EA per 30 days) PA NDS
Pulmonary Fibrosis Agents		
ESBRIET	5	PA NDS
OFEV	5	PA NDS
Respiratory Tract Agents, Other		
ADVAIR DISKUS	4	QL (60 EA per 30 days) ST
ADVAIR HFA	4	QL (24 GM per 30 days) ST
ANORO ELLIPTA	3	QL (60 EA per 30 days)
BEVESPI AEROSPHERE	3	QL (10.7 GM per 30 days) ST
BREO ELLIPTA	3	QL (60 EA per 30 days)
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
DULERA AERO 5MCG/ACT; 100MCG/ACT, 5MCG/ACT; 200MCG/ACT	3	QL (17.6 GM per 30 days) ST
FASENRA	5	PA NDS
FLUTICASONE PROPIONATE/SALMETEROL	3	QL (1 EA per 30 days)
<i>fluticasone propionate/salmeterol diskus</i>	2	QL (60 EA per 30 days)
NUCALA INJ 100MG	5	QL (3 EA per 28 days) PA NDS
STIOLTO RESPIMAT	3	QL (24 GM per 30 days)
SYMBICORT AERO 160MCG/ACT; 4.5MCG/ACT	3	QL (12 GM per 30 days)
SYMBICORT AERO 80MCG/ACT; 4.5MCG/ACT	3	QL (13.8 GM per 30 days)
TRELEGY ELLIPTA	3	QL (60 EA per 30 days)
<i>wixela inhub</i>	2	QL (60 EA per 30 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
<i>cyclobenzaprine hydrochloride er</i>	2	PA
<i>cyclobenzaprine hydrochloride tabs</i>	2	PA
FEXMID	4	PA
<i>methocarbamol tabs</i>	2	PA
Sleep Disorder Agents		
Sleep Promoting Agents		
BELSOMRA	3	QL (30 EA per 30 days)
<i>eszopiclone</i>	2	QL (30 EA per 30 days)
<i>temazepam</i>	2	QL (30 EA per 30 days)
<i>zolpidem tartrate er</i>	2	QL (30 EA per 30 days)
<i>zolpidem tartrate tabs</i>	1	QL (30 EA per 30 days)
<i>zolpidem tartrate subl</i>	2	QL (30 EA per 30 days)
Wakefulness Promoting Agents		
<i>armodafinil tabs 150mg, 200mg, 250mg</i>	2	QL (30 EA per 30 days) PA
<i>armodafinil tabs 50mg</i>	2	QL (60 EA per 30 days) PA
<i>modafinil</i>	2	QL (30 EA per 30 days) PA

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<i>valproic acid</i>	4
<i>valsartan</i>	23
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XPOVIO 60 MG ONCE WEEKLY	11
XPOVIO 80 MG ONCE WEEKLY	11
XPOVIO 80 MG TWICE WEEKLY	11
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<i>ziprasidone hcl</i>	15
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This abridged formulary was updated on August 7, 2020. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact the HOP Administration Unit at 1-800-773-7725, or for TTY users, 1-800-498-5428, 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, or visit www.HOPbenefits.com.

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