

# Health Options Program

## Abridged Gold5 Prescription Drug Formulary for the Value Medicare Rx Option *(Partial List of Covered Drugs)*

# 2022

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

This Abridged Gold5 Prescription Drug Formulary for the Value Medicare Rx Option (PDP) was updated on August 5, 2021. This is not a complete list of drugs covered by our plan. 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 [HOPbenefits.com](http://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 Value Medicare Rx Option.

This document includes a partial list of the drugs (formulary) for the plan, which is current as of August 5, 2021. 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, 2023, and from time to time during the year.

### ***What is the Value Medicare Rx Option Abridged Formulary?***

A formulary is a list of covered drugs selected by the Value Medicare Rx Option 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 Value Medicare Rx Option 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 Value Medicare Rx Option. For a complete listing of all prescription drugs covered by the Value Medicare Rx Option, please visit our website at [HOPbenefits.com](http://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 Value Medicare Rx Option only. If you have coverage through the Enhanced or Basic 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 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 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 find information in the section below titled "How do I request an exception to the Value Medicare Rx Option 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 Value Medicare Rx Option Formulary?"

The enclosed formulary is current as of August 5, 2021. To get updated information about the drugs covered by the Value Medicare Rx Option, 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 Value Medicare Rx Option will be posted to 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 21. 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 Value Medicare Rx Option covers 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 Value Medicare Rx Option requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from the Value Medicare Rx Option before you fill your prescriptions. If you don't get approval, the Value Medicare Rx Option may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, the Value Medicare Rx Option limits the amount of the drug that will be covered. For example, the Value Medicare Rx Option covers 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 Value Medicare Rx Option requires 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 Value Medicare Rx Option 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 Value 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 Value Medicare Rx Option 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 Value Medicare Rx Option 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 Value Medicare Rx Option does not cover your drug, you have two options:

- You can ask OptumRx for a list of similar drugs that are covered by the Value Medicare Rx Option. 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 Value Medicare Rx Option Formulary?***

You can ask the Value Medicare Rx Option 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 Value Medicare Rx Option limits 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 Value 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, tier, or utilization restriction exception. **When you request a formulary, tier, 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 Value Medicare Rx Option and filled at a network pharmacy.

### **For more information**

For more detailed information about the Value Medicare Rx Option prescription drug coverage, please review your *Evidence of Coverage for the Value Medicare Rx Option* and other plan materials. If you have questions about the Value Medicare Rx Option, 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 [medicare.gov](http://medicare.gov).

### **Value Medicare Rx Option Abridged Prescription Drug Formulary**

The abridged formulary that begins on page 1 provides coverage information about some of the drugs covered by the Value Medicare Rx Option.

If you have trouble finding your drug in the list, turn to the Index that begins on page 21.

**Remember:** This is only a partial listing of drugs covered by the Value Medicare Rx Option. 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 Value Medicare Rx Option has 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.

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

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

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**QL: Quantity Limit.** The Value Medicare Rx Option limits the amount of this drug that will be covered. See page iii for more information.

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**ST: Step Therapy.** The Value Medicare Rx Option requires 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.

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# 2022 Abridged Gold5 Prescription Drug Formulary

## DEDUCTIBLE

- In general, you must pay the annual deductible of \$480 before the Value Medicare Rx Option pays any portion of your prescription drug costs.

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## PREFERRED GENERIC DRUGS (TIER 1)

- In Initial Coverage, you'll pay a maximum of \$2 for up to a 30-day supply (and a maximum of up to \$6 for a 31- to 90-day supply) of preferred generic drugs without having to satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, you'll pay the greater of \$3.95 or 5%.

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## GENERIC DRUGS (TIER 2)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, you'll pay the greater of \$3.95 or 5%.

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## PREFERRED BRAND-NAME DRUGS

(TIER 3)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, you'll pay the greater of \$9.85 or 5%.

## NON-PREFERRED BRAND-NAME DRUGS (TIER 4)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, you'll pay the greater of \$9.85 or 5%.

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## SPECIALTY DRUGS (TIER 5)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, you'll pay the greater of \$3.95 or 5% for a **generic** prescription; you'll pay the greater of \$9.85 or 5% for a **brand** prescription.
- Specialty drugs are limited to a 30-day supply.

Drug Name	Drug Tier	Requirements/Limits
<b>Analgesics</b>		
<b>Nonsteroidal Anti-inflammatory Drugs</b>		
celecoxib caps 100mg, 200mg, 400mg	2	QL (60 EA per 30 days)
celecoxib caps 50mg	3	QL (60 EA per 30 days)
diclofenac sodium dr	2	
diclofenac sodium gel	2	QL (1000 GM per 30 days)
ibuprofen tabs 400mg, 600mg, 800mg	1	
meloxicam tabs	1	
nabumetone tabs	2	
naproxen tabs 250mg, 375mg, 500mg	1	
<b>Opioid Analgesics, Long-acting</b>		
fentanyl pt72 100mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr	2	NDS
morphine sulfate er tbc 100mg, 15mg, 30mg, 60mg	2	NDS
morphine sulfate er tbc 200mg	3	NDS
XTAMPZA ER	3	NDS
<b>Opioid Analgesics, Short-acting</b>		
acetaminophen/codeine tabs	2	NDS
hydrocodone bitartrate/acetaminophen tabs 325mg; 10mg, 325mg; 5mg	2	NDS
hydrocodone/acetaminophen tabs 325mg; 7.5mg	2	NDS
hydromorphone hcl tabs 2mg, 4mg	2	NDS
hydromorphone hcl tabs 8mg	4	NDS
morphine sulfate tabs	2	NDS
morphine sulfate soln	3	NDS
oxycodone hydrochloride tabs 10mg, 15mg, 5mg	2	NDS
oxycodone hydrochloride tabs 20mg, 30mg	3	NDS
oxycodone/acetaminophen tabs 325mg; 5mg, 325mg; 7.5mg	2	NDS
oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg	3	NDS
tramadol hcl tabs	1	NDS
<b>Anesthetics</b>		
<b>Local Anesthetics</b>		
lidocaine/prilocaine crea	3	QL (30 GM per 30 days) PA
lidocaine oint 5%	4	QL (150 GM per 30 days) PA
lidocaine ptch 5%	4	PA
<b>Anti-Addiction/Substance Abuse Treatment Agents</b>		
<b>Opioid Reversal Agents</b>		
naloxone hcl inj 0.4mg/ml	2	
NARCAN LIQD	3	
<b>Antibacterials</b>		
<b>Antibacterials, Other</b>		
clindamycin hcl caps 150mg	2	
methenamine hippurate	2	
metronidazole tabs 250mg, 500mg	1	
nitrofurantoin monohydrate caps	2	
XENLETA TABS	5	
<b>Beta-lactam, Cephalosporins</b>		
cefadroxil caps	2	
cefdinir caps	2	
cefpodoxime proxetil tabs	4	



Drug Name	Drug Tier	Requirements/Limits
<i>cefuroxime axetil tabs</i>	2	
<i>cephalexin caps 250mg, 500mg</i>	2	
<b>Beta-lactam, Penicillins</b>		
<i>amoxicillin/clavulanate potassium tabs 500mg; 125mg, 875mg; 125mg</i>	2	
<i>amoxicillin/clavulanate potassium tabs 250mg; 125mg</i>	4	
<i>amoxicillin caps, tabs</i>	1	
<i>penicillin v potassium tabs</i>	2	
<b>Carbapenems</b>		
<i>ertapenem</i>	4	
<i>imipenem/cilastatin</i>	4	
<b>Macrolides</b>		
<i>azithromycin tabs 250mg</i>	1	
<i>azithromycin tabs 500mg, 600mg</i>	3	
DIFICID TABS	5	
<b>Quinolones</b>		
<i>ciprofloxacin hydrochloride</i>	1	
<i>levofloxacin tabs</i>	2	
<b>Sulfonamides</b>		
<i>sulfadiazine tabs</i>	4	
<i>sulfamethoxazole/trimethoprim ds</i>	1	
<i>sulfamethoxazole/trimethoprim tabs</i>	1	
<i>sulfamethoxazole/trimethoprim susp</i>	3	
<b>Tetracyclines</b>		
<i>doxycycline hyclate caps 100mg</i>	2	
<i>doxycycline hyclate caps 50mg</i>	3	
<i>doxycycline hyclate tabs 100mg</i>	2	
<i>doxycycline monohydrate tabs 100mg</i>	2	
<i>doxycycline monohydrate tabs 50mg</i>	3	
<b>Anticonvulsants</b>		
<b>Anticonvulsants, Other</b>		
BRIVIACT SOLN, TABS	5	PA
FYCOMPA SUSP	4	
FYCOMPA TABS 2MG	4	
FYCOMPA TABS 10MG, 12MG, 4MG, 6MG, 8MG	5	
<i>lamotrigine tabs</i>	1	
<i>levetiracetam tabs</i>	1	
NAYZILAM	5	QL (10 EA per 30 days)
<i>topiramate tabs</i>	1	
XCOPRI TABS 100MG, 150MG, 50MG	4	PA
XCOPRI TABS 200MG	5	PA
XCOPRI TBPK 0	4	PA
XCOPRI TBPK 0	5	PA
<b>Gamma-aminobutyric Acid (GABA) Augmenting Agents</b>		
<i>clonazepam tabs 2mg</i>	1	QL (300 EA per 30 days)
<i>clonazepam tabs 0.5mg, 1mg</i>	1	QL (90 EA per 30 days)
<i>divalproex sodium dr</i>	2	
<i>divalproex sodium er</i>	2	
<i>gabapentin caps 100mg, 300mg</i>	1	QL (360 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>gabapentin caps 400mg</i>	2	QL (270 EA 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)
<i>primidone tabs</i>	2	
<b>Sodium Channel Agents</b>		
<i>carbamazepine tabs</i>	3	
<i>oxcarbazepine tabs</i>	2	
<i>phenytoin sodium extended</i>	2	
VIMPAT SOLN	5	
VIMPAT TABS 50MG	4	
VIMPAT TABS 100MG, 150MG, 200MG	5	
<b>Antidementia Agents</b>		
<b>Antidementia Agents, Other</b>		
NAMZARIC CP24	4	QL (30 EA per 30 days) ST
NAMZARIC C4PK	4	QL (56 EA per 365 days) ST
<b>Cholinesterase Inhibitors</b>		
<i>donepezil hcl tabs 10mg</i>	1	
<i>donepezil hcl tabs 23mg</i>	4	
<i>donepezil hydrochloride tabs 10mg, 5mg</i>	1	
<i>rivastigmine tartrate caps 1.5mg, 3mg, 6mg</i>	2	
<i>rivastigmine tartrate caps 4.5mg</i>	3	
<b>N-methyl-D-aspartate (NMDA) Receptor Antagonist</b>		
<i>memantine hydrochloride er</i>	4	QL (30 EA per 30 days)
<i>memantine hydrochloride tabs</i>	2	
<b>Antidepressants</b>		
<b>Antidepressants, Other</b>		
<i>bupropion hcl tabs 100mg</i>	2	
<i>bupropion hydrochloride er (sr) tb12 150mg, 200mg</i>	1	QL (60 EA per 30 days)
<i>bupropion hydrochloride er (sr) tb12 100mg</i>	1	QL (90 EA per 30 days)
<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>mirtazapine tabs</i>	2	
<b>SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor)</b>		
<i>citalopram hydrobromide tabs</i>	1	
<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)
<i>duloxetine hcl cpep 30mg</i>	2	QL (90 EA per 30 days)
<i>duloxetine hydrochloride cpep 20mg, 60mg</i>	2	QL (60 EA per 30 days)
<i>escitalopram oxalate tabs</i>	1	
<i>fluoxetine hcl caps 20mg</i>	1	
<i>fluoxetine hydrochloride caps 10mg, 40mg</i>	1	
<i>paroxetine hcl tabs 30mg, 40mg</i>	2	
<i>paroxetine hydrochloride tabs 10mg, 20mg</i>	2	
<i>sertraline hcl tabs 25mg, 50mg</i>	1	
<i>sertraline hydrochloride tabs 100mg</i>	1	
<i>trazodone hydrochloride tabs 100mg, 150mg, 50mg</i>	2	
TRINTELLIX	4	QL (30 EA per 30 days)
<i>venlafaxine hcl</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>venlafaxine hcl er cp24 150mg, 37.5mg</i>	2	
<i>venlafaxine hydrochloride er cp24 75mg</i>	2	
VIIBRYD STARTER PACK	4	QL (60 EA per 365 days)
VIIBRYD TABS	4	QL (30 EA per 30 days)
<b>Tricyclics</b>		
<i>amitriptyline hcl tabs 100mg, 150mg, 75mg</i>	4	PA
<i>amitriptyline hydrochloride tabs 10mg, 25mg, 50mg</i>	4	PA
<i>nortriptyline hcl caps 25mg, 75mg</i>	2	
<i>nortriptyline hydrochloride caps 10mg, 50mg</i>	2	
<b>Antiemetics</b>		
<b>Antiemetics, Other</b>		
<i>meclizine hcl tabs 12.5mg</i>	4	
<i>prochlorperazine maleate tabs</i>	2	
<b>Emetogenic Therapy Adjuncts</b>		
<i>ondansetron hydrochloride tabs</i>	1	B/D
<i>ondansetron odt</i>	2	B/D
<b>Antifungals</b>		
<b>Antifungals</b>		
<i>fluconazole tabs</i>	2	
JUBLIA	5	
<i>ketoconazole crea, sham</i>	2	
<i>nystatin crea, susp</i>	2	
<i>nystop</i>	3	
<i>terbinafine hcl tabs</i>	2	QL (84 EA per 180 days)
<b>Antigout Agents</b>		
<b>Antigout Agents</b>		
<i>allopurinol tabs</i>	1	
COLCHICINE TABS 0.6MG	3	
<i>febuxostat</i>	4	
<b>Antimigraine Agents</b>		
<b>Prophylactic</b>		
AIMOVIG INJ 140MG/ML	4	QL (1 ML per 30 days) PA
AIMOVIG INJ 70MG/ML	4	QL (2 ML per 30 days) PA
EMGALITY INJ 120MG/ML	4	QL (1 ML per 30 days) PA
EMGALITY INJ 100MG/ML	4	QL (3 ML per 30 days) PA
<b>Serotonin (5-HT) Receptor Agonist</b>		
<i>sumatriptan succinate tabs</i>	2	QL (9 EA per 30 days)
<b>Antineoplastics</b>		
<b>Antiandrogens</b>		
<i>abiraterone acetate</i>	5	PA
ERLEADA	5	PA
NUBEQA	5	PA
XTANDI	5	PA
<b>Antiangiogenic Agents</b>		
REVLIMID	5	PA
<b>Antiestrogens/Modifiers</b>		
<i>tamoxifen citrate tabs</i>	2	
<b>Antimetabolites</b>		
<i>hydroxyurea caps</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<b>Aromatase Inhibitors, 3rd Generation</b>		
<i>anastrozole tabs</i>	1	
<i>letrozole</i>	2	
<b>Molecular Target Inhibitors</b>		
CALQUENCE	5	PA
IMBRUVICA	5	PA
ODOMZO	5	PA
SPRYCEL	5	PA
TASIGNA	5	PA
<b>Monoclonal Antibody/Antibody-Drug Conjugate</b>		
MVASI	5	PA
RUXIENCE	5	PA
RYBREVANT	5	PA
TRAZIMERA	5	PA
ZIRABEV	5	PA
<b>Retinoids</b>		
TARGRETIN GEL	5	PA
<b>Antiparasitics</b>		
<b>Antiprotozoals</b>		
<i>hydroxychloroquine sulfate tabs</i>	2	
<i>primaquine phosphate tabs</i>	3	
<b>Antiparkinson Agents</b>		
<b>Anticholinergics</b>		
<i>benztropine mesylate tabs</i>	2	
<b>Dopamine Agonists</b>		
KYNMOBI	5	QL (150 EA per 30 days) PA
KYNMOBI TITRATION KIT	5	QL (20 EA per 365 days) PA
NEUPRO	4	ST
<i>pramipexole dihydrochloride</i>	2	
<i>ropinirole hcl tabs 0.5mg, 1mg, 2mg, 4mg, 5mg</i>	2	
<i>ropinirole hydrochloride tabs 0.25mg, 3mg</i>	2	
<b>Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors</b>		
<i>carbidopa/levodopa</i>	2	
<i>carbidopa/levodopa er</i>	3	
INBRIJA	5	PA
RYTARY	4	ST
<b>Antipsychotics</b>		
<b>2nd Generation/Atypical</b>		
ABILIFY MAINTENA	5	
<i>aripiprazole tabs</i>	2	QL (30 EA per 30 days)
ARISTADA	5	
ARISTADA INITIO	5	
INVEGA SUSTENNA INJ 39MG/0.25ML	4	
INVEGA SUSTENNA INJ 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	5	
INVEGA TRINZA	5	
LATUDA TABS 120MG, 20MG, 40MG, 60MG	5	QL (30 EA per 30 days)
LATUDA TABS 80MG	5	QL (60 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olanzapine tabs</i>	2	QL (30 EA per 30 days)
PERSERIS	5	
<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)
<i>risperidone tabs</i>	1	QL (60 EA per 30 days)
<b>Treatment-Resistant</b>		
<i>clozapine tabs 25mg</i>	2	QL (270 EA per 30 days)
<i>clozapine tabs 50mg</i>	3	QL (180 EA per 30 days)
<i>clozapine tabs 200mg</i>	4	QL (120 EA per 30 days)
<i>clozapine tabs 100mg</i>	4	QL (270 EA per 30 days)
<b>Antispasticity Agents</b>		
<b>Antispasticity Agents</b>		
<i>baclofen tabs 10mg, 20mg</i>	2	
<i>baclofen tabs 5mg</i>	3	
<i>tizanidine hcl tabs 2mg</i>	2	
<i>tizanidine hydrochloride tabs 4mg</i>	2	
<b>Antivirals</b>		
<b>Anti-hepatitis C (HCV) Agents</b>		
MAVYRET	5	QL (336 EA per 365 days) PA
VOSEVI	5	QL (84 EA per 365 days) PA
<b>Anti-HIV Agents, Integrase Inhibitors (INSTI)</b>		
ISENTRESS TABS	5	
TIVICAY TABS 10MG	4	
TIVICAY TABS 25MG, 50MG	5	
<b>Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)</b>		
<i>abacavir sulfate/lamivudine</i>	4	QL (30 EA per 30 days)
<b>Anti-HIV Agents, Protease Inhibitors (PI)</b>		
PREZISTA SUSP	5	
REYATAZ PACK	5	
<b>Anti-influenza Agents</b>		
<i>oseltamivir phosphate caps 75mg</i>	3	QL (110 EA per 365 days)
<i>oseltamivir phosphate caps 30mg</i>	3	QL (168 EA per 365 days)
<i>oseltamivir phosphate caps 45mg</i>	3	QL (84 EA per 365 days)
<i>oseltamivir phosphate susr</i>	3	QL (1080 ML per 365 days)
XOFLUZA TBPk 20MG, 40MG	3	QL (4 EA per 365 days)
<b>Antiherpetic Agents</b>		
<i>acyclovir tabs</i>	2	
<i>valacyclovir hcl tabs 1gm</i>	3	QL (120 EA per 30 days)
<i>valacyclovir hydrochloride tabs 500mg</i>	3	QL (120 EA per 30 days)
<b>Anxiolytics</b>		
<b>Anxiolytics, Other</b>		
<i>bupirone hcl tabs 15mg</i>	1	
<i>bupirone hcl tabs 30mg</i>	4	
<i>bupirone hydrochloride tabs 10mg, 5mg</i>	1	
<i>bupirone hydrochloride tabs 7.5mg</i>	4	
<b>Benzodiazepines</b>		
<i>alprazolam tabs 0.25mg, 0.5mg, 1mg</i>	1	QL (120 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>alprazolam tabs 2mg</i>	1	QL (150 EA per 30 days)
<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 tabs 2mg</i>	1	QL (150 EA per 30 days)
<i>lorazepam tabs 0.5mg, 1mg</i>	1	QL (90 EA per 30 days)
<b>Blood Glucose Regulators</b>		
<b><i>Antidiabetic Agents</i></b>		
FARXIGA	3	
<i>glimepiride</i>	1	
<i>glipizide er</i>	1	
<i>glipizide tabs</i>	1	
GLYXAMBI	3	
INVOKAMET	4	ST
INVOKAMET XR	4	ST
INVOKANA	4	ST
JANUMET	3	
JANUMET XR	3	
JANUVIA	3	
JARDIANCE	3	
JENTADUETO	3	
JENTADUETO XR	3	
<i>metformin hydrochloride er tb24 500mg, 750mg</i>	1	
<i>metformin hydrochloride tabs</i>	1	
OZEMPIC INJ 2MG/1.5ML	3	QL (1.5 ML per 28 days)
OZEMPIC INJ 2MG/1.5ML, 4MG/3ML	3	QL (3 ML per 28 days)
<i>pioglitazone hcl tabs 45mg</i>	1	
<i>pioglitazone hydrochloride tabs 15mg, 30mg</i>	1	
RYBELSUS TABS 14MG, 7MG	3	QL (30 EA per 30 days)
RYBELSUS TABS 3MG	3	QL (60 EA per 365 days)
SYNJARDY	3	
SYNJARDY XR	3	
TRADJENTA	3	
TRIJARDY XR	3	
TRULICITY	3	QL (2 ML per 28 days)
VICTOZA	3	QL (9 ML per 30 days)
XIGDUO XR	3	
<b><i>Glycemic Agents</i></b>		
BAQSIMI ONE PACK	3	
GLUCAGON EMERGENCY KIT	3	
GVOKE HYPOPEN 1-PACK	3	
GVOKE HYPOPEN 2-PACK	3	
GVOKE PFS	3	
<b><i>Insulins</i></b>		
HUMALOG	3	
HUMALOG JUNIOR KWIKPEN	3	
HUMALOG KWIKPEN	3	
HUMALOG MIX 50/50	3	
HUMALOG MIX 50/50 KWIKPEN	3	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)	3	
HUMULIN R U-500 KWIKPEN	3	
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	
LYUMJEV	3	
LYUMJEV KWIKPEN	3	
NOVOLIN 70/30	3	
NOVOLIN 70/30 FLEXPEN	3	
NOVOLIN 70/30 RELION	3	
NOVOLIN N	3	
NOVOLIN N FLEXPEN	3	
NOVOLIN N RELION	3	
NOVOLIN R	3	
NOVOLIN R FLEXPEN	3	
NOVOLIN R RELION	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	
<b>Blood Products and Modifiers</b>		
<i>Anticoagulants</i>		
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)

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin sodium inj 30mg/0.3ml</i>	4	QL (10.5 ML per 90 days)
<i>enoxaparin sodium inj 300mg/3ml</i>	4	QL (105 ML per 90 days)
<i>enoxaparin sodium inj 40mg/0.4ml</i>	4	QL (14 ML per 90 days)
<i>enoxaparin sodium inj 60mg/0.6ml</i>	4	QL (21 ML per 90 days)
<i>enoxaparin sodium inj 120mg/0.8ml, 80mg/0.8ml</i>	4	QL (28 ML per 90 days)
<i>enoxaparin sodium inj 100mg/ml, 150mg/ml</i>	4	QL (35 ML per 90 days)
FRAGMIN INJ 2500UNIT/0.2ML	4	QL (7 ML per 90 days)
FRAGMIN INJ 7500UNIT/0.3ML	5	QL (10.5 ML per 90 days)
FRAGMIN INJ 12500UNIT/0.5ML	5	QL (17.5 ML per 90 days)
FRAGMIN INJ 15000UNIT/0.6ML	5	QL (21 ML per 90 days)
FRAGMIN INJ 95000UNIT/3.8ML	5	QL (22.8 ML per 90 days)
FRAGMIN INJ 18000UNIT/0.72ML	5	QL (25.3 ML per 90 days)
FRAGMIN INJ 10000UNIT/ML	5	QL (35 ML per 90 days)
FRAGMIN INJ 5000UNIT/0.2ML	5	QL (7 ML per 90 days)
<i>warfarin sodium tabs</i>	1	
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)
<b>Blood Products and Modifiers, Other</b>		
NEULASTA	5	PA
NEULASTA ONPRO KIT	5	PA
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA
PROCRIT INJ 10000UNIT/ML, 20000UNIT/ML, 40000UNIT/ML	5	PA
ZARXIO	5	
<b>Platelet Modifying Agents</b>		
BRILINTA	3	
<i>clopidogrel tabs 75mg</i>	1	
<i>clopidogrel tabs 300mg</i>	2	
<b>Cardiovascular Agents</b>		
<b>Alpha-adrenergic Agonists</b>		
<i>clonidine hcl ptwk</i>	3	
<i>clonidine hydrochloride tabs</i>	1	
<i>midodrine hcl</i>	2	
<b>Alpha-adrenergic Blocking Agents</b>		
<i>prazosin hydrochloride caps</i>	2	
<i>terazosin hcl caps 10mg, 1mg, 5mg</i>	1	
<i>terazosin hydrochloride caps 2mg</i>	1	
<b>Angiotensin II Receptor Antagonists</b>		
<i>candesartan cilexetil</i>	1	
EDARBI	4	
<i>irbesartan</i>	1	
<i>losartan potassium tabs</i>	1	
<i>olmesartan medoxomil tabs</i>	2	
<i>telmisartan</i>	1	
<i>valsartan</i>	1	
<b>Angiotensin-converting Enzyme (ACE) Inhibitors</b>		
<i>benazepril hcl tabs 10mg, 40mg, 5mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>benazepril hydrochloride tabs 20mg</i>	1	
<i>enalapril maleate tabs</i>	1	
<i>lisinopril tabs</i>	1	
<i>quinapril hcl tabs 20mg, 40mg</i>	1	
<i>ramipril</i>	1	
<b>Antiarrhythmics</b>		
<i>amiodarone hydrochloride tabs 200mg</i>	1	
<i>amiodarone hydrochloride tabs 100mg, 400mg</i>	3	
<i>digoxin tabs 125mcg, 250mcg</i>	2	
<i>flecainide acetate</i>	2	
MULTAQ	3	
<i>sotalol hcl</i>	2	
<b>Beta-adrenergic Blocking Agents</b>		
<i>atenolol tabs</i>	1	
<i>bisoprolol fumarate</i>	2	
BYSTOLIC	3	
<i>carvedilol</i>	1	
<i>labetalol hydrochloride tabs</i>	2	
<i>metoprolol succinate er</i>	2	
<i>metoprolol tartrate tabs 100mg, 25mg, 50mg</i>	1	
<i>propranolol hcl tabs 40mg</i>	2	
<i>propranolol hydrochloride er cp24 60mg, 80mg</i>	2	
<i>propranolol hydrochloride tabs 10mg, 20mg, 60mg, 80mg</i>	2	
<b>Calcium Channel Blocking Agents, Dihydropyridines</b>		
<i>amlodipine besylate tabs</i>	1	
<i>felodipine er</i>	2	
<i>nifedipine er</i>	2	
<b>Calcium Channel Blocking Agents, Nondihydropyridines</b>		
<i>cartia xt</i>	2	
<i>dilt-xr</i>	2	
<i>diltiazem hcl tabs</i>	2	
<i>diltiazem hydrochloride er cp24 120mg, 180mg, 240mg, 300mg</i>	2	
<i>diltiazem hydrochloride er cp24 360mg</i>	4	
<i>verapamil hcl er tbc</i>	2	
<b>Cardiovascular Agents, Other</b>		
<i>amlodipine besylate/benazepril hydrochloride</i>	1	
<i>atenolol/chlorthalidone</i>	2	
BIDIL	3	
<i>bisoprolol fumarate/hydrochlorothiazide</i>	2	
CORLANOR TABS	4	QL (60 EA per 30 days) PA
EDARBYCLOR	4	
ENTRESTO	3	QL (60 EA per 30 days)
<i>lisinopril/hydrochlorothiazide</i>	1	
<i>losartan potassium/hydrochlorothiazide</i>	1	
<i>olmesartan medoxomil/hydrochlorothiazide</i>	2	
<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
<i>valsartan/hydrochlorothiazide</i>	1	
<b>Diuretics, Loop</b>		
<i>bumetanide tabs</i>	1	
<i>furosemide tabs</i>	1	
<i>toremide tabs</i>	1	
<b>Diuretics, Potassium-sparing</b>		
<i>amiloride hcl tabs</i>	2	
<i>spironolactone tabs</i>	1	
<b>Diuretics, Thiazide</b>		
<i>chlorthalidone tabs 25mg, 50mg</i>	2	
<i>hydrochlorothiazide caps, tabs</i>	1	
<i>metolazone</i>	2	
<b>Dyslipidemics, Fibric Acid Derivatives</b>		
<i>fenofibrate tabs 145mg, 160mg, 48mg, 54mg</i>	2	
<i>gemfibrozil tabs</i>	2	
<b>Dyslipidemics, HMG CoA Reductase Inhibitors</b>		
<i>atorvastatin calcium</i>	1	
LIVALO	4	ST
<i>lovastatin tabs</i>	1	
<i>pravastatin sodium</i>	1	
<i>rosuvastatin calcium</i>	1	
<i>simvastatin tabs</i>	1	
<b>Dyslipidemics, Other</b>		
<i>ezetimibe</i>	2	
<i>ezetimibe/simvastatin</i>	2	
<i>icosapent ethyl</i>	4	PA
NEXLETOL	4	QL (30 EA per 30 days) PA
NEXLIZET	4	QL (30 EA per 30 days) PA
<i>omega-3-acid ethyl esters</i>	4	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
<b>Vasodilators, Direct-acting Arterial/Venous</b>		
<i>isosorbide mononitrate er tb24 30mg, 60mg</i>	1	
<i>isosorbide mononitrate er tb24 120mg</i>	2	
<i>nitroglycerin subl 0.3mg, 0.4mg, 0.6mg</i>	2	
<b>Vasodilators, Direct-acting Arterial</b>		
<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	
<b>Central Nervous System Agents</b>		
<b>Attention Deficit Hyperactivity Disorder Agents, Amphetamines</b>		
<i>amphetamine/dextroamphetamine tabs</i>	3	QL (90 EA per 30 days)
<i>dextroamphetamine sulfate tabs 10mg</i>	3	QL (180 EA per 30 days)
<i>dextroamphetamine sulfate tabs 5mg</i>	3	QL (90 EA per 30 days)
<b>Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines</b>		
<i>atomoxetine hydrochloride caps 100mg, 18mg, 25mg</i>	4	QL (30 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>atomoxetine caps 40mg, 60mg, 80mg</i>	4	QL (30 EA per 30 days)
<i>atomoxetine caps 10mg</i>	4	QL (60 EA per 30 days)
<i>methylphenidate hydrochloride tabs</i>	2	QL (90 EA per 30 days)
<b>Central Nervous System, Other</b>		
AUSTEDO	5	QL (120 EA per 30 days) PA
<i>butalbital/acetaminophen/caffeine tabs 325mg; 50mg; 40mg</i>	3	PA
INGREZZA CAPS 60MG, 80MG	5	QL (30 EA per 30 days) PA
INGREZZA CAPS 40MG	5	QL (60 EA per 30 days) PA
NUEDEXTA	5	PA
<b>Fibromyalgia Agents</b>		
<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)
SAVELLA	3	QL (60 EA per 30 days)
SAVELLA TITRATION PACK	3	QL (110 EA per 365 days)
<b>Multiple Sclerosis Agents</b>		
AUBAGIO	5	QL (30 EA per 30 days) PA
AVONEX PEN	5	QL (4 EA per 28 days) PA
AVONEX INJ 30MCG/0.5ML	5	QL (4 EA per 28 days) PA
BAFIERTAM	5	QL (120 EA per 30 days) PA
BETASERON	5	QL (15 EA per 30 days) PA
EXTAVIA	5	QL (15 EA per 30 days) PA
GILENYA	5	QL (30 EA per 30 days) PA
MAYZENT STARTER PACK	5	QL (24 EA per 365 days) PA
MAYZENT TABS 0.25MG	5	QL (120 EA per 30 days) PA
MAYZENT TABS 2MG	5	QL (30 EA per 30 days) PA
PLEGRIDY	5	QL (1 ML per 28 days) PA
PLEGRIDY STARTER PACK	5	QL (2 ML per 365 days) PA
REBIF	5	QL (6 ML per 28 days) PA
REBIF REBIDOSE	5	QL (6 ML per 28 days) PA
REBIF REBIDOSE TITRATION PACK	5	QL (8.4 ML per 365 days) PA
REBIF TITRATION PACK	5	QL (8.4 ML per 365 days) PA
VUMERITY CPDR 231MG	5	QL (120 EA per 30 days) PA
VUMERITY CPDR 231MG	5	QL (212 EA per 365 days) PA
ZEPOSIA	5	QL (30 EA per 30 days) PA
ZEPOSIA 7-DAY STARTER PACK	5	QL (14 EA per 365 days) PA
ZEPOSIA STARTER KIT	5	QL (74 EA per 365 days) PA
<b>Dental and Oral Agents</b>		
<b>Dental and Oral Agents</b>		
<i>chlorhexidine gluconate soln</i>	1	
<i>doxycycline hyclate tabs 20mg</i>	2	
<b>Dermatological Agents</b>		
<b>Acne and Rosacea Agents</b>		
FINACEA FOAM	3	
<i>metronidazole crea 0.75%</i>	3	
<i>metronidazole gel 0.75%</i>	3	
<i>metronidazole gel 1%</i>	4	
<i>metronidazole lotn 0.75%</i>	4	
<b>Dermatitis and Pruitus Agents</b>		

Drug Name	Drug Tier	Requirements/Limits
<i>augmented betamethasone dipropionate crea</i>	2	
<i>augmented betamethasone dipropionate oint</i>	3	
<i>clobetasol propionate crea, oint</i>	2	
<i>clobetasol propionate soln</i>	3	
EUCRISA	4	PA
<i>fluocinonide crea 0.05%</i>	3	
<i>fluocinonide crea 0.1%</i>	3	QL (120 GM per 30 days)
<i>fluocinonide oint, soln</i>	3	
<i>hydrocortisone crea 2.5%</i>	2	
<i>hydrocortisone oint 2.5%</i>	2	
<i>tacrolimus oint 0.03%, 0.1%</i>	4	
<i>triamcinolone acetonide crea</i>	2	
<i>triamcinolone acetonide oint 0.025%, 0.1%, 0.5%</i>	2	
<b>Dermatological Agents, Other</b>		
<i>clotrimazole/betamethasone dipropionate crea</i>	2	
<i>fluorouracil crea 5%</i>	2	
<i>fluorouracil crea 0.5%</i>	4	
SANTYL	4	
<b>Topical Anti-infectives</b>		
<i>ciclopirox nail lacquer</i>	3	PA
<i>mupirocin oint</i>	2	
<b>Electrolytes/Minerals/Metals/Vitamins</b>		
<b>Electrolyte/Mineral Replacement</b>		
<i>klor-con 8</i>	2	
<i>klor-con m20</i>	2	
<i>potassium chloride er cpcr</i>	2	
<i>potassium chloride er tbcr 10meq, 20meq, 8meq</i>	2	
<i>potassium citrate er</i>	4	
<b>Phosphate Binders</b>		
AURYXIA	5	PA
<i>sevelamer carbonate tabs</i>	4	
VELPHORO	5	
<b>Gastrointestinal Agents</b>		
<b>Anti-Constipation Agents</b>		
<i>lactulose soln</i>	2	
LINZESS	3	QL (30 EA per 30 days)
MOTEGRITY	3	QL (30 EA per 30 days)
RELISTOR TABS	5	QL (90 EA per 30 days) ST
RELISTOR INJ 8MG/0.4ML	5	QL (12 ML per 30 days) ST
RELISTOR INJ 12MG/0.6ML	5	QL (18 ML per 30 days) ST
<b>Anti-Diarrheal Agents</b>		
<i>diphenoxylate/atropine tabs</i>	3	
<i>loperamide hcl caps</i>	2	
<b>Antispasmodics, Gastrointestinal</b>		
<i>dicyclomine hydrochloride caps, tabs</i>	2	
<i>glycopyrrolate tabs 1mg, 2mg</i>	3	
<b>Gastrointestinal Agents, Other</b>		
CLENPIQ	3	
<i>gavilyte-c</i>	2	



Drug Name	Drug Tier	Requirements/Limits
<i>peg-3350/electrolytes</i>	2	
<i>peg-3350/nacl/na bicarbonate/kcl</i>	2	
SUPREP BOWEL PREP KIT	3	
XIFAXAN	5	PA
<b>Histamine2 (H2) Receptor Antagonists</b>		
<i>famotidine tabs 20mg, 40mg</i>	2	
<i>nizatidine soln</i>	4	
<b>Protectants</b>		
<i>misoprostol tabs 100mcg</i>	2	
<i>misoprostol tabs 200mcg</i>	3	
<i>sucralfate tabs</i>	2	
<b>Proton Pump Inhibitors</b>		
DEXILANT	4	QL (30 EA per 30 days)
<i>esomeprazole magnesium cpdr</i>	2	QL (60 EA per 30 days)
<i>lansoprazole cpdr</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)
<b>Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment</b>		
<b>Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment</b>		
CREON CPEP 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	
ZENPEP CPEP 105000UNIT; 25000UNIT; 79000UNIT, 14000UNIT; 3000UNIT; 10000UNIT, 168000UNIT; 40000UNIT; 126000UNIT, 24000UNIT; 5000UNIT; 17000UNIT, 42000UNIT; 10000UNIT; 32000UNIT, 63000UNIT; 15000UNIT; 47000UNIT, 84000UNIT; 20000UNIT; 63000UNIT	3	
<b>Genitourinary Agents</b>		
<b>Antispasmodics, Urinary</b>		
MYRBETRIQ	3	
<i>oxybutynin chloride er</i>	2	
<i>oxybutynin chloride tabs</i>	2	
<i>solifenacin succinate</i>	2	
<i>tolterodine tartrate er</i>	3	
<i>trospium chloride</i>	3	
<b>Benign Prostatic Hypertrophy Agents</b>		
<i>alfuzosin hcl er</i>	2	
<i>doxazosin mesylate</i>	2	
<i>dutasteride caps</i>	2	
<i>finasteride tabs</i>	1	
<i>tadalafil tabs 2.5mg, 5mg</i>	3	QL (30 EA per 30 days) PA
<i>tamsulosin hydrochloride</i>	2	
<b>Genitourinary Agents, Other</b>		
<i>bethanechol chloride tabs</i>	2	
ELMIRON	4	

Drug Name	Drug Tier	Requirements/Limits
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</b>		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</i>		
dexamethasone tabs 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	2	
fludrocortisone acetate tabs	2	
methylprednisolone dose pack tbpk	2	
prednisone tbpk	2	
prednisone tabs 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</b>		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)</i>		
desmopressin acetate tabs	3	
GENOTROPIN	5	PA
GENOTROPIN MINIQUICK	5	PA
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)</b>		
<i>Androgens</i>		
ANDRODERM PT24 2MG/24HR, 4MG/24HR	3	PA
TESTOSTERONE GEL 25MG/2.5GM, 50MG/5GM	3	PA
testosterone gel 20.25mg/1.25gm, 40.5mg/2.5gm	3	PA
<i>Estrogens</i>		
CLIMARA PRO	4	
estradiol crea, oral tabs	2	
estradiol vaginal tabs	4	
ESTRING	4	QL (1 EA per 90 days)
PREMARIN CREA	4	
PREMARIN TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	4	
PREMPHASE	4	
PREMPRO	4	
<i>Selective Estrogen Receptor Modifying Agents</i>		
OSPHENA	3	QL (30 EA per 30 days) PA
raloxifene hydrochloride	2	
<b>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</b>		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</i>		
euthyrox tabs 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 50mcg, 75mcg, 88mcg	4	
levothyroxine sodium tabs	2	
liothyronine sodium tabs	2	
SYNTHROID TABS	4	
<b>Hormonal Agents, Suppressant (Adrenal)</b>		
<i>Hormonal Agents, Suppressant (Adrenal)</i>		
ISTURISA	5	PA
LYSODREN	5	
<b>Hormonal Agents, Suppressant (Pituitary)</b>		
<i>Hormonal Agents, Suppressant (Pituitary)</i>		
cabergoline	3	
ELIGARD INJ 30MG	4	QL (1 EA per 112 days) PA
ELIGARD INJ 45MG	4	QL (1 EA per 168 days) PA
ELIGARD INJ 7.5MG	4	QL (1 EA per 28 days) PA

Drug Name	Drug Tier	Requirements/Limits
ELIGARD INJ 22.5MG	4	QL (1 EA per 84 days) PA
LUPRON DEPOT (1-MONTH)	5	QL (1 EA per 28 days) PA
LUPRON DEPOT (3-MONTH)	5	QL (1 EA per 84 days) PA
LUPRON DEPOT (4-MONTH)	5	QL (1 EA per 112 days) PA
LUPRON DEPOT (6-MONTH)	5	QL (1 EA per 168 days) PA
LUPRON DEPOT-PED (1-MONTH)	5	QL (1 EA per 28 days) PA
LUPRON DEPOT-PED (3-MONTH)	5	QL (1 EA per 84 days) PA
ORGOVYX	5	PA
ORLISSA TABS 150MG	5	QL (30 EA per 30 days) PA
ORLISSA TABS 200MG	5	QL (60 EA per 30 days) PA
<b>Hormonal Agents, Suppressant (Thyroid)</b>		
<i>Antithyroid Agents</i>		
<i>methimazole tabs 10mg, 5mg</i>	2	
<i>propylthiouracil tabs</i>	2	
<b>Immunological Agents</b>		
<i>Immunoglobulins</i>		
GAMASTAN	3	PA
PRIVIGEN	5	PA
<i>Immunological Agents, Other</i>		
COSENTYX	5	PA
COSENTYX SENSOREADY PEN	5	PA
RINVOQ	5	PA
SKYRIZI PEN	5	PA
SKYRIZI INJ 75MG/0.83ML	5	PA
TALTZ	5	PA
TREMFYA	5	PA
XELJANZ XR	5	PA
XELJANZ TABS	5	PA
<i>Immunosuppressants</i>		
<i>azathioprine tabs</i>	2	B/D
CIMZIA STARTER KIT	5	PA
ENBREL	5	PA
ENBREL MINI	5	PA
ENBREL SURECLICK	5	PA
HUMIRA	5	PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJ 0, 80MG/0.8ML	5	PA
HUMIRA PEN	5	PA
HUMIRA PEN-CD/UC/HS STARTER	5	PA
HUMIRA PEN-PEDIATRIC UC STARTER PACK	5	PA
HUMIRA PEN-PS/UV STARTER	5	PA
<i>leflunomide</i>	2	
<i>methotrexate tabs</i>	2	
<i>mycophenolate mofetil tabs</i>	4	B/D
<i>tacrolimus caps 0.5mg, 1mg, 5mg</i>	4	B/D
<i>Vaccines</i>		
ADACEL	3	
SHINGRIX	3	
<b>Inflammatory Bowel Disease Agents</b>		

Drug Name	Drug Tier	Requirements/Limits
<b>Aminosalicylates</b>		
<i>balsalazide disodium</i>	4	
MESALAMINE DR TBEC 800MG	4	
<i>mesalamine dr tbec 1.2gm</i>	4	
<i>sulfasalazine tabs</i>	2	
<b>Metabolic Bone Disease Agents</b>		
<b>Metabolic Bone Disease Agents</b>		
<i>alendronate sodium tabs 10mg, 35mg, 5mg</i>	1	
<i>alendronate sodium tabs 70mg</i>	1	QL (4 EA per 28 days)
<i>calcitriol caps</i>	2	
<i>cinacalcet hydrochloride tabs 30mg, 60mg</i>	4	
<i>cinacalcet hydrochloride tabs 90mg</i>	5	
FORTEO INJ 620MCG/2.48ML	5	PA
<i>ibandronate sodium tabs</i>	2	QL (1 EA per 28 days)
PROLIA	4	QL (2 ML per 365 days)
RAYALDEE	5	
<i>risedronate sodium tabs 150mg</i>	2	QL (1 EA per 28 days)
<i>risedronate sodium tabs 30mg, 5mg</i>	4	
<i>risedronate sodium tabs 35mg</i>	4	QL (4 EA per 28 days)
TERIPARATIDE	5	PA
TYMLOS	5	PA
XGEVA	5	PA
<b>Miscellaneous Therapeutic Agents</b>		
<b>Miscellaneous Therapeutic Agents</b>		
<i>bd veo insulin syringe ultra-afine/0.3ml/31g x 6mm</i>	2	QL (200 EA per 30 days)
OMNIPOD 5 PACK	3	QL (30 EA per 30 days)
OMNIPOD DASH 5 PACK	3	QL (30 EA per 30 days)
OMNIPOD DASH SYSTEM	3	QL (1 EA per 365 days)
OMNIPOD STARTER KIT	3	QL (1 EA per 365 days)
V-GO 20	3	
V-GO 30	3	
V-GO 40	3	
<b>Ophthalmic Agents</b>		
<b>Ophthalmic Agents, Other</b>		
COMBIGAN	3	
<i>dorzolamide hcl/timolol maleate</i>	2	
<i>neomycin/polymyxin/dexamethasone</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	4	
<i>tobramycin/dexamethasone</i>	3	
XIIDRA	4	QL (60 EA per 30 days)
ZYLET	4	
<b>Ophthalmic Anti-allergy Agents</b>		
<i>olopatadine hydrochloride soln 0.2%</i>	3	
<b>Ophthalmic Anti-Infectives</b>		
BESIVANCE	4	

Drug Name	Drug Tier	Requirements/Limits
<i>erythromycin</i>	2	
<i>moxifloxacin hydrochloride soln</i>	3	
<i>ofloxacin</i>	2	
ZIRGAN	4	
<b>Ophthalmic Anti-inflammatories</b>		
FLAREX	3	
<i>fluorometholone</i>	3	
ILEVRO	3	QL (6 ML per 30 days)
<i>ketorolac tromethamine</i>	2	
LOTEMAX SM	4	QL (20 GM per 365 days)
<i>prednisolone acetate</i>	2	
PROLENSA	4	QL (12 ML per 365 days)
<b>Ophthalmic Beta-Adrenergic Blocking Agents</b>		
<i>carteolol hcl</i>	2	
<i>levobunolol hcl soln 0.5%</i>	2	
<i>timolol maleate soln 0.25%, 0.5%</i>	1	
<i>timolol maleate soln 0.5%</i>	4	
<b>Ophthalmic Intraocular Pressure Lowering Agents, Other</b>		
ALPHAGAN P SOLN 0.1%	3	
<i>brimonidine tartrate soln 0.2%</i>	2	
<i>brimonidine tartrate soln 0.15%</i>	4	
RHOPRESSA	3	QL (2.5 ML per 25 days)
<b>Ophthalmic Prostaglandin and Prostanoid Analogs</b>		
<i>latanoprost soln</i>	1	
LUMIGAN	3	QL (2.5 ML per 25 days)
VYZULTA	4	QL (5 ML per 25 days)
<b>Otic Agents</b>		
<b>Otic Agents</b>		
<i>acetic acid</i>	2	
<i>neomycin/polymyxin/hydrocortisone susp</i>	3	
<b>Respiratory Tract/Pulmonary Agents</b>		
<b>Anti-inflammatories, Inhaled Corticosteroids</b>		
ARNUITY ELLIPTA	3	QL (30 EA per 30 days)
ASMANEX HFA	4	QL (13 GM per 30 days)
ASMANEX TWISTHALER 120 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 14 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 30 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 60 METERED DOSES	4	QL (1 EA per 30 days)
ASMANEX TWISTHALER 7 METERED DOSES	4	QL (1 EA per 30 days)
BREZTRI AEROSPHERE	3	QL (23.6 GM per 28 days)
<i>budesonide</i>	4	QL (120 ML per 30 days) B/D
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>момetasone furoate</i>	4	QL (34 GM per 30 days)
QVAR REDHALER	4	QL (21.2 GM per 30 days) ST
<b>Antihistamines</b>		

Drug Name	Drug Tier	Requirements/Limits
<i>azelastine hydrochloride soln 0.1%</i>	2	QL (60 ML per 30 days)
<i>hydroxyzine hcl tabs 50mg</i>	4	
<i>hydroxyzine hydrochloride tabs 10mg, 25mg</i>	4	
<i>levocetirizine dihydrochloride tabs</i>	2	
<b>Antileukotrienes</b>		
<i>montelukast sodium tabs</i>	1	
<i>montelukast sodium chew</i>	2	
<i>zafirlukast</i>	4	
<b>Bronchodilators, Anticholinergic</b>		
ATROVENT HFA	4	QL (25.8 GM per 30 days)
INCRUSE ELLIPTA	3	QL (30 EA per 30 days)
<i>ipratropium bromide nasal soln</i>	2	
<i>ipratropium bromide inhalation soln</i>	2	QL (312.5 ML per 30 days) B/D
LONHALA MAGNAIR REFILL KIT	5	QL (60 ML per 30 days)
SPIRIVA HANDIHALER	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT AERS 2.5MCG/ACT	3	
SPIRIVA RESPIMAT AERS 1.25MCG/ACT	3	QL (8 GM per 30 days)
YUPELRI	5	QL (90 ML per 30 days) B/D
<b>Bronchodilators, Sympathomimetic</b>		
<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 hfa aers 108mcg/act</i>	2	QL (48 GM per 30 days)
<i>albuterol sulfate nebu 2.5mg/0.5ml</i>	2	QL (100 EA per 30 days) B/D
<i>albuterol sulfate nebu 0.083%</i>	2	QL (525 ML per 30 days) B/D
<i>albuterol sulfate nebu 0.63mg/3ml, 1.25mg/3ml</i>	4	QL (375 ML per 30 days) B/D
EPINEPHRINE INJ 0.15MG/0.3ML, 0.3MG/0.3ML	3	
<i>epinephrine inj 0.15mg/0.15ml, 0.3mg/0.3ml</i>	3	
PROAIR HFA	3	QL (17 GM per 30 days)
PROAIR RESPICLICK	3	QL (2 EA per 30 days)
SEREVENT DISKUS	3	QL (60 EA per 30 days)
<b>Cystic Fibrosis Agents</b>		
TOBI PODHALER	5	QL (224 EA per 56 days)
<i>tobramycin</i>	5	B/D
<b>Pulmonary Antihypertensives</b>		
AMBRISENTAN	5	QL (30 EA per 30 days) PA
OPSUMIT	5	QL (30 EA per 30 days) PA
ORENITRAM TBCR 0.25MG, 1MG, 2.5MG, 5MG	5	PA
<i>sildenafil citrate tabs</i>	3	QL (90 EA per 30 days) PA
<b>Respiratory Tract Agents, Other</b>		
ANORO ELLIPTA	3	QL (60 EA per 30 days)
BREO ELLIPTA	3	QL (60 EA per 30 days)
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
DULERA AERO 5MCG/ACT; 50MCG/ACT	4	QL (13 GM per 30 days)
DULERA AERO 5MCG/ACT; 100MCG/ACT, 5MCG/ACT; 200MCG/ACT	4	QL (17.6 GM per 30 days)
FASENRA	5	PA
FASENRA PEN	5	PA
<i>ipratropium bromide/albuterol sulfate</i>	2	QL (540 ML per 30 days) B/D
NUCALA INJ 100MG	5	QL (3 EA per 28 days) PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NUCALA INJ 100MG/ML	5	QL (3 ML per 28 days) PA
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)
<b>Skeletal Muscle Relaxants</b>		
<i>Skeletal Muscle Relaxants</i>		
<i>cyclobenzaprine hydrochloride tabs 10mg, 5mg</i>	4	PA
<i>methocarbamol tabs</i>	4	PA
<b>Sleep Disorder Agents</b>		
<i>Sleep Promoting Agents</i>		
BELSOMRA	3	QL (30 EA per 30 days)
<i>eszopiclone</i>	4	QL (30 EA per 30 days)
<i>temazepam caps 15mg, 30mg</i>	2	QL (30 EA per 30 days)
<i>zolpidem tartrate er</i>	4	QL (30 EA per 30 days)
<i>zolpidem tartrate tabs</i>	2	QL (30 EA per 30 days)
<i>Wakefulness Promoting Agents</i>		
XYREM	5	QL (540 ML per 30 days) PA

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DULERA	19
<i>duloxetine hcl</i>	3
<i>duloxetine hydrochloride</i>	3
<i>dutasteride</i>	14
EDARBI	9
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EMGALITY	4
<i>enalapril maleate</i>	10
ENBREL	16
ENBREL MINI	16
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<i>enoxaparin sodium</i>	9
ENTRESTO	10
EPINEPHRINE	19
ERLEADA	4
<i>ertapenem</i>	2
<i>erythromycin</i>	18
<i>escitalopram oxalate</i>	3
<i>esomeprazole magnesium</i>	14
<i>estradiol</i>	15
ESTRING	15
<i>eszopiclone</i>	20
EUCRISA	13
<i>euthyrox</i>	15
EXTAVIA	12
<i>ezetimibe</i>	11
<i>ezetimibe/simvastatin</i>	11
<i>famotidine</i>	14
FARXIGA	7
FASENRA	19
FASENRA PEN	19
<i>febuxostat</i>	4
<i>felodipine er</i>	10
<i>fenofibrate</i>	11
<i>fentanyl</i>	1
FINACEA	12
<i>finasteride</i>	14
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<i>flecainide acetate</i>	10
FLOVENT DISKUS	18
FLOVENT HFA	18
<i>fluconazole</i>	4
<i>fludrocortisone acetate</i>	15
<i>fluocinonide</i>	13
<i>fluorometholone</i>	18
<i>fluorouracil</i>	13
<i>fluoxetine hcl</i>	3
<i>fluoxetine hydrochloride</i>	3
<i>fluticasone propionate</i>	18
FORTEO	17
FRAGMIN	9
<i>furosemide</i>	11
FYCOMPA	2
<i>gabapentin</i>	2
GAMASTAN	16
<i>gavilyte-c</i>	13
<i>gemfibrozil</i>	11
GENOTROPIN	15
GENOTROPIN MINIQUICK	15
GILENYA	12
<i>glimepiride</i>	7
<i>glipizide</i>	7
<i>glipizide er</i>	7
GLUCAGON EMERGENCY KIT	7
<i>glycopyrrolate</i>	13
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GVOKE HYPOPEN 2-PACK	7
GVOKE PFS	7
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HUMALOG JUNIOR KWIKPEN	7
HUMALOG KWIKPEN	7
HUMALOG MIX 50/50	7
HUMALOG MIX 50/50 KWIKPEN	7
HUMALOG MIX 75/25	8
HUMALOG MIX 75/25 KWIKPEN	8
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HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	16
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HUMULIN 70/30 KWIKPEN	8
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HUMULIN R U-500 (CONCENTRATED)	8
HUMULIN R U-500 KWIKPEN	8
<i>hydralazine hcl</i>	11
<i>hydralazine hydrochloride</i>	11
<i>hydrochlorothiazide</i>	11
<i>hydrocodone bitartrate/acetaminophen</i>	1
<i>hydrocodone/acetaminophen</i>	1
<i>hydrocortisone</i>	13
<i>hydromorphone hcl</i>	1
<i>hydroxychloroquine sulfate</i>	5
<i>hydroxyurea</i>	4
<i>hydroxyzine hcl</i>	19
<i>hydroxyzine hydrochloride</i>	19
<i>ibandronate sodium</i>	17
<i>ibuprofen</i>	1
<i>icosapent ethyl</i>	11
ILEVRO	18
IMBRUVICA	5
<i>imipenem/cilastatin</i>	2
INBRIJA	5
INCRUSE ELLIPTA	19
INGREZZA	12
INSULIN ASPART	8
INSULIN ASPART FLEXPEN	8
INSULIN ASPART PENFILL	8
INSULIN ASPART	8
PROTAMINE/INSULIN ASPART	
INSULIN ASPART	8
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INSULIN LISPRO	8
INSULIN LISPRO JUNIOR KWIKPEN	8
INSULIN LISPRO KWIKPEN	8
INSULIN LISPRO	8
PROTAMINE/INSULIN LISPRO KWIKPEN	
INVEGA SUSTENNA	5
INVEGA TRINZA	5
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<i>ipratropium bromide</i>	19
<i>ipratropium bromide/albuterol sulfate</i>	19
<i>irbesartan</i>	9
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<i>isosorbide mononitrate er</i>	11
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<i>ketoconazole</i>	4
<i>ketorolac tromethamine</i>	18
<i>klor-con 8</i>	13
<i>klor-con m20</i>	13
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KYNMOBI TITRATION KIT	5
<i>labetalol hydrochloride</i>	10
<i>lactulose</i>	13
<i>lamotrigine</i>	2
<i>lansoprazole</i>	14
LANTUS	8
LANTUS SOLOSTAR	8
<i>latanoprost</i>	18
LATUDA	5
<i>leflunomide</i>	16
<i>letrozole</i>	5
LEVEMIR	8
LEVEMIR FLEXTOUCH	8
<i>levetiracetam</i>	2
<i>levobunolol hcl</i>	18
<i>levocetirizine dihydrochloride</i>	19
<i>levofloxacin</i>	2
<i>levothyroxine sodium</i>	15
<i>lidocaine</i>	1
<i>lidocaine/prilocaine</i>	1
LINZESS	13
<i>liothyronine sodium</i>	15
<i>lisinopril</i>	10
<i>lisinopril/hydrochlorothiazide</i>	10
LIVALO	11
LONHALA MAGNAIR REFILL KIT	19
<i>loperamide hcl</i>	13
<i>lorazepam</i>	7
<i>losartan potassium</i>	9
<i>losartan potassium/hydrochlorothiazide</i>	10
LOTEMAX SM	18
<i>lovastatin</i>	11
LUMIGAN	18
LUPRON DEPOT (1-MONTH)	16
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LUPRON DEPOT (6-MONTH)	16
LUPRON DEPOT-PED (1-MONTH)	16
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<i>meloxicam</i>	1
<i>memantine hydrochloride</i>	3
<i>memantine hydrochloride er</i>	3
MESALAMINE DR	17
<i>metformin hydrochloride</i>	7
<i>metformin hydrochloride er</i>	7
<i>methenamine hippurate</i>	1
<i>methimazole</i>	16
<i>methocarbamol</i>	20
<i>methotrexate</i>	16
<i>methylphenidate hydrochloride</i>	12
<i>methylprednisolone dose pack</i>	15
<i>metolazone</i>	11
<i>metoprolol succinate er</i>	10
<i>metoprolol tartrate</i>	10
<i>metronidazole</i>	1
<i>metronidazole</i>	12
<i>midodrine hcl</i>	9
<i>minoxidil</i>	11
<i>mirtazapine</i>	3
<i>misoprostol</i>	14
<i>mometasone furoate</i>	18
<i>montelukast sodium</i>	19
<i>morphine sulfate</i>	1
<i>morphine sulfate er</i>	1
MOTEGRITY	13
<i>moxifloxacin hydrochloride</i>	18
MULTAQ	10
<i>mupirocin</i>	13
MVASI	5
<i>mycophenolate mofetil</i>	16
MYRBETRIQ	14
<i>nabumetone</i>	1
<i>naloxone hcl</i>	1
NAMZARIC	3
<i>naproxen</i>	1
NARCAN	1
NAYZILAM	2
<i>neomycin/polymyxin/dexamethasone</i>	17
<i>neomycin/polymyxin/hydrocortisone</i>	18
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<i>nifedipine er</i>	10
<i>nitrofurantoin monohydrate</i>	1
<i>nitroglycerin</i>	11
<i>nizatidine</i>	14
<i>nortriptyline hcl</i>	4
<i>nortriptyline hydrochloride</i>	4
NOVOLIN 70/30	8
NOVOLIN 70/30 FLEXPEN	8
NOVOLIN 70/30 RELION	8
NOVOLIN N	8
NOVOLIN N FLEXPEN	8
NOVOLIN N RELION	8
NOVOLIN R	8
NOVOLIN R FLEXPEN	8
NOVOLIN R RELION	8
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NOVOLOG MIX 70/30 PREFILLED	8
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NUBEQA	4
NUCALA	19
NUEDEXTA	12
<i>nystatin</i>	4
<i>nystop</i>	4
ODOMZO	5
<i>ofloxacin</i>	18
<i>olanzapine</i>	6
<i>olmesartan medoxomil</i>	9
<i>olmesartan medoxomil/hydrochlorothiazide</i>	10
<i>olopatadine hydrochloride</i>	17
<i>omega-3-acid ethyl esters</i>	11
<i>omeprazole</i>	14
OMNIPOD 5 PACK	17
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<i>ondansetron hydrochloride</i>	4
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OPSUMIT	19
ORENITRAM	19
ORGOVYX	16
ORILISSA	16
<i>oseltamivir phosphate</i>	6
OSPHENA	15
<i>oxcarbazepine</i>	3
<i>oxybutynin chloride</i>	14
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<i>oxycodone hydrochloride</i>	1
<i>oxycodone/acetaminophen</i>	1
OZEMPIC	7
<i>pantoprazole sodium</i>	14
<i>paroxetine hcl</i>	3
<i>paroxetine hydrochloride</i>	3
<i>peg-3350/electrolytes</i>	14
<i>peg-3350/nacl/na bicarbonate/kcl</i>	14
<i>penicillin v potassium</i>	2
PERSERIS	6
<i>phenytoin sodium extended</i>	3
<i>pioglitazone hcl</i>	7
<i>pioglitazone hydrochloride</i>	7
PLEGRIDY	12
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<i>polymyxin b sulfate/trimethoprim sulfate</i>	17
<i>potassium chloride er</i>	13
<i>potassium citrate er</i>	13
<i>pramipexole dihydrochloride</i>	5
<i>pravastatin sodium</i>	11
<i>prazosin hydrochloride</i>	9
<i>prednisolone acetate</i>	18
<i>prednisone</i>	15
<i>pregabalin</i>	12
PREMARIN	15
PREMPHASE	15
PREMPRO	15
PREZISTA	6
<i>primaquine phosphate</i>	5
<i>primidone</i>	3
PRIVIGEN	16
PROAIR HFA	19
PROAIR RESPICLICK	19
<i>prochlorperazine maleate</i>	4
PROCRIT	9
PROLENSA	18
PROLIA	17
<i>propranolol hcl</i>	10
<i>propranolol hydrochloride</i>	10
<i>propranolol hydrochloride er</i>	10
<i>propylthiouracil</i>	16
<i>quetiapine fumarate</i>	6
<i>quinapril hcl</i>	10
QVAR REDIHALER	18
<i>raloxifene hydrochloride</i>	15
<i>ramipril</i>	10
<i>ranolazine er</i>	10
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REPATHA SURECLICK	11
RESTASIS	17
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REXULTI	6
REYATAZ	6
RHOPRESSA	18
RINVOQ	16
<i>risedronate sodium</i>	17
<i>risperidone</i>	6
<i>rivastigmine tartrate</i>	3
ROCKLATAN	17
<i>ropinirole hcl</i>	5
<i>ropinirole hydrochloride</i>	5
<i>rosuvastatin calcium</i>	11
RUXIENCE	5
RYBELSUS	7
RYBREVANT	5
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<i>sertraline hcl</i>	3
<i>sertraline hydrochloride</i>	3
<i>sevelamer carbonate</i>	13
SHINGRIX	16
<i>sildenafil citrate</i>	19
SIMBRINZA	17
<i>simvastatin</i>	11
SKYRIZI	16
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<i>solifenacin succinate</i>	14
<i>sotalol hcl</i>	10
SPIRIVA HANDIHALER	19
SPIRIVA RESPIMAT	19
<i>spironolactone</i>	11
SPRYCEL	5
STIOLTO RESPIMAT	20
<i>sucralfate</i>	14
<i>sulfadiazine</i>	2
<i>sulfamethoxazole/trimethoprim</i>	2
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<i>sulfasalazine</i>	17
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<i>tacrolimus</i>	16
<i>tadalafil</i>	14
TALTZ	16
<i>tamoxifen citrate</i>	4
<i>tamsulosin hydrochloride</i>	14
TARGRETIN	5
TASIGNA	5
<i>telmisartan</i>	9
<i>temazepam</i>	20
<i>terazosin hcl</i>	9
<i>terazosin hydrochloride</i>	9
<i>terbinafine hcl</i>	4
TERIPARATIDE	17
TESTOSTERONE	15
<i>timolol maleate</i>	18
TIVICAY	6
<i>tizanidine hcl</i>	6
<i>tizanidine hydrochloride</i>	6
TOBI PODHALER	19
TOBRADEX ST	17
<i>tobramycin</i>	19
<i>tobramycin/dexamethasone</i>	17
<i>tolterodine tartrate er</i>	14
<i>topiramate</i>	2
<i>toremide</i>	11
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TOUJEO SOLOSTAR	8
TRADJENTA	7
<i>tramadol hcl</i>	1
TRAZIMERA	5
<i>trazodone hydrochloride</i>	3
TRELEGY ELLIPTA	20
TREMFYA	16
TRESIBA	8
TRESIBA FLEXTOUCH	8
<i>triamcinolone acetonide</i>	13
<i>triamterene/hydrochlorothiazide</i>	10
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TRINTELLIX	3
<i>trospium chloride</i>	14
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<i>valacyclovir hcl</i>	6
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<i>venlafaxine hcl</i>	3
<i>venlafaxine hcl er</i>	4
<i>venlafaxine hydrochloride er</i>	4
<i>verapamil hcl er</i>	10
V-GO 20	17
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V-GO 40	17
VICTOZA	7
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VIIBRYD STARTER PACK	4
VIMPAT	3
VOSEVI	6
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<i>warfarin sodium</i>	9
<i>wixela inhub</i>	20
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XARELTO STARTER PACK	9
XCOPRI	2
XELJANZ	16
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XENLETA	1
XGEVA	17
XIFAXAN	14
XIGDUO XR	7
XIIDRA	17
XOFLUZA	6
XTAMPZA ER	1
XTANDI	4
XYREM	20
YUPELRI	19
<i>zafirlukast</i>	19
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This abridged formulary was updated on August 5, 2021. 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 [HOPbenefits.com](http://HOPbenefits.com).

**THE VALUE MEDICARE Rx OPTION (PDP) IS A STAND-ALONE PRESCRIPTION DRUG PLAN WITH A MEDICARE CONTRACT. ENROLLMENT IN THE VALUE MEDICARE Rx OPTION (PDP) DEPENDS ON CONTRACT RENEWAL. CMS CONTRACT NUMBER: E3014; FORMULARY ID: 22334**

