2017

Your family
Our focus

Formulary
List of covered Drugs

Health Partners
Medicare Special

Health Partners Plans

Health Partners Medicare Special (HMO SNP)

2017 Formulary

(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

Formulary ID 17378, Version 13

This formulary was updated on 7/1/2017. For more recent information or other questions, please contact Health Partners Medicare at 1-866-901-8000 or, for TTY users, 711, 24 hours a day, seven days a week, or visit www.HPPMedicare.com.

This information is available for free in other languages. Please call our Member Relations number at 1-866-901-8000. (TTY users should call 711.) Hours are 24 hours a day, seven days a week.

Esta información se puede obtener en otros idiomas gratuitamente. Comuníquese con nuestro Departamento de Servicios para los Miembros al 1-866-901-8000 (los usuarios de TTY deben llamar al 711). Disponible las 24 horas al día, los siete días a la semana.

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 Health Partners Medicare. When it refers to "plan" or "our plan," it means Health Partners Medicare Special.

This document includes a list of the drugs (formulary) for our plan which is current as of 7/1/2017. For an 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, 2017, and from time to time during the year.

What is the Health Partners Medicare Special Formulary?

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

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2017 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2017 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. 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. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 60 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 60-day supply of the drug. 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. The enclosed formulary is current as of 7/1/2017. To get updated information about the drugs covered by Health Partners Medicare Special, please contact us. Our contact information appears on the front and back cover pages.

Our print formulary will be updated, either by reprinting or through the use of correction sheets, in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. 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 number 99. 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 105. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Health Partners Medicare Special covers both brand name drugs and generic drugs. A generic drug is approved by the 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 may have additional requirements or limits on coverage. These requirements and limits may include:

- Prior Authorization: Health Partners Medicare Special requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Health Partners Medicare Special before you fill your prescriptions. If you don't get approval, Health Partners Medicare Special may not cover the drug.

- Quantity Limits: For certain drugs, Health Partners Medicare Special limits the amount of the drug that Health Partners Medicare Special will cover. For example, Health Partners Medicare Special provides 12 tablets per day per prescription for Endocet tablets, 5-325mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Health Partners Medicare Special 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, Health Partners Medicare Special may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Health Partners Medicare Special 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 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.HPPMedicare.com. We have posted online documents that explain 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 Health Partners Medicare Special 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 Health Partners Medicare Special Formulary?" on this page 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 Member Relations and ask if your drug is covered.

If you learn that Health Partners Medicare Special does not cover your drug, you have two options:

- You can ask us for a list of similar drugs that are covered by Health Partners Medicare Special. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Health Partners Medicare Special.
- You can ask Health Partners Medicare Special 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 Health Partners Medicare Special Formulary?

You can ask Health Partners Medicare Special 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 a drug even if it is not on our formulary. If approved, this drug will be covered at a predetermined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health Partners Medicare Special limits the amount of the 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, Health Partners Medicare Special will only approve your request for an exception if the alternative drugs included on the plan's formulary 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 us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary 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 believe 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 (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with a 98-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 (unless you have a prescription for fewer days) while you pursue a formulary exception.

If you are a **current member** and have a change in treatment setting due to a change in the level of care you require you can ask us to make a formulary exception.

Examples of level of care changes might include:

- Discharge from a hospital to home
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan
- Changing from Hospice Status and reverting back to standard Medicare Part A and B coverage
- Ending a long-term care stay and returning to the community
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered, are known to have risks.

For more information

For more detailed information about your Health Partners Medicare Special prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Health Partners Medicare Special, 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.

Health Partners Medicare Special's Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Special. If you have trouble finding your drug in the list, turn to the Index that begins on page 105.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., SPIRIVA) and generic drugs are listed in lower-case italics (e.g., *valsartan*).

The information in the Requirements/Limits column tells you if Health Partners Medicare Special has any special requirements for coverage of your drug.

Drugs marked LA: This prescription may be available only at certain pharmacies. For more information call us anytime at 1-866-901-8000. TTY users should call 711.

LEGEND

TIER	NAME
1	Covered

SYMBOL	NAME	DESCRIPTION
QL	Quantity Limit	There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame.
PA	Prior Authorization	You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
ST	Step Therapy	In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
LA	Limited Access	This prescription drug is limited to certain pharmacies.
FDA	FDA Quantity Limit	There is an FDA limit on the amount of this drug that is covered per prescription, or within a specific time frame.
NDS	Non-Extended Day Supply	You cannot obtain an extended day supply for this type of drug. We will cover up to a 30-day supply per prescription only.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
butalbital-aspirin-caffeine	1-Covered	PA
celecoxib	1-Covered	
diclofenac potassium	1-Covered	
diclofenac sodium (dr 25 mg tab, dr 50 mg tab, dr 75 mg tab, ec 25 mg tab, ec 50 mg tab, ec 75 mg tab)	1-Covered	
diclofenac sodium er	1-Covered	
diclofenac sodium-misoprostol	1-Covered	
diflunisal	1-Covered	
etodolac	1-Covered	
fenoprofen calcium	1-Covered	
flurbiprofen	1-Covered	
ibuprofen (100 mg/5 ml susp, 400 mg tablet, 600 mg tablet, 800 mg tablet)	1-Covered	
indomethacin (25 mg capsule, 50 mg capsule)	1-Covered	PA
indomethacin er	1-Covered	PA
ketoprofen (50 mg capsule, 75 mg capsule)	1-Covered	
ketoprofen er 200 mg capsule	1-Covered	QL (1 PER 1 DAYS)
meclofenamate sodium	1-Covered	
mefenamic acid	1-Covered	
meloxicam 15 mg tablet	1-Covered	QL (1 PER 1 DAYS)
meloxicam 7.5 mg tablet	1-Covered	QL (2 PER 1 DAYS)
meloxicam 7.5 mg/5 ml susp	1-Covered	
nabumetone	1-Covered	
naproxen (125 mg/5 ml suspen, 250 mg tablet, dr 375 mg tablet, 375 mg tablet, ec 375 mg tablet, 500 mg kit, 500 mg tablet, dr 500 mg tablet, ec 500 mg tablet)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
naproxen sodium (275 mg tab, 550 mg tab)	1-Covered	
naproxen sodium cr	1-Covered	
naproxen sodium ds	1-Covered	
naproxen sodium er	1-Covered	
oxaprozin	1-Covered	
piroxicam	1-Covered	
sulindac	1-Covered	
tolmetin sodium (400 mg cap, 600 mg tab)	1-Covered	
OPIOID ANALGESICS, LONG-ACTING		
fentanyl	1-Covered	QL (10 PER 30 DAYS)
KADIAN (ER 10 MG CAPSULE, ER 20 MG CAPSULE, ER 30 MG CAPSULE, ER 40 MG CAPSULE, ER 50 MG CAPSULE, ER 60 MG CAPSULE, ER 80 MG CAPSULE, ER 100 MG CAPSULE, ER 200 MG CAPSULE)	1-Covered	
methadone hcl (hcl 5 mg tablet, 5 mg/5 ml solution, 10 mg/5 ml solution, hcl 10 mg tablet)	1-Covered	
morphine sulfate er (er 15 mg tablet, er 30 mg tablet, er 100 mg tablet, er 200 mg tablet)	1-Covered	QL (3 PER 1 DAYS)
morphine sulfate er (sulf er 60 mg tablet, sulfate er 10 mg cap, sulfate er 20 mg cap, sulfate er 30 mg cap, sulfate er 50 mg cap, sulfate er 60 mg cap, sulfate er 80 mg cap, sulfate er 100 mg cap)	1-Covered	
NUCYNTA ER	1-Covered	
oxycodone hcl er	1-Covered	PA
OXYCONTIN (10 MG TABLET, 20 MG TABLET, 40 MG TABLET, 80 MG TABLET)	1-Covered	PA
OXYCONTIN (15 MG TABLET, 30 MG TABLET, 60 MG TABLET)	1-Covered	PA, QL (2 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
oxymorphone hcl er	1-Covered	
tramadol hcl er	1-Covered	
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-cod #2 tablet	1-Covered	QL (13 PER 1 DAYS)
acetaminophen-cod #3 tablet	1-Covered	QL (12 PER 1 DAYS)
acetaminophen-cod #4 tablet	1-Covered	QL (6 PER 1 DAYS)
acetaminophen-codeine (acetamin-codein 300-30 mg/12.5, acetaminop-codeine 120-12 mg/5)	1-Covered	
asa-butalb-caffeine-codeine	1-Covered	
butalb-caff-acetaminoph-codein	1-Covered	PA
butalbital compound-codeine	1-Covered	
butorphanol 10 mg/ml spray	1-Covered	
DURAMORPH	1-Covered	
ENDOCET (7.5-325 MG TABLET, 10-325 MG TABLET)	1-Covered	
ENDOCET 5-325 TABLET	1-Covered	QL (12 PER 1 DAYS)
fentanyl citrate (cit 1,200 mcg, cit 1,600 mcg, citrate 200 mcg, citrate 400 mcg, citrate 600 mcg, citrate 800 mcg)	1-Covered	PA
hydrocodon-acetaminoph 7.5-325	1-Covered	QL (8 PER 1 DAYS)
hydrocodon-acetaminophen 5-325	1-Covered	QL (12 PER 1 DAYS)
hydrocodon-acetaminophn 10-325	1-Covered	QL (6 PER 1 DAYS)
hydrocodone-acetaminophen (hydrocodon-acetamin 7.5-325/15, hydrocodon-acetaminoph 2.5-325, hydrocodone-acetamin 2.5-108/5, hydrocodone-acetamin 5-217/10)	1-Covered	
hydrocodone-ibuprofen (5-200 mg, 10-200)	1-Covered	
hydrocodone-ibuprofen 7.5-200	1-Covered	QL (5 PER 1 DAYS)
hydromorphone hcl (2 mg tablet, 4 mg tablet, 8 mg tablet)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
morphine sulfate (2 mg/ml syringe, 2 mg/ml isecure syr, 4 mg/ml syringe, 4 mg/ml isecure syr, 8 mg/ml isecure syr, 8 mg/ml syringe, 10 mg/ml syringe, 10 mg/ml isecure syr, sulf 10 mg/5 ml soln, sulf 20 mg/5 ml soln, sulf 100 mg/5 ml soln, sulfate ir 15 mg tab, sulfate ir 30 mg tab)	1-Covered	
oxycodone hcl (5 mg/5 ml soln, 5 mg capsule, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet, 100 mg/5 ml soln)	1-Covered	
oxycodone hcl-aspirin	1-Covered	
oxycodone hcl-ibuprofen	1-Covered	
oxycodone-acetaminophen (oxycodon-acetaminophen 2.5-325, oxycodone-acetaminophen 5-325)	1-Covered	QL (12 PER 1 DAYS)
oxycodone-acetaminophen (oxycodon-acetaminophen 7.5-325, oxycodone-acetaminophen 10-325)	1-Covered	
oxymorphone hcl	1-Covered	
pentazocine-naloxone hcl	1-Covered	QL (12 PER 1 DAYS)
tramadol hcl	1-Covered	
tramadol hcl-acetaminophen	1-Covered	QL (8 PER 1 DAYS)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine 5% ointment	1-Covered	
lidocaine 5% patch	1-Covered	PA
lidocaine hcl 2% jelly	1-Covered	
lidocaine hcl viscous	1-Covered	
lidocaine-prilocaine	1-Covered	
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
disulfiram	1-Covered	
naltrexone hcl	1-Covered	
VIVITROL	1-Covered	NDS (Non-Extended Day Supply)
OPIOID DEPENDENCE TREATMENTS		
BUNAVAIL	1-Covered	PA
buprenorphine hcl (0.3 mg/ml vial, 0.3 mg/ml syring)	1-Covered	
buprenorphine hcl (2 mg tablet, 8 mg tablet)	1-Covered	PA
buprenorphine-naloxone	1-Covered	PA
SUBOXONE	1-Covered	PA
ZUBSOLV (1.4-0.36 MG TABLET, 2.9-0.71 MG TABLET, 5.7-1.4 MG TABLET, 8.6-2.1 MG TABLET, 11.4-2.9 MG TABLET)	1-Covered	PA
OPIOID REVERSAL AGENTS		
EVZIO	1-Covered	
naloxone hcl (0.4 mg/ml vial, 2 mg/2 ml syringe, 4 mg/10 ml vial)	1-Covered	
NARCAN 4 MG NASAL SPRAY	1-Covered	
SMOKING CESSATION AGENTS		
bupropion hcl sr 150 mg tablet	1-Covered	QL (2 PER 1 DAYS)
CHANTIX	1-Covered	
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
ZYBAN	1-Covered	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate (1 gram/4 ml vial, 500 mg/2 ml vial)	1-Covered	
GENTAK	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
gentamicin sulfate (0.1% ointment, 0.1% cream, 0.3% eye ointment, 0.3% eye drops, 3 mg/ml eye drops, 3 mg/gm eye oint, 10 mg/ml vial, ped 20 mg/2 ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 800 mg/20 ml vial)	1-Covered	
gentamicin sulfate in ns (70 mg/ns 50 ml pb, isoton 80 mg/100 ml, 80 mg/ns 50 ml pb, 90 mg/ns 100 ml pb, iso 120 mg/100 ml, isoton 60 mg/50 ml, 60 mg/ns 50 ml pb, isoton 80 mg/50 ml, 80 mg/ns 100 ml pb, 100 mg/ns 100 ml, iso 100 mg/100 ml)	1-Covered	
neomycin sulfate	1-Covered	
paromomycin sulfate	1-Covered	
streptomycin sulfate	1-Covered	
tobramycin 0.3% eye drops	1-Covered	
tobramycin sulfate (1.2 gm vial, 1.2 gram/30 ml vial, 10 mg/ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 1,200 mg/30 ml vial)	1-Covered	
ANTIBACTERIALS, OTHER		
bacitracin (500 unit/gm ophth, 50,000 unit vial)	1-Covered	
BACTROBAN NASAL	1-Covered	
chloramphenicol sod succinate	1-Covered	
clindamycin hcl	1-Covered	
clindamycin palmitate hcl	1-Covered	
clindamycin pediatric	1-Covered	
clindamycin phosphate (ph 1% solution, ph 1% gel, 2% vaginal cream, ph 9 g/60 ml vial, phosp 1% lotion, 150 mg/ml addvan, 300 mg/2 ml addvan, ph 300 mg/2 ml vl, 600 mg/4 ml addvan, ph 600 mg/4 ml vl, ph 900 mg/6 ml vl, phos 1% pledget, 900 mg/6 ml addvan)	1-Covered	
clindamycin phosphate-d5w	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
colistimethate	1-Covered	
CUBICIN	1-Covered	ST
daptomycin	1-Covered	ST
erythromycin-benzoyl peroxide	1-Covered	
linezolid (100 mg/5 ml susp, 600 mg tablet, 600 mg/300 ml iv sol)	1-Covered	PA
methenamine hippurate	1-Covered	
metronidazole (vaginal 0.75% gl, 250 mg tablet, 375 mg capsule, 500 mg/100 ml, 500 mg tablet)	1-Covered	
mupirocin	1-Covered	
neomycin-polymyxin b	1-Covered	
nitrofurantoin (25 mg/5 ml susp, mcr 25 mg cap, mcr 100 mg cap)	1-Covered	
nitrofurantoin mcr 50 mg cap	1-Covered	QL (112 PER 30 DAYS)
nitrofurantoin mono-macro	1-Covered	
polymyxin b sulfate	1-Covered	
SYNERCID	1-Covered	NDS (Non-Extended Day Supply)
trimethoprim	1-Covered	
TYGACIL	1-Covered	
vancomycin hcl (1 gm vial, 1 gm add-van vial, hcl 5 gm vial, hcl 10 gm vial, 500 mg a-v vial, 500 mg vial, hcl 750 mg vial)	1-Covered	
vancomycin hcl 125 mg capsule	1-Covered	QL (4 PER 1 DAYS)
vancomycin hcl 250 mg capsule	1-Covered	QL (8 PER 1 DAYS)
XIFAXAN	1-Covered	PA
BETA-LACTAM, CEPHALOSPORINS		
cefaclor (250 mg capsule, 500 mg capsule)	1-Covered	
cefaclor er	1-Covered	
cefadroxil (1 gm tablet, 250 mg/5 ml susp, 500 mg/5 ml susp, 500 mg capsule)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cefazolin 1 g/50 ml-dextrose	1-Covered	
cefazolin sodium	1-Covered	
cefdinir (125 mg/5 ml susp, 250 mg/5 ml susp, 300 mg capsule)	1-Covered	
cefepime hcl	1-Covered	
cefepime-dextrose	1-Covered	
cefixime	1-Covered	
cefotetan (1 gm vial, 2 gm vial)	1-Covered	
cefoxitin	1-Covered	
cefoxitin sodium	1-Covered	
cefpodoxime proxetil (50 mg/5 ml susp, 100 mg tablet, 100 mg/5 ml susp, 200 mg tablet)	1-Covered	
cefprozil (125 mg/5 ml susp, 250 mg/5 ml susp, 250 mg tablet, 500 mg tablet)	1-Covered	
ceftazidime	1-Covered	
ceftriaxone (1 gm vial, 2 gm add vial, 2 gm vial, 10 gm vial, 100 gram bulk bag, 250 mg vial, 500 mg vial)	1-Covered	
cefuroxime	1-Covered	
cefuroxime sodium	1-Covered	
cephalexin (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 500 mg capsule)	1-Covered	
SPECTRACEF 400 MG DOSE PACK TB	1-Covered	
SUPRAX 400 MG CAPSULE	1-Covered	
TEFLARO	1-Covered	
BETA-LACTAM, OTHER		
AZACTAM-ISO-OSMOTIC DEXTROSE	1-Covered	PA - TO CONFIRM PART D COVERAGE
aztreonam 1 gm vial	1-Covered	
imipenem-cilastatin sodium	1-Covered	
INVANZ 1 GM VIAL	1-Covered	
meropenem iv 500 mg vial	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BETA-LACTAM, PENICILLINS		
amoxicillin (125 mg tab chew, 125 mg/5 ml susp, 200 mg/5 ml susp, 250 mg capsule, 250 mg tab chew, 250 mg/5 ml susp, 400 mg/5 ml susp, 500 mg tablet, 500 mg capsule, 875 mg tablet)	1-Covered	
amoxicillin-clavulanate pot er	1-Covered	
amoxicillin-clavulanate potass (200-28.5 mg tab chew, 200-28.5 mg/5 ml sus, 250-62.5 mg/5 ml sus, 250-125 mg tablet, 400-57 mg/5 ml susp, 400-57 mg tab chew, 500-125 mg tablet, 600-42.9 mg/5 ml sus, 875-125 mg tablet)	1-Covered	
ampicillin sodium (1 gm a-v vial, 1 gm vial, 2 gm vial, 10 gm vial, 125 mg vial)	1-Covered	
ampicillin trihydrate (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 500 mg capsule)	1-Covered	
ampicillin-sulbactam	1-Covered	
BICILLIN L-A	1-Covered	
dicloxacillin sodium	1-Covered	
nafcillin 1 gm/ 50 ml inj	1-Covered	
nafcillin sodium (1 gm add-van vial, 1 gm vial, 10 gm bulk vial, 10 gm vial)	1-Covered	
oxacillin	1-Covered	
oxacillin sodium (1 gm vial, 2 gm add-vantage vl, 2 gm vial, 10 gm vial)	1-Covered	
pen g 1.2 million unit/2 ml	1-Covered	
penicillin g potassium	1-Covered	
penicillin g sodium	1-Covered	
penicillin gk-iso-osm dextrose (2 million unit/50 ml, 3 million unit/50 ml)	1-Covered	
penicillin v potassium (125 mg/5 ml soln, 250 mg tablet, 250 mg/5 ml soln, 500 mg tablet)	1-Covered	
piperacillin-tazobactam (3.375 gm vl, 4.5 gm vial, 40.5 gram)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MACROLIDES		
AZASITE	1-Covered	
azithromycin (1 gm pwd packet, 250 mg tablet, 500 mg tablet, i.v. 500 mg vial)	1-Covered	
azithromycin (100 mg/5 ml, 200 mg/5 ml)	1-Covered	QL (25 PER 1 DAYS)
azithromycin 600 mg tablet	1-Covered	QL (2 PER 1 DAYS)
clarithromycin (125 mg/5 ml, 250 mg/5 ml)	1-Covered	
clarithromycin (250 mg tablet, 500 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
clarithromycin er	1-Covered	
ERY-TAB	1-Covered	
ERYTHROCIN LACTOBIONATE (500 MG VIAL, 500 MG ADDVNT VL)	1-Covered	
erythromycin (0.5% eye ointment, 2% gel, 2% solution, ec 250 mg cap, 250 mg filmtab, dr 250 mg cap, 500 mg filmtab)	1-Covered	
erythromycin ethylsuccinate (200 mg/5 ml gran, es 400 mg tab)	1-Covered	
ZMAX	1-Covered	
QUINOLONES		
ciprofloxacin (250 mg/5 ml susp, 400 mg/40 ml vl, 500 mg/5 ml susp)	1-Covered	
ciprofloxacin er	1-Covered	
ciprofloxacin hcl (0.2% otic soln, 0.3% eye drop, hcl 100 mg tab, hcl 250 mg tab, hcl 500 mg tab, hcl 750 mg tab)	1-Covered	
ciprofloxacn-d5w 200 mg/100 ml	1-Covered	
gatifloxacin	1-Covered	
levofloxacin (0.5% eye drops, 25 mg/ml solution, 250 mg/10 ml soln, 500 mg/20 ml vial, 500 mg/20 ml soln, 750 mg/30 ml vial)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
levofloxacin (250 mg tablet, 500 mg tablet, 750 mg tablet)	1-Covered	QL (1 PER 1 DAYS)
levofloxacin-d5w (500 mg/100, 750 mg/150)	1-Covered	
moxifloxacin	1-Covered	
moxifloxacin hcl 400 mg tablet	1-Covered	
ofloxacin (0.3% eye drops, 0.3% ear drops, 300 mg tablet, 400 mg tablet)	1-Covered	
SULFONAMIDES		
SILVADENE	1-Covered	
silver sulfadiazine	1-Covered	
sodium sulfacetamide 10% lot	1-Covered	
SSD	1-Covered	
sulfacetamide sodium (eye drops, eye ointment, sod top susp, sodium lotn)	1-Covered	
sulfadiazine	1-Covered	
sulfamethoxazole-trimethoprim (ds tablet, inj vial, ss tablet, susp)	1-Covered	
TETRACYCLINES		
demeclocycline hcl	1-Covered	
doxycycline hyclate (hyc 100 mg vial, hyc dr 50 mg tab, hyc dr 75 mg tab, hyc dr 100 mg tab, hyc dr 150 mg tab, hyc dr 200 mg tab, hyclate 20 mg tab, hyclate 50 mg cap, hyclate 100 mg tab, hyclate 100 mg cap)	1-Covered	
doxycycline monohydrate (25 mg/5 ml susp, mono 50 mg cap, mono 50 mg tablet, mono 75 mg tablet, mono 75 mg capsule, mono 100 mg tablet, mono 100 mg cap, mono 150 mg tablet)	1-Covered	
minocycline hcl (50 mg capsule, 75 mg capsule, 100 mg capsule)	1-Covered	
tetracycline hcl	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT (10 MG/ML ORAL SOLN, 10 MG TABLET, 25 MG TABLET, 50 MG TABLET, 50 MG/5 ML VIAL, 75 MG TABLET, 100 MG TABLET)	1-Covered	
FYCOMPA (0.5 MG/ML ORAL SUSP, 2 MG TABLET, 4 MG TABLET, 6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET)	1-Covered	
levetiracetam (100 mg/ml soln, 250 mg tablet, 500 mg/5 ml vial, 500 mg tablet, 500 mg/5 ml soln, 750 mg tablet, 1,000 mg tablet)	1-Covered	
levetiracetam er	1-Covered	
levetiracetam-nacl	1-Covered	
POTIGA	1-Covered	ST
ROWEEPRA	1-Covered	
SPRITAM	1-Covered	
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN	1-Covered	ST
ethosuximide (250 mg/5 ml soln, 250 mg capsule)	1-Covered	
zonisamide	1-Covered	
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
diazepam (2.5 mg gel sys, 10 mg gel syst, 20 mg gel syst)	1-Covered	
divalproex sodium	1-Covered	
divalproex sodium er	1-Covered	
gabapentin (100 mg capsule, 250 mg/5 ml soln, 300 mg/6 ml soln, 300 mg capsule, 400 mg capsule)	1-Covered	
gabapentin 600 mg tablet	1-Covered	QL (6 PER 1 DAYS)
gabapentin 800 mg tablet	1-Covered	QL (4 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GABITRIL 12 MG TABLET	1-Covered	ST, QL (4 PER 1 DAYS)
GABITRIL 16 MG TABLET	1-Covered	ST, QL (3 PER 1 DAYS)
GRALISE	1-Covered	
ONFI (10 MG TABLET, 20 MG TABLET)	1-Covered	ST
ONFI 2.5 MG/ML SUSPENSION	1-Covered	
phenobarbital (15 mg tablet, 16.2 mg tablet, 20 mg/5 ml soln, 20 mg/5 ml elix, 30 mg tablet, 32.4 mg tablet, 60 mg tablet, 64.8 mg tablet, 97.2 mg tablet, 100 mg tablet)	1-Covered	
primidone	1-Covered	
SABRIL	1-Covered	ST, LA, NDS (Non-Extended Day Supply)
tiagabine hcl	1-Covered	
valproate sodium	1-Covered	
valproic acid (250 mg capsule, 250 mg/5 ml soln, 500 mg/10 ml sol)	1-Covered	
GLUTAMATE REDUCING AGENTS		
felbamate (400 mg tablet, 600 mg tablet, 600 mg/5 ml susp)	1-Covered	
LAMICTAL (BLUE)	1-Covered	
LAMICTAL (GREEN)	1-Covered	
LAMICTAL (ORANGE)	1-Covered	
LAMICTAL XR (BLUE)	1-Covered	
LAMICTAL XR (GREEN)	1-Covered	
LAMICTAL XR (ORANGE)	1-Covered	
lamotrigine (5 mg disper tablet, 25 mg disper tab, 25 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1-Covered	
lamotrigine er	1-Covered	
lamotrigine odt	1-Covered	
topiramate (15 mg cap, 25 mg cap)	1-Covered	
topiramate (25 mg tablet, 50 mg tablet, 100 mg tablet)	1-Covered	QL (6 PER 1 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
topiramate 200 mg tablet	1-Covered	QL (4 PER 1 DAYS)
topiramate er	1-Covered	
TROKENDI XR	1-Covered	ST
SODIUM CHANNEL AGENTS		
APTIOM	1-Covered	
BANZEL (40 MG/ML SUSPENSION, 200 MG TABLET, 400 MG TABLET)	1-Covered	ST
carbamazepine (100 mg tab chew, 100 mg/5 ml susp, 200 mg tablet)	1-Covered	
carbamazepine er	1-Covered	
CEREBYX 500 MG PE/10 ML VIAL	1-Covered	
DILANTIN 30 MG CAPSULE	1-Covered	ST
fosphenytoin 100 mg pe/2 ml vl	1-Covered	
oxcarbazepine (150 mg tablet, 300 mg/5 ml susp, 300 mg tablet, 600 mg tablet)	1-Covered	
OXTELLAR XR	1-Covered	ST
PEGANONE	1-Covered	ST
phenytoin (50 mg infatab, 50 mg tablet chew, 100 mg/4 ml susp, 125 mg/5 ml susp)	1-Covered	
phenytoin sodium (50 mg/ml vial, 50 mg/ml ampul, 100 mg/2 ml vial, 250 mg/5 ml vial)	1-Covered	
phenytoin sodium extended	1-Covered	
TEGRETOL XR 100 MG TABLET	1-Covered	ST
VIMPAT (10 MG/ML SOLUTION, 50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG/20 ML VIAL, 200 MG TABLET)	1-Covered	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
ergoloid mesylates	1-Covered	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CHOLINESTERASE INHIBITORS		
donepezil hcl (5 mg tablet, 10 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
donepezil hcl 23 mg tablet	1-Covered	
donepezil hcl odt	1-Covered	QL (2 PER 1 DAYS)
galantamine er	1-Covered	
galantamine hbr	1-Covered	
galantamine hydrobromide	1-Covered	
NAMZARIC	1-Covered	
rivastigmine (1.5 mg capsule, 3 mg capsule, 4.5 mg capsule, 6 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
rivastigmine (4.6 mg/24hr patch, 9.5 mg/24hr patch, 13.3 mg/24hr ptch)	1-Covered	QL (1 PER 1 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (5 mg tablet, 10 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
memantine hcl (hcl 2 mg/ml solution, 5-10 mg titration pk)	1-Covered	
NAMENDA XR	1-Covered	
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
APLENZIN	1-Covered	
bupropion hcl	1-Covered	QL (4 PER 1 DAYS)
bupropion hcl sr (100 mg tablet, 200 mg tablet, 200 mg tab)	1-Covered	QL (2 PER 1 DAYS)
bupropion hcl xl 150 mg tablet	1-Covered	QL (3 PER 1 DAYS)
bupropion hcl xl 300 mg tablet	1-Covered	QL (1 PER 1 DAYS)
chlordiazepoxide-amitriptyline	1-Covered	
FORFIVO XL	1-Covered	
mirtazapine (15 mg tablet, 15 mg odt)	1-Covered	QL (3 PER 1 DAYS)
mirtazapine (30 mg tablet, 30 mg odt)	1-Covered	QL (2 PER 1 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
mirtazapine (7.5 mg tablet, 45 mg tablet, 45 mg odt)	1-Covered	QL (1 PER 1 DAYS)
olanzapine-fluoxetine hcl	1-Covered	
perphenazine-amitriptyline	1-Covered	
MONOAMINE OXIDASE INHIBITORS		
EMSAM	1-Covered	
MARPLAN	1-Covered	
phenelzine sulfate	1-Covered	
tranylcypromine sulfate	1-Covered	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR		
BRISDELLE	1-Covered	
citalopram hbr (20 mg tablet, 40 mg tablet)	1-Covered	QL (1.5 PER 1 DAYS)
citalopram hbr 10 mg tablet	1-Covered	QL (3 PER 1 DAYS)
citalopram hbr 10 mg/5 ml soln	1-Covered	
desvenlafaxine er	1-Covered	
desvenlafaxine succinate er	1-Covered	
escitalopram 10 mg tablet	1-Covered	QL (1.5 PER 1 DAYS)
escitalopram 20 mg tablet	1-Covered	QL (1 PER 1 DAYS)
escitalopram 5 mg tablet	1-Covered	QL (3 PER 1 DAYS)
escitalopram oxalate 5 mg/5 ml	1-Covered	QL (20 PER 1 DAYS)
FETZIMA	1-Covered	
fluoxetine dr	1-Covered	
fluoxetine hcl (10 mg tablet, 10 mg capsule)	1-Covered	QL (3 PER 1 DAYS)
fluoxetine hcl (20 mg tablet, 20 mg capsule)	1-Covered	QL (4 PER 1 DAYS)
fluoxetine hcl (20 mg/5 ml solution, hcl 60 mg tablet)	1-Covered	
fluoxetine hcl 40 mg capsule	1-Covered	QL (2 PER 1 DAYS)
fluvoxamine maleate (50 mg tab, 100 mg tab)	1-Covered	QL (3 PER 1 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fluvoxamine maleate 25 mg tab	1-Covered	QL (1 PER 1 DAYS)
fluvoxamine maleate er	1-Covered	
maprotiline hcl	1-Covered	
nefazodone hcl (50 mg tablet, 100 mg tablet, 250 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
nefazodone hcl 150 mg tablet	1-Covered	QL (4 PER 1 DAYS)
nefazodone hcl 200 mg tablet	1-Covered	QL (3 PER 1 DAYS)
paroxetine cr	1-Covered	
paroxetine er	1-Covered	
paroxetine hcl	1-Covered	
PAXIL 10 MG/5 ML SUSPENSION	1-Covered	
PEXEVA	1-Covered	
PRISTIQ	1-Covered	
sertraline 20 mg/ml oral conc	1-Covered	QL (10 PER 1 DAYS)
sertraline hcl (25 mg tablet, 50 mg tablet)	1-Covered	QL (3 PER 1 DAYS)
sertraline hcl 100 mg tablet	1-Covered	QL (2 PER 1 DAYS)
trazodone hcl	1-Covered	
TRINTELLIX	1-Covered	
venlafaxine hcl	1-Covered	
venlafaxine hcl er (er 150 mg cap, er 150 mg tab)	1-Covered	QL (2 PER 1 DAYS)
venlafaxine hcl er (er 37.5 mg cap, er 37.5 mg tab, er 75 mg cap, er 75 mg tab)	1-Covered	QL (3 PER 1 DAYS)
venlafaxine hcl er 225 mg tab	1-Covered	QL (1 PER 1 DAYS)
VIIBRYD	1-Covered	
TRICYCLICS		
amitriptyline hcl	1-Covered	
amoxapine	1-Covered	
clomipramine hcl	1-Covered	
desipramine hcl	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxepin hcl (10 mg/ml oral conc, 10 mg capsule, 25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule)	1-Covered	
imipramine hcl	1-Covered	
imipramine pamoate	1-Covered	
nortriptyline hcl (10 mg/5 ml sol, hcl 10 mg cap, hcl 25 mg cap, hcl 50 mg cap, hcl 75 mg cap)	1-Covered	
protriptyline hcl	1-Covered	
trimipramine maleate (25 mg cap, 50 mg cap)	1-Covered	QL (6 PER 1 DAYS)
trimipramine maleate 100 mg cp	1-Covered	QL (3 PER 1 DAYS)
ANTIEMETICS		
ANTIEMETICS, OTHER		
meclizine hcl (12.5 mg tablet, 25 mg tablet)	1-Covered	
metoclopramide hcl (5 mg tablet, 5 mg/5 ml syrup, 5 mg/5 ml soln, 10 mg/2 ml vial, 10 mg tablet)	1-Covered	
metoclopramide hcl odt	1-Covered	
perphenazine	1-Covered	
prochlorperazine	1-Covered	
prochlorperazine edisylate	1-Covered	
prochlorperazine maleate	1-Covered	
promethazine 50 mg tablet	1-Covered	PA
promethazine hcl (12.5 mg suppos, 25 mg suppository, 50 mg suppository)	1-Covered	
TRANSDERM-SCOP	1-Covered	
trimethobenzamide hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMETOGENIC THERAPY ADJUNCTS		
aprepitant	1-Covered	PA - TO CONFIRM PART D COVERAGE
dronabinol	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EMEND (40 MG CAPSULE, 80 MG CAPSULE, 125 MG POWDER PACKET, 125 MG CAPSULE, 150 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE
EMEND TRIPACK	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (3 PER 14 DAYS)
granisetron hcl (0.1 mg/ml vial, 4 mg/4 ml vial)	1-Covered	
granisetron hcl 1 mg tablet	1-Covered	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl (4 mg/2 ml vial, 4 mg/2 ml amp)	1-Covered	
ondansetron hcl (4 mg/5 ml solution, hcl 24 mg tablet)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl 4 mg tablet	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (6 PER 1 DAYS)
ondansetron hcl 8 mg tablet	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (3 PER 1 DAYS)
ondansetron odt	1-Covered	PA - TO CONFIRM PART D COVERAGE
ANTIFUNGALS		
ABELCET	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
AMBISOME	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
amphotericin b	1-Covered	PA - TO CONFIRM PART D COVERAGE
CANCIDAS	1-Covered	
ciclopirox (0.77% gel, 0.77% cream, 0.77% topical susp, 1% shampoo, 8% solution)	1-Covered	
clotrimazole (1% solution, 1% cream, 10 mg troche)	1-Covered	
econazole nitrate	1-Covered	
fluconazole (10 mg/ml susp, 40 mg/ml susp, 50 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1-Covered	
fluconazole in saline (200 mg/100 ml, 400 mg/200 ml)	1-Covered	
fluconazole-nacl (200 mg/100 ml, 400 mg/200 ml)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
flucytosine	1-Covered	
griseofulvin (125 mg/5 ml susp, micro 500 mg tab)	1-Covered	
griseofulvin ultramicrosize	1-Covered	
GYNAZOLE 1	1-Covered	
itraconazole	1-Covered	
ketoconazole (2% shampoo, 2% cream, 200 mg tablet)	1-Covered	
naftifine hcl	1-Covered	
NOXAFIL (40 MG/ML SUSPENSION, DR 100 MG TABLET)	1-Covered	
NYAMYC	1-Covered	
nystatin (100,000 unit/gm cream, 100,000 units/gm oint, 100,000 unit/ml susp, 100,000 unit/gm powd, 500,000 unit oral tab, 500,000 unit/5 ml sus, 50,000,000 units pwd, 150,000,000 units pwd, 500,000,000 units pwd)	1-Covered	
nystatin-triamcinolone	1-Covered	
NYSTOP	1-Covered	
ONMEL	1-Covered	
oxiconazole nitrate	1-Covered	
SPORANOX 10 MG/ML SOLUTION	1-Covered	
terbinafine hcl	1-Covered	QL (1 PER 1 DAYS)
terconazole (0.4% cream, 0.8% cream, 80 mg suppository)	1-Covered	
voriconazole (40 mg/ml susp, 50 mg tablet, 200 mg tablet, 200 mg vial)	1-Covered	
ANTIGOUT AGENTS		
allopurinol	1-Covered	
allopurinol sodium	1-Covered	
colchicine	1-Covered	
probenecid	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
probenecid-colchicine	1-Covered	
ANTIMIGRAINE AGENTS		
ERGOT ALKALOIDS		
dihydroergotamine mesylate (1 mg/ml vl, 1 mg/ml am)	1-Covered	
ERGOMAR	1-Covered	
MIGRANAL	1-Covered	
SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS		
almotriptan malate	1-Covered	
frovatriptan succinate	1-Covered	
naratriptan	1-Covered	QL (9 PER 30 DAYS)
naratriptan hcl	1-Covered	QL (9 PER 30 DAYS)
rizatriptan	1-Covered	
sumatriptan	1-Covered	
sumatriptan succinate (25 mg tablet, 50 mg tablet, 100 mg tablet)	1-Covered	QL (9 PER 30 DAYS)
sumatriptan succinate (4 mg/0.5 ml cart, 4 mg/0.5 ml inject, 6 mg/0.5 ml vial, 6 mg/0.5 ml refill, 6 mg/0.5 ml inject, 6 mg/0.5 ml syrng)	1-Covered	
TREXIMET	1-Covered	
zolmitriptan	1-Covered	
zolmitriptan odt	1-Covered	
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
guanidine hcl	1-Covered	
MESTINON 60 MG/5 ML SYRUP	1-Covered	
pyridostigmine bromide	1-Covered	
pyridostigmine bromide er	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone	1-Covered	
rifabutin	1-Covered	
ANTITUBERCULARS		
CAPASTAT SULFATE	1-Covered	
ethambutol hcl	1-Covered	
isoniazid (50 mg/5 ml solution, 100 mg/ml vial, 100 mg tablet, 300 mg tablet)	1-Covered	
PASER	1-Covered	
PRIFTIN	1-Covered	
pyrazinamide	1-Covered	
rifampin	1-Covered	
RIFATER	1-Covered	
SIRTURO	1-Covered	NDS (Non-Extended Day Supply)
TRECATOR	1-Covered	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
BICNU	1-Covered	
busulfan	1-Covered	NDS (Non-Extended Day Supply)
BUSULFEX	1-Covered	NDS (Non-Extended Day Supply)
cyclophosphamide (25 mg capsule, 50 mg capsule)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE	1-Covered	
HEXALEN	1-Covered	NDS (Non-Extended Day Supply)
ifosfamide (1 gm/20 ml vial, 1 gm vial, 3 gm vial, 3 gm/ 60 ml vial)	1-Covered	
LEUKERAN	1-Covered	
MATULANE	1-Covered	NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
melphalan hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
MUSTARGEN	1-Covered	
TREANDA (25 MG VIAL, 100 MG VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VALCHLOR	1-Covered	NDS (Non-Extended Day Supply)
YONDELIS	1-Covered	NDS (Non-Extended Day Supply)
ANTIANDROGENS		
bicalutamide	1-Covered	QL (1 PER 1 DAYS)
flutamide	1-Covered	
NILANDRON	1-Covered	QL (2 PER 1 DAYS)
nilutamide	1-Covered	NDS (Non-Extended Day Supply)
XTANDI	1-Covered	NDS (Non-Extended Day Supply)
ZYTIGA 250 MG TABLET	1-Covered	NDS (Non-Extended Day Supply)
ANTIANGIOGENIC AGENTS		
POMALYST	1-Covered	NDS (Non-Extended Day Supply)
REVLIMID	1-Covered	NDS (Non-Extended Day Supply)
THALOMID	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ANTIESTROGENS/MODIFIERS		
EMCYT	1-Covered	
FARESTON	1-Covered	QL (4 PER 1 DAYS)
FASLODEX	1-Covered	NDS (Non-Extended Day Supply)
SOLTAMOX	1-Covered	
tamoxifen citrate	1-Covered	
ANTIMETABOLITES		
ALIMTA 500 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
cladribine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
CLOLAR	1-Covered	NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cytarabine (2 g/20 ml vial, 20 mg/ml vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cytarabine 100 mg/5 ml vial	1-Covered	
DROXIA	1-Covered	
ELITEK	1-Covered	NDS (Non-Extended Day Supply)
fluorouracil (2% topical soln, 5% top solution, 5% cream)	1-Covered	
fluorouracil (2.5 gm/50 ml btl, 2.5 gm/50 ml vial, 5 gm/100 ml vial, 500 mg/10 ml vial, 1,000 mg/20 ml vl, 2,500 mg/50 ml vl, 5,000 mg/100 ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
FOLOTYN	1-Covered	NDS (Non-Extended Day Supply)
gemcitabine hcl 1 gram vial	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
hydroxyurea	1-Covered	
LONSURF	1-Covered	NDS (Non-Extended Day Supply)
mercaptopurine	1-Covered	
NIPENT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
PURIXAN	1-Covered	
TABLOID	1-Covered	
ANTINEOPLASTICS, OTHER		
ABRAXANE	1-Covered	NDS (Non-Extended Day Supply)
amifostine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ARRANON	1-Covered	NDS (Non-Extended Day Supply)
azacitidine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BELEODAQ	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
bleomycin sulfate 30 unit vial	1-Covered	PA - TO CONFIRM PART D COVERAGE
carboplatin (50 mg/5 ml vial, 150 mg/15 ml vial, 150 mg vial, 450 mg/45 ml vial, 600 mg/60 ml vial)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cisplatin	1-Covered	
COSMEGEN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
CYRAMZA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
dacarbazine 200 mg vial	1-Covered	
DACOGEN	1-Covered	
daunorubicin hcl (20 mg/4 ml vial, 20 mg vial)	1-Covered	
decitabine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
dexrazoxane	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DOCEFREZ 20 MG VIAL	1-Covered	NDS (Non-Extended Day Supply)
docetaxel (20 mg/2 ml vial, 20 mg/ml vial, 80 mg/4 ml vial, 80 mg/8 ml vial, 140 mg/7 ml vial, 160 mg/16 ml vial, 160 mg/8 ml vial, 200 mg/20 ml vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DOXIL	1-Covered	
doxorubicin hcl (10 mg vial, 10 mg/5 ml vial, 20 mg/10 ml vial, 50 mg vial, 50 mg/25 ml vial, 150 mg/75 ml vial, 200 mg/100 ml vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE
doxorubicin hcl liposome	1-Covered	
ELLENCE	1-Covered	NDS (Non-Extended Day Supply)
epirubicin hcl (hcl 50 mg vial, 50 mg/25 ml vial, hcl 200 mg vial, 200 mg/100 ml vial)	1-Covered	
ERWINAZE	1-Covered	NDS (Non-Extended Day Supply)
FARYDAK	1-Covered	NDS (Non-Extended Day Supply)
fludarabine phosphate (50 mg vial, 50 mg/2 ml vial)	1-Covered	
FUSILEV	1-Covered	NDS (Non-Extended Day Supply)
HALAVEN	1-Covered	NDS (Non-Extended Day Supply)
idarubicin hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
irinotecan hcl 100 mg/5 ml vl	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISTODAX	1-Covered	NDS (Non-Extended Day Supply)
IXEMPRA 45 MG KIT	1-Covered	NDS (Non-Extended Day Supply)
JEVTANA	1-Covered	NDS (Non-Extended Day Supply)
leucovorin calcium	1-Covered	
levoleucovorin calcium (50 mg vial, 175 mg/17.5 ml, 250 mg/25 ml vl)	1-Covered	PA - TO CONFIRM PART D COVERAGE
LYNPARZA	1-Covered	NDS (Non-Extended Day Supply)
LYSODREN	1-Covered	
mesna	1-Covered	
MESNEX 400 MG TABLET	1-Covered	NDS (Non-Extended Day Supply)
mitomycin	1-Covered	
mitoxantrone hcl	1-Covered	
oxaliplatin (50 mg vial, 50 mg/10 ml vial, 100 mg vial, 100 mg/20 ml vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
paclitaxel	1-Covered	
PROLEUKIN	1-Covered	NDS (Non-Extended Day Supply)
RUBRACA (200 MG TABLET, 300 MG TABLET)	1-Covered	NDS (Non-Extended Day Supply)
SYLATRON	1-Covered	NDS (Non-Extended Day Supply)
SYNRIBO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
thiotepa	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TRISENOX	1-Covered	NDS (Non-Extended Day Supply)
UVADEX	1-Covered	PA - TO CONFIRM PART D COVERAGE
VELCADE	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VIDAZA	1-Covered	
vinblastine sulfate	1-Covered	PA - TO CONFIRM PART D COVERAGE
VINCASAR PFS	1-Covered	PA - TO CONFIRM PART D COVERAGE
vincristine sulfate	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
vinorelbine 50 mg/5 ml vial	1-Covered	
ZALTRAP 100 MG/4 ML VIAL	1-Covered	NDS (Non-Extended Day Supply)
ZANOSAR	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZINECARD	1-Covered	NDS (Non-Extended Day Supply)
ZOLINZA	1-Covered	NDS (Non-Extended Day Supply)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole	1-Covered	QL (1 PER 1 DAYS)
exemestane	1-Covered	
letrozole	1-Covered	
ENZYME INHIBITORS		
ETOPOPHOS	1-Covered	
etoposide (100 mg/5 ml vial, 500 mg/25 ml vial, 1,000 mg/50 ml vial)	1-Covered	
topotecan hcl (4 mg/4 ml vial, 4 mg vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
MOLECULAR TARGET INHIBITORS		
AFINITOR	1-Covered	NDS (Non-Extended Day Supply)
AFINITOR DISPERZ	1-Covered	NDS (Non-Extended Day Supply)
ALECENSA	1-Covered	NDS (Non-Extended Day Supply)
BOSULIF	1-Covered	NDS (Non-Extended Day Supply)
CABOMETYX	1-Covered	NDS (Non-Extended Day Supply)
CAPRELSA	1-Covered	NDS (Non-Extended Day Supply)
COMETRIQ	1-Covered	NDS (Non-Extended Day Supply)
COTELLIC	1-Covered	LA, NDS (Non-Extended Day Supply)
ERIVEDGE	1-Covered	NDS (Non-Extended Day Supply)
GILOTRIF	1-Covered	NDS (Non-Extended Day Supply)
IBRANCE	1-Covered	NDS (Non-Extended Day Supply)
ICLUSIG	1-Covered	NDS (Non-Extended Day Supply)
imatinib mesylate	1-Covered	NDS (Non-Extended Day Supply)
IMBRUVICA	1-Covered	NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INLYTA	1-Covered	NDS (Non-Extended Day Supply)
IRESSA	1-Covered	NDS (Non-Extended Day Supply)
JAKAFI	1-Covered	NDS (Non-Extended Day Supply)
KISQALI	1-Covered	NDS (Non-Extended Day Supply)
KYPROLIS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LENVIMA	1-Covered	NDS (Non-Extended Day Supply)
MEKINIST	1-Covered	NDS (Non-Extended Day Supply)
NEXAVAR	1-Covered	QL (4 PER 1 DAYS), NDS (Non-Extended Day Supply)
NINLARO	1-Covered	NDS (Non-Extended Day Supply)
ODOMZO	1-Covered	LA, NDS (Non-Extended Day Supply)
SPRYCEL	1-Covered	NDS (Non-Extended Day Supply)
STIVARGA	1-Covered	NDS (Non-Extended Day Supply)
SUTENT (25 MG CAPSULE, 50 MG CAPSULE)	1-Covered	QL (1 PER 1 DAYS), NDS (Non-Extended Day Supply)
SUTENT 12.5 MG CAPSULE	1-Covered	QL (3 PER 1 DAYS), NDS (Non-Extended Day Supply)
SUTENT 37.5 MG CAPSULE	1-Covered	NDS (Non-Extended Day Supply)
TAFINLAR	1-Covered	NDS (Non-Extended Day Supply)
TAGRISSO	1-Covered	LA, NDS (Non-Extended Day Supply)
TARCEVA	1-Covered	NDS (Non-Extended Day Supply)
TASIGNA	1-Covered	NDS (Non-Extended Day Supply)
TORISEL	1-Covered	NDS (Non-Extended Day Supply)
TYKERB	1-Covered	NDS (Non-Extended Day Supply)
VENCLEXTA (10 MG TABLET, 50 MG TABLET)	1-Covered	
VENCLEXTA 100 MG TABLET	1-Covered	NDS (Non-Extended Day Supply)
VENCLEXTA STARTING PACK	1-Covered	
VOTRIENT	1-Covered	NDS (Non-Extended Day Supply)
XALKORI	1-Covered	NDS (Non-Extended Day Supply)
ZELBORAF	1-Covered	NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZYDELIG	1-Covered	NDS (Non-Extended Day Supply)
ZYKADIA	1-Covered	NDS (Non-Extended Day Supply)
MONOCLONAL ANTIBODIES		
AVASTIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BAVENCIO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DARZALEX	1-Covered	LA, NDS (Non-Extended Day Supply)
EMPLICITI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ERBITUX 100 MG/50 ML VIAL	1-Covered	NDS (Non-Extended Day Supply)
HERCEPTIN 440 MG VIAL	1-Covered	NDS (Non-Extended Day Supply)
KADCYLA 100 MG VIAL	1-Covered	NDS (Non-Extended Day Supply)
KEYTRUDA (50 MG VIAL, 100 MG/4 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LARTRUVO	1-Covered	NDS (Non-Extended Day Supply)
OPDIVO 40 MG/4 ML VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
PERJETA	1-Covered	NDS (Non-Extended Day Supply)
RITUXAN	1-Covered	NDS (Non-Extended Day Supply)
SYLVANT 100 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TECENTRIQ	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VECTIBIX 100 MG/5 ML VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
YERVOY 50 MG/10 ML VIAL	1-Covered	NDS (Non-Extended Day Supply)
RETINOIDS		
bexarotene	1-Covered	NDS (Non-Extended Day Supply)
PANRETIN	1-Covered	
TARGRETIN (75 MG SOFTGEL, 75 MG CAPSULE)	1-Covered	NDS (Non-Extended Day Supply)
TARGRETIN 1% GEL	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tretinoin 10 mg capsule	1-Covered	NDS (Non-Extended Day Supply)
ANTIPARASITICS		
ANTIHELMINTHICS		
ALBENZA	1-Covered	
BILTRICIDE	1-Covered	
STROMECTOL	1-Covered	
ANTIPROTOZOALS		
ALINIA (100 MG/5 ML SUSPENSION, 500 MG TABLET)	1-Covered	
atovaquone	1-Covered	
atovaquone-proguanil hcl	1-Covered	
chloroquine phosphate	1-Covered	
COARTEM	1-Covered	
DARAPRIM	1-Covered	
hydroxychloroquine sulfate	1-Covered	
mefloquine hcl	1-Covered	
NEBUPENT	1-Covered	PA - TO CONFIRM PART D COVERAGE
PENTAM 300	1-Covered	
primaquine	1-Covered	QL (2 PER 1 DAYS)
quinine sulfate	1-Covered	
PEDICULICIDES/SCABICIDES		
lindane 1% shampoo	1-Covered	
malathion	1-Covered	
permethrin 5% cream	1-Covered	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (mes 0.5 mg tab, mes 1 mg tablet, mes 2 mg tablet, 2 mg/2 ml vial, 2 mg/2 ml ampule)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
trihexyphenidyl hcl (2 mg tablet, 2 mg/5 ml elx, 5 mg tablet)	1-Covered	
ANTIPARKINSON AGENTS, OTHER		
amantadine (50 mg/5 ml solution, 100 mg tablet, 100 mg/10 ml soln, 100 mg capsule)	1-Covered	
carbidopa-levodopa-entacapone	1-Covered	
entacapone	1-Covered	
NUPLAZID	1-Covered	
tolcapone	1-Covered	
DOPAMINE AGONISTS		
APOKYN	1-Covered	NDS (Non-Extended Day Supply)
bromocriptine mesylate	1-Covered	
MIRAPEX ER 3.75 MG TABLET	1-Covered	
NEUPRO	1-Covered	
pramipexole 0.75 mg tablet	1-Covered	
pramipexole dihydrochloride (0.125 mg tablet, 0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 1.5 mg tablet)	1-Covered	QL (3 PER 1 DAYS)
pramipexole er	1-Covered	
ropinirole er	1-Covered	
ropinirole hcl	1-Covered	
DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	1-Covered	
carbidopa-levodopa	1-Covered	
carbidopa-levodopa er	1-Covered	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
AZILECT	1-Covered	
rasagiline mesylate	1-Covered	
selegiline hcl	1-Covered	
ZELAPAR	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (10 mg tablet, 25 mg tablet, 25 mg/ml amp, 50 mg tablet, 100 mg tablet, 200 mg tablet)	1-Covered	
fluphenazine decanoate	1-Covered	
fluphenazine hcl (1 mg tablet, 2.5 mg/ml vial, 2.5 mg tablet, 2.5 mg/5 ml elix, 5 mg/ml conc, 5 mg tablet, 10 mg tablet)	1-Covered	
haloperidol (0.5 mg tablet, 1 mg tablet, 2 mg tablet, 5 mg/ml ampul, 5 mg tablet, 10 mg tablet, 20 mg tablet)	1-Covered	
haloperidol decanoate	1-Covered	
haloperidol decanoate 100	1-Covered	
haloperidol lactate	1-Covered	
loxapine (10 mg capsule, 25 mg capsule, 50 mg capsule)	1-Covered	
loxapine 5 mg capsule	1-Covered	QL (12 PER 1 DAYS)
molindone hcl	1-Covered	
pimozide	1-Covered	
thioridazine hcl	1-Covered	
thiothixene	1-Covered	
trifluoperazine hcl	1-Covered	
2ND GENERATION/ATYPICAL		
ABILIFY 1 MG/ML SOLUTION	1-Covered	
ABILIFY MAINTENA	1-Covered	NDS (Non-Extended Day Supply)
aripiprazole (2 mg tablet, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet)	1-Covered	
aripiprazole odt	1-Covered	
ARISTADA (ER 441 MG/1.6 ML, ER 662 MG/2.4 ML, ER 882 MG/3.2 ML)	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FANAPT	1-Covered	
GEODON 20 MG/ML VIAL	1-Covered	
INVEGA SUSTENNA 117 MG/0.75 ML	1-Covered	QL (0.75 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 156 MG/ML SYRG	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 234 MG/1.5 ML	1-Covered	QL (1.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 39 MG/0.25 ML	1-Covered	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5 ML	1-Covered	QL (0.5 PER 28 DAYS)
INVEGA TRINZA 273 MG/0.875 ML	1-Covered	QL (0.875 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 410 MG/1.315 ML	1-Covered	QL (1.315 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 546 MG/1.75 ML	1-Covered	QL (1.75 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 819 MG/2.625 ML	1-Covered	QL (2.625 PER 84 DAYS), NDS (Non-Extended Day Supply)
LATUDA	1-Covered	
olanzapine (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet)	1-Covered	QL (1 PER 1 DAYS)
olanzapine 10 mg vial	1-Covered	
olanzapine odt	1-Covered	
paliperidone er 1.5 mg tablet	1-Covered	QL (8 PER 1 DAYS)
paliperidone er 3 mg tablet	1-Covered	QL (4 PER 1 DAYS)
paliperidone er 6 mg tablet	1-Covered	QL (2 PER 1 DAYS)
paliperidone er 9 mg tablet	1-Covered	QL (1 PER 1 DAYS)
quetiapine fumarate (300 mg tab, 400 mg tab)	1-Covered	QL (2 PER 1 DAYS)
quetiapine fumarate (50 mg tab, 100 mg tab, 200 mg tab)	1-Covered	QL (3 PER 1 DAYS)
quetiapine fumarate 25 mg tab	1-Covered	QL (4 PER 1 DAYS)
quetiapine fumarate er	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REXULTI (0.25 MG TABLET, 0.5 MG TABLET, 1 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
REXULTI (2 MG TABLET, 3 MG TABLET, 4 MG TABLET)	1-Covered	QL (1 PER 1 DAYS)
RISPERDAL CONSTA (12.5 MG, 25 MG)	1-Covered	
RISPERDAL CONSTA (37.5 MG, 50 MG)	1-Covered	NDS (Non-Extended Day Supply)
risperidone (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet, 4 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
risperidone 0.5 mg odt	1-Covered	QL (4 PER 1 DAYS)
risperidone 1 mg odt	1-Covered	QL (1 PER 1 DAYS)
risperidone 1 mg/ml solution	1-Covered	
risperidone 3 mg odt	1-Covered	QL (3 PER 1 DAYS)
risperidone odt (0.25 mg odt, 2 mg odt, 4 mg odt)	1-Covered	QL (2 PER 1 DAYS)
SAPHRIS	1-Covered	
SEROQUEL XR (150 MG TABLET, 200 MG TABLET)	1-Covered	QL (1 PER 1 DAYS)
SEROQUEL XR (50 MG TABLET, 300 MG TABLET, 400 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
VRAYLAR	1-Covered	
ziprasidone hcl	1-Covered	QL (2 PER 1 DAYS)
ZYPREXA RELPREVV (210 MG VIAL, 210 MG VL KIT)	1-Covered	
TREATMENT-RESISTANT		
clozapine 100 mg tablet	1-Covered	QL (9 PER 1 DAYS)
clozapine 200 mg tablet	1-Covered	QL (4 PER 1 DAYS)
clozapine 25 mg tablet	1-Covered	QL (3 PER 1 DAYS)
clozapine 50 mg tablet	1-Covered	QL (2 PER 1 DAYS)
clozapine odt	1-Covered	
VERSACLOZ	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTISPASTICITY AGENTS		
baclofen	1-Covered	
dantrolene sodium	1-Covered	
tizanidine hcl (2 mg tablet, 4 mg tablet)	1-Covered	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
cidofovir	1-Covered	
ganciclovir sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
VALCYTE 50 MG/ML SOLUTION	1-Covered	
valganciclovir hcl (hcl 50 mg/ml, 450 mg tablet)	1-Covered	
ZIRGAN	1-Covered	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	QL (20 PER 1 DAYS)
entecavir	1-Covered	
EPIVIR HBV 25 MG/5 ML SOLN	1-Covered	
lamivudine 100 mg tablet	1-Covered	
lamivudine hbv	1-Covered	
TYZEKA	1-Covered	NDS (Non-Extended Day Supply)
ANTI-HEPATITIS C (HCV) AGENTS		
HARVONI	1-Covered	PA, NDS (Non-Extended Day Supply)
INTRON A (10 MILLION UNITS VIL, 18 MILLION UNIT/3 ML, 18 MILLION UNITS VIL, 25 MILLION UNIT/2.5ML, 50 MILLION UNITS VIL)	1-Covered	NDS (Non-Extended Day Supply)
PEGASYS	1-Covered	NDS (Non-Extended Day Supply)
PEGASYS PROCLICK	1-Covered	NDS (Non-Extended Day Supply)
PEGINTRON	1-Covered	NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PEGINTRON REDIPEN	1-Covered	NDS (Non-Extended Day Supply)
REBETOL 40 MG/ML SOLUTION	1-Covered	PA
RIBASPHERE (200 MG TABLET, 200 MG CAPSULE)	1-Covered	PA, QL (7 PER 1 DAYS)
ribavirin (200 mg capsule, 200 mg tablet)	1-Covered	PA, QL (7 PER 1 DAYS)
SOVALDI	1-Covered	PA, NDS (Non-Extended Day Supply)
ZEPATIER	1-Covered	PA, NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
GENVOYA	1-Covered	
ISENTRESS 100 MG POWDER PACKET	1-Covered	
ISENTRESS 100 MG TABLET CHEW	1-Covered	QL (8 PER 1 DAYS)
ISENTRESS 25 MG TABLET CHEW	1-Covered	QL (6 PER 1 DAYS)
ISENTRESS 400 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
STRIBILD	1-Covered	
TIVICAY	1-Covered	
VITEKTA	1-Covered	
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
ATRIPLA	1-Covered	QL (1 PER 1 DAYS)
COMPLERA	1-Covered	QL (1 PER 1 DAYS)
EDURANT	1-Covered	QL (1 PER 1 DAYS)
INTELENCE 100 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
INTELENCE 200 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
INTELENCE 25 MG TABLET	1-Covered	
nevirapine 200 mg tablet	1-Covered	QL (2 PER 1 DAYS)
nevirapine 50 mg/5 ml susp	1-Covered	QL (40 PER 1 DAYS)
nevirapine er 100 mg tablet	1-Covered	
nevirapine er 400 mg tablet	1-Covered	QL (1 PER 1 DAYS)
ODEFSEY	1-Covered	
RESCRIPTOR 100 MG TABLET	1-Covered	QL (12 PER 1 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RESCRIPTOR 200 MG TABLET	1-Covered	QL (6 PER 1 DAYS)
SUSTIVA 200 MG CAPSULE	1-Covered	QL (3 PER 1 DAYS)
SUSTIVA 50 MG CAPSULE	1-Covered	QL (8 PER 1 DAYS)
SUSTIVA 600 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir	1-Covered	QL (2 PER 1 DAYS)
abacavir-lamivudine	1-Covered	QL (1 PER 1 DAYS)
abacavir-lamivudine-zidovudine	1-Covered	
DESCOVY	1-Covered	
didanosine (dr 125 mg capsule, dr 200 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
didanosine (dr 250 mg capsule, dr 400 mg capsule)	1-Covered	QL (1 PER 1 DAYS)
EMTRIVA 10 MG/ML SOLUTION	1-Covered	QL (24 PER 1 DAYS)
EMTRIVA 200 MG CAPSULE	1-Covered	QL (1 PER 1 DAYS)
EPZICOM	1-Covered	QL (1 PER 1 DAYS)
lamivudine 10 mg/ml oral soln	1-Covered	
lamivudine 150 mg tablet	1-Covered	QL (2 PER 1 DAYS)
lamivudine 300 mg tablet	1-Covered	QL (1 PER 1 DAYS)
lamivudine-zidovudine	1-Covered	QL (2 PER 1 DAYS)
RETROVIR 200 MG/20 ML VIAL	1-Covered	
stavudine (15 mg capsule, 20 mg capsule)	1-Covered	QL (4 PER 1 DAYS)
stavudine (30 mg capsule, 40 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
stavudine 1 mg/ml solution	1-Covered	QL (80 PER 1 DAYS)
TRUVADA (100 MG-150 MG TABLET, 133 MG-200 MG TABLET, 167 MG-250 MG TABLET)	1-Covered	
TRUVADA 200 MG-300 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
VIDEX	1-Covered	QL (40 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIREAD (150 MG TABLET, 200 MG TABLET, 250 MG TABLET, POWDER)	1-Covered	
VIREAD 300 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
ZERIT 1 MG/ML SOLUTION	1-Covered	
ZIAGEN 20 MG/ML SOLUTION	1-Covered	QL (30 PER 1 DAYS)
zidovudine 100 mg capsule	1-Covered	QL (6 PER 1 DAYS)
zidovudine 300 mg tablet	1-Covered	QL (2 PER 1 DAYS)
zidovudine 50 mg/5 ml syrup	1-Covered	QL (60 PER 1 DAYS)
ANTI-HIV AGENTS, OTHER		
FUZEON	1-Covered	NDS (Non-Extended Day Supply)
PREZCOBIX	1-Covered	
SELZENTRY (150 MG TABLET, 300 MG TABLET)	1-Covered	QL (4 PER 1 DAYS)
SELZENTRY (25 MG TABLET, 75 MG TABLET)	1-Covered	
TRIUMEQ	1-Covered	
TYBOST	1-Covered	
ANTI-HIV AGENTS, PROTEASE INHIBITORS		
APTIVUS 100 MG/ML SOLUTION	1-Covered	QL (10 PER 1 DAYS)
APTIVUS 250 MG CAPSULE	1-Covered	QL (4 PER 1 DAYS)
CRIXIVAN	1-Covered	
EVOTAZ	1-Covered	
INVIRASE 200 MG CAPSULE	1-Covered	QL (10 PER 1 DAYS)
INVIRASE 500 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
KALETRA 100-25 MG TABLET	1-Covered	QL (10 PER 1 DAYS)
KALETRA 200-50 MG TABLET	1-Covered	QL (5 PER 1 DAYS)
KALETRA 80 MG-20 MG/ML SOLN	1-Covered	QL (14 PER 1 DAYS)
LEXIVA 50 MG/ML SUSPENSION	1-Covered	QL (56 PER 1 DAYS)
LEXIVA 700 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
lopinavir-ritonavir	1-Covered	
NORVIR (100 MG TABLET, 100 MG SOFTGEL CAP)	1-Covered	QL (12 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NORVIR 80 MG/ML SOLUTION	1-Covered	QL (16 PER 1 DAYS)
PREZISTA 100 MG/ML SUSPENSION	1-Covered	
PREZISTA 150 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
PREZISTA 600 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
PREZISTA 75 MG TABLET	1-Covered	QL (8 PER 1 DAYS)
PREZISTA 800 MG TABLET	1-Covered	QL (1 PER 1 DAYS)
REYATAZ (150 MG CAPSULE, 200 MG CAPSULE)	1-Covered	QL (2 PER 1 DAYS)
REYATAZ 300 MG CAPSULE	1-Covered	QL (1 PER 1 DAYS)
REYATAZ 50 MG POWDER PACKET	1-Covered	
VIRACEPT 250 MG TABLET	1-Covered	QL (9 PER 1 DAYS)
VIRACEPT 625 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate	1-Covered	
RELENZA	1-Covered	
rimantadine hcl	1-Covered	
TAMIFLU (6 MG/ML SUSPENSION, 30 MG CAPSULE, 45 MG CAPSULE, 75 MG CAPSULE)	1-Covered	
ANTIHERPETIC AGENTS		
acyclovir (5% ointment, 200 mg capsule, 200 mg/5 ml susp, 400 mg tablet, 800 mg tablet)	1-Covered	
acyclovir sodium (sodium 1 gm vial, sodium 500 mg vial, 500 mg/10 ml vial, 1,000 mg/20 ml vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE
famciclovir	1-Covered	QL (3 PER 1 DAYS)
trifluridine	1-Covered	
valacyclovir	1-Covered	QL (4 PER 1 DAYS)
ZOVIRAX 5% CREAM	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl	1-Covered	
estazolam	1-Covered	
BENZODIAZEPINES		
alprazolam	1-Covered	
alprazolam er	1-Covered	
ALPRAZOLAM INTENSOL	1-Covered	
alprazolam odt	1-Covered	
alprazolam xr	1-Covered	
chlordiazepoxide 10 mg capsule	1-Covered	QL (10 PER 1 DAYS)
chlordiazepoxide 25 mg capsule	1-Covered	QL (12 PER 1 DAYS)
chlordiazepoxide 5 mg capsule	1-Covered	QL (8 PER 1 DAYS)
clonazepam	1-Covered	
clorazepate dipotassium	1-Covered	
diazepam (2 mg tablet, 5 mg tablet, 10 mg tablet)	1-Covered	QL (4 PER 1 DAYS)
diazepam (5 mg/5 ml solution, 5 mg/5 ml oral soln)	1-Covered	QL (40 PER 1 DAYS)
diazepam 5 mg/ml oral conc	1-Covered	QL (8 PER 1 DAYS)
lorazepam 0.5 mg tablet	1-Covered	QL (20 PER 1 DAYS)
lorazepam 1 mg tablet	1-Covered	QL (10 PER 1 DAYS)
lorazepam 2 mg tablet	1-Covered	QL (5 PER 1 DAYS)
LORAZEPAM INTENSOL	1-Covered	QL (5 PER 1 DAYS)
oxazepam	1-Covered	
BIPOLAR AGENTS		
MOOD STABILIZERS		
EQUETRO	1-Covered	ST
lithium	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lithium carbonate	1-Covered	
lithium carbonate er	1-Covered	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose	1-Covered	QL (3 PER 1 DAYS)
BYDUREON	1-Covered	
BYDUREON PEN	1-Covered	
BYETTA	1-Covered	
chlorpropamide 100 mg tablet	1-Covered	QL (7 PER 1 DAYS)
chlorpropamide 250 mg tablet	1-Covered	QL (3 PER 1 DAYS)
CYCLOSET	1-Covered	
glimepiride	1-Covered	
glipizide	1-Covered	QL (4 PER 1 DAYS)
glipizide er 10 mg tablet	1-Covered	QL (2 PER 1 DAYS)
glipizide er 2.5 mg tablet	1-Covered	
glipizide er 5 mg tablet	1-Covered	QL (3 PER 1 DAYS)
glipizide xl 10 mg tablet	1-Covered	QL (2 PER 1 DAYS)
glipizide xl 2.5 mg tablet	1-Covered	
glipizide xl 5 mg tablet	1-Covered	QL (3 PER 1 DAYS)
glipizide-metformin	1-Covered	QL (4 PER 1 DAYS)
glyburide	1-Covered	QL (4 PER 1 DAYS)
glyburide micronized	1-Covered	QL (2 PER 1 DAYS)
glyburide-metformin hcl	1-Covered	QL (4 PER 1 DAYS)
INVOKAMET	1-Covered	
INVOKAMET XR	1-Covered	
INVOKANA	1-Covered	
JANUMET	1-Covered	
JANUMET XR	1-Covered	
JANUVIA	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
JARDIANCE	1-Covered	
JENTADUETO	1-Covered	
JENTADUETO XR	1-Covered	
metformin hcl 1,000 mg tablet	1-Covered	QL (2.5 PER 1 DAYS)
metformin hcl 500 mg tablet	1-Covered	QL (5 PER 1 DAYS)
metformin hcl 850 mg tablet	1-Covered	QL (3 PER 1 DAYS)
metformin hcl er (er 500 mg osm-tb, er 500 mg tablet)	1-Covered	QL (4 PER 1 DAYS)
metformin hcl er (er mg osm-tab, hcl er mg tab)	1-Covered	
metformin hcl er 750 mg tablet	1-Covered	QL (2 PER 1 DAYS)
miglitol	1-Covered	
nateglinide 120 mg tablet	1-Covered	QL (3 PER 1 DAYS)
nateglinide 60 mg tablet	1-Covered	QL (6 PER 1 DAYS)
pioglitazone hcl	1-Covered	QL (1 PER 1 DAYS)
pioglitazone-glimepiride	1-Covered	QL (1 PER 1 DAYS)
pioglitazone-metformin	1-Covered	QL (3 PER 1 DAYS)
repaglinide (0.5 mg tablet, 1 mg tablet)	1-Covered	QL (4 PER 1 DAYS)
repaglinide 2 mg tablet	1-Covered	QL (8 PER 1 DAYS)
repaglinide-metformin hcl	1-Covered	QL (5 PER 1 DAYS)
SYMLINPEN 120	1-Covered	
SYMLINPEN 60	1-Covered	
SYNJARDY (5-1,000 MG TABLET, 12.5-500 MG TABLET, 12.5-1,000 MG TABLET)	1-Covered	QL (2 PER 1 DAYS)
SYNJARDY 5-500 MG TABLET	1-Covered	QL (4 PER 1 DAYS)
tolazamide 250 mg tablet	1-Covered	QL (4 PER 1 DAYS)
tolazamide 500 mg tablet	1-Covered	QL (2 PER 30 DAYS)
tolbutamide	1-Covered	QL (6 PER 1 DAYS)
TRADJENTA	1-Covered	
TRULICITY	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VICTOZA 2-PAK	1-Covered	
VICTOZA 3-PAK	1-Covered	
GLYCEMIC AGENTS		
GLUCAGEN	1-Covered	
GLUCAGON EMERGENCY KIT	1-Covered	
PROGLYCEM	1-Covered	
INSULINS		
AFREZZA	1-Covered	
APIDRA	1-Covered	QL (40 PER 30 DAYS)
APIDRA SOLOSTAR	1-Covered	QL (45 PER 30 DAYS)
BASAGLAR KWIKPEN U-100	1-Covered	
HUMALOG 100 UNITS/ML CARTRIDGE	1-Covered	QL (45 PER 30 DAYS)
HUMALOG 100 UNITS/ML VIAL	1-Covered	QL (40 PER 30 DAYS)
HUMALOG KWIKPEN U-100	1-Covered	QL (45 PER 30 DAYS)
HUMALOG KWIKPEN U-200	1-Covered	
HUMALOG MIX 50-50	1-Covered	QL (40 PER 30 DAYS)
HUMALOG MIX 50-50 KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMALOG MIX 75-25	1-Covered	QL (40 PER 30 DAYS)
HUMALOG MIX 75-25 KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMULIN 70-30	1-Covered	QL (40 PER 30 DAYS)
HUMULIN 70/30 KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMULIN N	1-Covered	QL (40 PER 30 DAYS)
HUMULIN N KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMULIN R	1-Covered	QL (40 PER 30 DAYS)
HUMULIN R U-500	1-Covered	
HUMULIN R U-500 KWIKPEN	1-Covered	
LANTUS	1-Covered	QL (40 PER 30 DAYS)
LANTUS SOLOSTAR	1-Covered	QL (45 PER 30 DAYS)
LEVEMIR	1-Covered	QL (40 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LEVEMIR FLEXPEN	1-Covered	QL (45 PER 30 DAYS)
LEVEMIR FLEXTOUCH	1-Covered	QL (45 PER 30 DAYS)
NOVOLIN 70-30	1-Covered	QL (40 PER 30 DAYS)
NOVOLIN N	1-Covered	QL (40 PER 30 DAYS)
NOVOLIN R	1-Covered	QL (40 PER 30 DAYS)
NOVOLOG 100 UNIT/ML CARTRIDGE	1-Covered	QL (45 PER 30 DAYS)
NOVOLOG 100 UNIT/ML VIAL	1-Covered	QL (40 PER 30 DAYS)
NOVOLOG FLEXPEN	1-Covered	QL (45 PER 30 DAYS)
NOVOLOG MIX 70-30	1-Covered	QL (40 PER 30 DAYS)
NOVOLOG MIX 70-30 FLEXPEN	1-Covered	QL (45 PER 30 DAYS)
TOUJEO SOLOSTAR	1-Covered	
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS		
ANTICOAGULANTS		
COUMADIN	1-Covered	
ELIQUIS 2.5 MG TABLET	1-Covered	QL (2 PER 1 DAYS)
ELIQUIS 5 MG TABLET	1-Covered	QL (74 PER 30 DAYS)
enoxaparin 150 mg/ml syringe	1-Covered	NDS (Non-Extended Day Supply)
enoxaparin sodium (30 mg/0.3 ml syr, 40 mg/0.4 ml syr, 60 mg/0.6 ml syr, 80 mg/0.8 ml syr, 100 mg/ml syringe, 120 mg/0.8 ml syr, 300 mg/3 ml vial)	1-Covered	
fondaparinux sodium	1-Covered	
heparin sodium (sod 1,000 unit/ml vial, sod 5,000 unit/ml vial, sod 10,000 unit/ml vl, 10,000 unit/10 ml vial, sod 20,000 unit/ml vl, 30,000 unit/30 ml vial, 40,000 units/4 ml vial, 50,000 units/5 ml vial, 50,000 unit/10 ml vial, 50,000 units/10 ml vl)	1-Covered	
heparin sodium-d5w (heparin 20,000 unit/500 ml-d5w, heparin-d5w 25,000 unit/500 ml, heparin-d5w 25,000 unit/250 ml)	1-Covered	
JANTOVEN	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRADAXA	1-Covered	
warfarin sodium	1-Covered	
XARELTO	1-Covered	
BLOOD FORMATION MODIFIERS		
anagrelide hcl	1-Covered	
LEUKINE	1-Covered	NDS (Non-Extended Day Supply)
MOZOBIL	1-Covered	NDS (Non-Extended Day Supply)
NEULASTA	1-Covered	PA, NDS (Non-Extended Day Supply)
NEUMEGA	1-Covered	NDS (Non-Extended Day Supply)
NEUPOGEN	1-Covered	PA, NDS (Non-Extended Day Supply)
PROCRIT	1-Covered	PA
PROMACTA	1-Covered	PA, LA, NDS (Non-Extended Day Supply)
ZARXIO	1-Covered	PA, NDS (Non-Extended Day Supply)
COAGULANTS		
tranexamic acid (650 mg tablet, 1,000 mg/10 ml)	1-Covered	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er	1-Covered	QL (3 PER 1 DAYS)
BRILINTA	1-Covered	
cilostazol	1-Covered	
clopidogrel 300 mg tablet	1-Covered	
clopidogrel 75 mg tablet	1-Covered	QL (4 PER 1 DAYS)
dipyridamole	1-Covered	PA
EFFIENT	1-Covered	
ticlopidine hcl	1-Covered	PA, QL (2 PER 1 DAYS)
ZONTIVITY	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	1-Covered	QL (4 PER 28 DAYS)
clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)	1-Covered	
guanfacine hcl	1-Covered	PA
methyldopa	1-Covered	PA
methyldopate hcl	1-Covered	
midodrine hcl	1-Covered	
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin mesylate	1-Covered	QL (2 PER 1 DAYS)
phenoxybenzamine hcl	1-Covered	NDS (Non-Extended Day Supply)
prazosin hcl	1-Covered	
terazosin hcl	1-Covered	QL (2 PER 1 DAYS)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1-Covered	
irbesartan	1-Covered	QL (1 PER 1 DAYS)
losartan potassium (25 mg tab, 50 mg tab)	1-Covered	QL (3 PER 1 DAYS)
losartan potassium 100 mg tab	1-Covered	QL (1 PER 1 DAYS)
olmesartan medoxomil	1-Covered	
telmisartan	1-Covered	
valsartan	1-Covered	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl	1-Covered	QL (2 PER 1 DAYS)
captopril	1-Covered	
enalapril maleate	1-Covered	
fosinopril sodium	1-Covered	
lisinopril (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	1-Covered	QL (3 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lisinopril (20 mg tablet, 30 mg tablet, 40 mg tablet)	1-Covered	QL (2 PER 1 DAYS)
moexipril hcl	1-Covered	
perindopril erbumine	1-Covered	
QBRELIS	1-Covered	
quinapril hcl	1-Covered	QL (2 PER 1 DAYS)
ramipril	1-Covered	QL (2 PER 1 DAYS)
trandolapril	1-Covered	
ANTIARRHYTHMICS		
amiodarone hcl (hcl 100 mg tablet, 150 mg/3 ml amp, 150 mg/3 ml vial, hcl 200 mg tablet, hcl 400 mg tablet, 450 mg/9 ml vial, 900 mg/18 ml vial)	1-Covered	
disopyramide phosphate	1-Covered	PA
dofetilide	1-Covered	
flecainide acetate	1-Covered	
mexiletine hcl	1-Covered	
MULTAQ	1-Covered	
PACERONE 100 MG TABLET	1-Covered	
procainamide hcl	1-Covered	
propafenone hcl	1-Covered	
propafenone hcl er	1-Covered	
quinidine gluconate (80 mg/ml vial, er 324 mg tab)	1-Covered	
quinidine sulfate	1-Covered	
sotalol	1-Covered	
sotalol af	1-Covered	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	1-Covered	
atenolol	1-Covered	
betaxolol hcl (10 mg tablet, 20 mg tablet)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bisoprolol fumarate	1-Covered	
carvedilol	1-Covered	
COREG CR	1-Covered	
labetalol hcl (100 mg tablet, 100 mg/20 ml vl, 200 mg/40 ml vl, 200 mg tablet, 300 mg tablet)	1-Covered	
metoprolol succ er 200 mg tab	1-Covered	QL (2 PER 1 DAYS)
metoprolol succinate (er 25 mg tab, er 50 mg tab, er 100 mg tab)	1-Covered	QL (3 PER 1 DAYS)
metoprolol tartrate (1 mg/ml carpuject, tart 5 mg/5 ml amp, tart 5 mg/5 ml vial, tartrate 25 mg tab, tartrate 37.5 mg tb, tartrate 50 mg tab, tartrate 75 mg tab, tartrate 100 mg tab)	1-Covered	
nadolol	1-Covered	
pindolol	1-Covered	
propranolol hcl (1 mg/ml vial, 10 mg tablet, 20 mg/5 ml soln, 20 mg tablet, 40 mg tablet, 40 mg/5 ml soln, 60 mg tablet, 80 mg tablet)	1-Covered	
propranolol hcl er	1-Covered	
timolol maleate (5 mg tablet, 10 mg tablet, 20 mg tablet)	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS		
AFEDITAB CR	1-Covered	QL (2 PER 1 DAYS)
amlodipine besylate 10 mg tab	1-Covered	QL (1 PER 1 DAYS)
amlodipine besylate 2.5 mg tab	1-Covered	QL (3 PER 1 DAYS)
amlodipine besylate 5 mg tab	1-Covered	QL (2 PER 1 DAYS)
CARTIA XT	1-Covered	
DILT-CD (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE)	1-Covered	
DILT-XR	1-Covered	
diltiazem 12hr er	1-Covered	
diltiazem 24hr cd (120 mg cap, 300 mg cap)	1-Covered	QL (1 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
diltiazem 24hr cd (180 mg cap, 240 mg cap, 360 mg cap)	1-Covered	QL (2 PER 1 DAYS)
diltiazem 24hr er (er 120 mg cap, er 300 mg cap)	1-Covered	QL (1 PER 1 DAYS)
diltiazem 24hr er (er 180 mg cap, er 240 mg cap, er 360 mg cap)	1-Covered	QL (2 PER 1 DAYS)
diltiazem 24hr er 420 mg cap	1-Covered	
diltiazem er (er 180 mg capsule, er 240 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
diltiazem er 120 mg capsule	1-Covered	QL (1 PER 1 DAYS)
diltiazem hcl (25 mg/5 ml vial, 30 mg tablet, 50 mg/10 ml vial, 60 mg tablet, 90 mg tablet, hcl 100 mg vial, 120 mg tablet, 125 mg/25 ml vial)	1-Covered	
felodipine er	1-Covered	QL (1 PER 1 DAYS)
isradipine	1-Covered	
MATZIM LA	1-Covered	
nicardipine hcl (20 mg capsule, 30 mg capsule)	1-Covered	
NIFEDICAL XL	1-Covered	
nifedipine	1-Covered	PA
nifedipine er	1-Covered	QL (2 PER 1 DAYS)
nimodipine	1-Covered	
nisoldipine (er 20 mg tablet, er 30 mg tablet, er 40 mg tablet)	1-Covered	
nisoldipine (er 8.5 mg tablet, er 17 mg tablet, er 25.5 mg tablet, er 34 mg tablet)	1-Covered	QL (1 PER 1 DAYS)
TAZTIA XT	1-Covered	
verapamil er (er 120 mg capsule, er 180 mg capsule, er 240 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
verapamil er (er 120 mg tablet, er 180 mg tablet, er 240 mg tablet)	1-Covered	
verapamil er pm	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
verapamil hcl (2.5 mg/ml vial, 2.5 mg/ml ampul, 40 mg tablet, 80 mg tablet, 120 mg tablet, 360 mg cap pellet)	1-Covered	
verapamil sr	1-Covered	QL (2 PER 1 DAYS)
CARDIOVASCULAR AGENTS, OTHER		
amiloride-hydrochlorothiazide	1-Covered	
amlodipine besylate-benazepril	1-Covered	QL (1 PER 1 DAYS)
amlodipine-atorvastatin	1-Covered	
amlodipine-olmesartan	1-Covered	
amlodipine-valsartan	1-Covered	
amlodipine-valsartan-hctz	1-Covered	
atenolol-chlorthalidone	1-Covered	
benazepril-hydrochlorothiazide	1-Covered	
bisoprolol-hydrochlorothiazide	1-Covered	
candesartan-hydrochlorothiazid	1-Covered	
captopril-hydrochlorothiazide	1-Covered	
CLORPRES	1-Covered	
CORLANOR	1-Covered	
DEMSER	1-Covered	NDS (Non-Extended Day Supply)
DIGITEK	1-Covered	
DIGOX	1-Covered	
digoxin (0.05 mg/ml solution, 0.125 mg tablet, 0.25 mg/ml syringe, 0.25 mg tablet, 125 mcg tablet, 250 mcg tablet, 500 mcg/2 ml ampule)	1-Covered	
DUTOPROL	1-Covered	
enalapril-hydrochlorothiazide	1-Covered	
fosinopril-hydrochlorothiazide	1-Covered	
irbesartan-hydrochlorothiazide	1-Covered	QL (1 PER 1 DAYS)
LANOXIN (62.5 MCG TABLET, 125 MCG TABLET, 187.5 MCG TABLET, 250 MCG TABLET)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lisinopril-hydrochlorothiazide	1-Covered	
losartan-hctz 50-12.5 mg tab	1-Covered	QL (2 PER 1 DAYS)
losartan-hydrochlorothiazide (100-12.5 mg tab, 100-25 mg tab)	1-Covered	QL (1 PER 1 DAYS)
methyldopa-hydrochlorothiazide	1-Covered	PA
metoprolol-hydrochlorothiazide	1-Covered	
moexipril-hydrochlorothiazide	1-Covered	
NORTHERA	1-Covered	
olmesartan-amlodipine-hctz	1-Covered	
olmesartan-hydrochlorothiazide	1-Covered	
pentoxifylline	1-Covered	
propranolol-hydrochlorothiazid	1-Covered	
quinapril-hydrochlorothiazide	1-Covered	
RANEXA	1-Covered	
reserpine 0.1 mg tablet	1-Covered	PA, QL (1 PER 1 DAYS)
reserpine 0.25 mg tablet	1-Covered	PA
spironolactone-hctz	1-Covered	
telmisartan-amlodipine	1-Covered	
telmisartan-hydrochlorothiazid	1-Covered	
trandolapril-verapamil er	1-Covered	
triamterene-hydrochlorothiazid	1-Covered	
valsartan-hydrochlorothiazide	1-Covered	QL (1 PER 1 DAYS)
VECAMYL	1-Covered	LA, NDS (Non-Extended Day Supply)
DIURETICS, CARBONIC ANHYDRASE INHIBITORS		
acetazolamide	1-Covered	
acetazolamide sodium	1-Covered	
KEVEYIS	1-Covered	NDS (Non-Extended Day Supply)
DIURETICS, LOOP		
bumetanide (0.25 mg/ml vial, 0.5 mg tablet, 1 mg/4 ml vial, 1 mg tablet, 2 mg tablet, 2.5 mg/10 ml vial)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EDECRIN	1-Covered	
ethacrynate sodium	1-Covered	
ethacrynic acid	1-Covered	
furosemide (10 mg/ml syringe, 10 mg/ml solution, 20 mg tablet, 20 mg/2 ml vial, 40 mg/4 ml vial, 40 mg/4 ml syringe, 40 mg/5 ml soln, 40 mg tablet, 80 mg tablet, 100 mg/10 ml vial)	1-Covered	
torsemide	1-Covered	
DIURETICS, POTASSIUM-SPARING		
amiloride hcl	1-Covered	
DYRENIUM	1-Covered	
eplerenone	1-Covered	
spironolactone	1-Covered	
DIURETICS, THIAZIDE		
chlorothiazide	1-Covered	
chlorothiazide sodium	1-Covered	
chlorthalidone	1-Covered	
DIURIL	1-Covered	
hydrochlorothiazide	1-Covered	
indapamide	1-Covered	
methyclothiazide	1-Covered	
metolazone	1-Covered	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate (48 mg tablet, 54 mg tablet, 67 mg capsule, 120 mg tablet, 134 mg capsule, 145 mg tablet, 160 mg tablet, 200 mg capsule)	1-Covered	QL (1 PER 1 DAYS)
fenofibrate (50 mg capsule, 150 mg capsule)	1-Covered	
fenofibrate 40 mg tablet	1-Covered	QL (3 PER 1 DAYS)
fenofibric acid (dr 45 mg cap, dr 135 mg cap)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fenofibric acid 105 mg tablet	1-Covered	QL (1 PER 1 DAYS)
fenofibric acid 35 mg tablet	1-Covered	QL (3 PER 1 DAYS)
gemfibrozil	1-Covered	QL (2 PER 1 DAYS)
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin 20 mg tablet	1-Covered	QL (3 PER 1 DAYS)
atorvastatin calcium (10 mg tablet, 40 mg tablet, 80 mg tablet)	1-Covered	QL (1 PER 1 DAYS)
lovastatin (10 mg tablet, 20 mg tablet)	1-Covered	QL (1 PER 1 DAYS)
lovastatin 40 mg tablet	1-Covered	QL (2 PER 1 DAYS)
pravastatin sodium	1-Covered	QL (1 PER 1 DAYS)
rosuvastatin calcium	1-Covered	
simvastatin	1-Covered	QL (1 PER 1 DAYS)
DYSLIPIDEMICS, OTHER		
cholestyramine light (packet, powder)	1-Covered	
colestipol hcl (hcl 1 gm tablet, hcl granules, hcl granules packet, micronized 1 gm tab)	1-Covered	
ezetimibe	1-Covered	
ezetimibe-simvastatin	1-Covered	
JUXTAPID	1-Covered	PA, NDS (Non-Extended Day Supply)
KYNAMRO	1-Covered	PA, NDS (Non-Extended Day Supply)
niacin er	1-Covered	
NIACOR	1-Covered	
omega-3 acid ethyl esters	1-Covered	
PRALUENT PEN	1-Covered	PA
PRALUENT SYRINGE	1-Covered	PA
REPATHA PUSHTRONEX	1-Covered	PA
REPATHA SURECLICK	1-Covered	PA
REPATHA SYRINGE	1-Covered	PA
WELCHOL	1-Covered	
ZETIA	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tablet, 20 mg/ml vial, 25 mg tablet, 50 mg tablet, 100 mg tablet)	1-Covered	
minoxidil	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
GONITRO	1-Covered	
isosorbide dinitrate (5 mg tablet, 10 mg tablet, 20 mg tablet, 30 mg tablet, er 40 mg tablet)	1-Covered	
isosorbide mononitrate	1-Covered	
isosorbide mononitrate er	1-Covered	
NITRO-BID	1-Covered	
NITRO-DUR (0.3 MG/HR, 0.8 MG/HR)	1-Covered	
nitroglycerin (0.3 mg tablet sl, lingual 0.4 mg, 0.4 mg tablet sl, 0.6 mg tablet sl, 5 mg/ml vial, 400 mcg spray)	1-Covered	
nitroglycerin patch	1-Covered	
NITROSTAT	1-Covered	
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
dextroamp-amphetamin 30 mg tab	1-Covered	QL (2 PER 1 DAYS)
dextroamphetamine sulfate (5 mg tab, 10 mg tab)	1-Covered	
dextroamphetamine sulfate er	1-Covered	
dextroamphetamine-amphet er	1-Covered	QL (1 PER 1 DAYS)
dextroamphetamine-amphetamine (dextroamp-amphetam 12.5 mg tab, dextroamp-amphetamin 10 mg tab, dextroamp-amphetamin 15 mg tab, dextroamp-amphetamin 20 mg tab)	1-Covered	QL (3 PER 1 DAYS)
dextroamphetamine-amphetamine (dextroamp-amphetam 7.5 mg tab, dextroamp-amphetamine 5 mg tab)	1-Covered	QL (4 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VYVANSE (10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE, 50 MG CAPSULE, 60 MG CAPSULE, 70 MG CAPSULE)	1-Covered	
ZENZEDI (2.5 MG TABLET, 7.5 MG TABLET, 15 MG TABLET, 20 MG TABLET, 30 MG TABLET)	1-Covered	
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
clonidine hcl er	1-Covered	
dexmethylphenidate er 20 mg cp	1-Covered	
dexmethylphenidate hcl	1-Covered	QL (2 PER 1 DAYS)
guanfacine hcl er	1-Covered	
methylphenidate er (er 18 mg tab, er 27 mg tab, er 54 mg tab)	1-Covered	QL (1 PER 1 DAYS)
methylphenidate er (er 20 mg tab, er 20 mg cap, er 40 mg cap)	1-Covered	
methylphenidate er 36 mg tab	1-Covered	QL (2 PER 1 DAYS)
methylphenidate hcl (2.5 mg chew tb, 5 mg/5 ml soln, 5 mg chew tab, 10 mg/5 ml sol, 10 mg chew tab)	1-Covered	
methylphenidate hcl (5 mg tablet, 10 mg tablet, 20 mg tablet)	1-Covered	QL (3 PER 1 DAYS)
methylphenidate hcl cd (20 mg cap, 40 mg cap)	1-Covered	
methylphenidate la (20 mg cap, 40 mg cap, 60 mg cap)	1-Covered	
methylphenidate sr	1-Covered	
STRATTERA (10 MG CAPSULE, 25 MG CAPSULE, 40 MG CAPSULE)	1-Covered	QL (2 PER 1 DAYS)
STRATTERA (60 MG CAPSULE, 80 MG CAPSULE, 100 MG CAPSULE)	1-Covered	QL (1 PER 1 DAYS)
STRATTERA 18 MG CAPSULE	1-Covered	QL (4 PER 1 DAYS)
CENTRAL NERVOUS SYSTEM, OTHER		
butalbital-acetaminophen-caffe (butalb-acetamin-caff 50-325-40, butalbit-acetaminophen-caff cp)	1-Covered	PA

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
butalbital-acetaminophn 50-325	1-Covered	PA
HORIZANT ER 300 MG TABLET	1-Covered	
NUEDEXTA	1-Covered	
riluzole	1-Covered	
tetrabenazine	1-Covered	NDS (Non-Extended Day Supply)
FIBROMYALGIA AGENTS		
duloxetine hcl	1-Covered	
LYRICA (20 MG/ML ORAL SOLUTION, 25 MG CAPSULE, 50 MG CAPSULE, 75 MG CAPSULE, 100 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE, 225 MG CAPSULE, 300 MG CAPSULE)	1-Covered	
SAVELLA	1-Covered	
MULTIPLE SCLEROSIS AGENTS		
AMPYRA	1-Covered	FDA (2 / 1 DAYS), NDS (Non-Extended Day Supply)
AUBAGIO	1-Covered	PA, NDS (Non-Extended Day Supply)
AVONEX (30 MCG VIAL KIT, PREFILLED SYR 30 MCG, PREFILLED SYR 30 MCG KT)	1-Covered	NDS (Non-Extended Day Supply)
AVONEX PEN (30 MCG/0.5 ML, 30 MCG/0.5 ML KIT)	1-Covered	NDS (Non-Extended Day Supply)
BETASERON	1-Covered	NDS (Non-Extended Day Supply)
COPAXONE	1-Covered	NDS (Non-Extended Day Supply)
GILENYA	1-Covered	NDS (Non-Extended Day Supply)
GLATOPA	1-Covered	NDS (Non-Extended Day Supply)
PLEGRIDY PEN	1-Covered	NDS (Non-Extended Day Supply)
TECFIDERA	1-Covered	NDS (Non-Extended Day Supply)
TYSABRI	1-Covered	NDS (Non-Extended Day Supply)
DENTAL AND ORAL AGENTS		
cevimeline hcl	1-Covered	
chlorhexidine 0.12% rinse	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DENTA 5000 PLUS	1-Covered	
PERIOGARD	1-Covered	
pilocarpine hcl (5 mg tablet, 7.5 mg tablet)	1-Covered	
SF 5000 PLUS	1-Covered	
triamcinolone 0.1% paste	1-Covered	
DERMATOLOGICAL AGENTS		
8-MOP	1-Covered	
acitretin	1-Covered	
adapalene	1-Covered	
ALA-CORT 2.5% CREAM	1-Covered	
ammonium lactate	1-Covered	
calcipotriene (cream, ointment, solution)	1-Covered	
calcipotriene-betamethasone dp	1-Covered	
calcitriol 3 mcg/g ointment	1-Covered	
CLARAVIS	1-Covered	
clindamycin phos-benzoyl perox	1-Covered	
clindamycin phos-tretinoin	1-Covered	
clindamycin-benzoyl peroxide	1-Covered	
clotrimazole-betamethasone (crm, lot)	1-Covered	
diclofenac sodium (sodium 1% gel, 1.5% topical soln)	1-Covered	
doxepin 5% cream	1-Covered	
ELIDEL	1-Covered	
fluorouracil 0.5% cream	1-Covered	
imiquimod	1-Covered	
metronidazole (0.75% cream, topical 0.75% gl, 0.75% lotion, top 1% gel pump, topical 1% gel)	1-Covered	
MICORT HC 2.5% CREAM	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
podofilox	1-Covered	
SANTYL	1-Covered	
selenium sulfide 2.5% lotion	1-Covered	
tacrolimus (0.03%, 0.1%)	1-Covered	
tazarotene	1-Covered	
TAZORAC	1-Covered	
TOLAK	1-Covered	
tretinoin (0.01% gel, 0.025% gel, 0.025% cream, 0.05% gel, 0.05% cream, 0.1% cream)	1-Covered	
tretinoin microsphere	1-Covered	
ENZYME REPLACEMENT/MODIFIERS		
ADAGEN	1-Covered	NDS (Non-Extended Day Supply)
ALDURAZYME	1-Covered	LA, NDS (Non-Extended Day Supply)
BUPHENYL 500 MG TABLET	1-Covered	
CARBAGLU	1-Covered	NDS (Non-Extended Day Supply)
CEREZYME	1-Covered	LA, NDS (Non-Extended Day Supply)
CREON	1-Covered	
CYSTADANE	1-Covered	
FABRAZYME	1-Covered	NDS (Non-Extended Day Supply)
KANUMA	1-Covered	NDS (Non-Extended Day Supply)
KUVAN (100 MG TABLET, 100 MG POWDER PACKET)	1-Covered	NDS (Non-Extended Day Supply)
LUMIZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE, LA, NDS (Non-Extended Day Supply)
NAGLAZYME	1-Covered	NDS (Non-Extended Day Supply)
ORFADIN (2 MG CAPSULE, 4 MG/ML SUSPENSION, 5 MG CAPSULE, 10 MG CAPSULE)	1-Covered	NDS (Non-Extended Day Supply)
PANCREAZE	1-Covered	
PERTZYE DR 4,000 UNIT CAPSULE	1-Covered	
RAVICTI	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
STRENSIQ	1-Covered	LA, NDS (Non-Extended Day Supply)
VPRIV	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ZAVESCA	1-Covered	NDS (Non-Extended Day Supply)
GASTROINTESTINAL AGENTS		
ANTISPASMODICS, GASTROINTESTINAL		
atropine sulfate (0.05 mg/ml syringe, 0.1 mg/ml abboject, 0.1 mg/ml syringe)	1-Covered	
dicyclomine hcl (10 mg capsule, 10 mg/5 ml soln, 20 mg/2 ml vial, 20 mg tablet)	1-Covered	
glycopyrrolate (0.2 mg/ml vial, 0.4 mg/2 ml vl, 1 mg/5 ml vial, 1 mg tablet, 2 mg tablet, 4 mg/20 ml vial)	1-Covered	
methscopolamine bromide	1-Covered	
propantheline bromide	1-Covered	
GASTROINTESTINAL AGENTS, OTHER		
cromolyn 100 mg/5 ml oral conc	1-Covered	
diphenoxylate-atropine (diphenoxylat-atrop 2.5-0.025/5, diphenoxylate-atrop 2.5-0.025)	1-Covered	
GATTEX	1-Covered	NDS (Non-Extended Day Supply)
lansoprazol-amoxicil-clarithro	1-Covered	
loperamide 2 mg capsule	1-Covered	
MYTESI	1-Covered	
OCALIVA	1-Covered	NDS (Non-Extended Day Supply)
RELISTOR (12 MG/0.6 ML KIT, 12 MG/0.6 ML VIAL, 150 MG TABLET)	1-Covered	
ursodiol	1-Covered	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine (200 mg tablet, 300 mg tablet, 300 mg/5 ml soln, 400 mg tablet, 800 mg tablet)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
famotidine (20 mg tablet, 20 mg piggyback, 20 mg/2 ml vial, 40 mg/5 ml susp, 40 mg tablet)	1-Covered	
ranitidine hcl (15 mg/ml syrup, hcl 50 mg/2 ml vial, 150 mg/10 ml syrup, hcl 150 mg/6 ml vl, 150 mg tablet, 150 mg capsule, 300 mg capsule, 300 mg tablet)	1-Covered	
IRRITABLE BOWEL SYNDROME AGENTS		
alosetron hcl	1-Covered	
LINZESS	1-Covered	QL (1 PER 1 DAYS)
VIBERZI	1-Covered	
LAXATIVES		
COLYTE WITH FLAVOR PACKETS	1-Covered	
COLYTE WITH FLAVOR PACKS	1-Covered	
CONSTULOSE	1-Covered	
ENULOSE	1-Covered	
GAVILYTE-C	1-Covered	
GAVILYTE-G	1-Covered	
GAVILYTE-H AND BISACODYL	1-Covered	
GAVILYTE-N	1-Covered	
GENERLAC	1-Covered	
GOLYTELY (PACKET, SOLUTION)	1-Covered	
KRISTALOSE	1-Covered	
lactulose	1-Covered	
MOVIPREP	1-Covered	
NULYTELY WITH FLAVOR PACKS	1-Covered	
peg 3350-electrolyte	1-Covered	
peg-3350 and electrolytes	1-Covered	
polyethylene glycol 3350	1-Covered	
TRILYTE WITH FLAVOR PACKETS	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROTECTANTS		
CARAFATE 1 GM/10 ML SUSP	1-Covered	
misoprostol	1-Covered	
sucralfate	1-Covered	
PROTON PUMP INHIBITORS		
esomeprazole magnesium	1-Covered	
esomeprazole sodium	1-Covered	
lansoprazole (dr 15 mg capsule, dr 30 mg capsule)	1-Covered	
omeprazole (dr 20 mg capsule, dr 40 mg capsule)	1-Covered	QL (2 PER 1 DAYS)
omeprazole dr 10 mg capsule	1-Covered	QL (1 PER 1 DAYS)
omeprazole-sodium bicarbonate (20-1,100 cap, 40-1,100 cap)	1-Covered	
pantoprazole sodium (dr 20 mg tab, dr 40 mg tab)	1-Covered	QL (2 PER 1 DAYS)
rabeprazole sodium	1-Covered	
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin er	1-Covered	
flavoxate hcl	1-Covered	
MYRBETRIQ	1-Covered	
oxybutynin 5 mg tablet	1-Covered	QL (4 PER 1 DAYS)
oxybutynin 5 mg/5 ml syrup	1-Covered	QL (20 PER 1 DAYS)
oxybutynin chloride er	1-Covered	QL (2 PER 1 DAYS)
tolterodine tartrate	1-Covered	
tolterodine tartrate er	1-Covered	QL (1 PER 1 DAYS)
trospium chloride	1-Covered	
trospium chloride er	1-Covered	
VESICARE	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	1-Covered	
dutasteride	1-Covered	QL (1 PER 1 DAYS)
dutasteride-tamsulosin	1-Covered	QL (1 PER 1 DAYS)
finasteride	1-Covered	QL (1 PER 1 DAYS)
tamsulosin hcl	1-Covered	
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	1-Covered	
CYSTAGON	1-Covered	
DEPEN	1-Covered	
ELMIRON	1-Covered	
phenazopyridine hcl	1-Covered	
potassium citrate er	1-Covered	
PHOSPHATE BINDERS		
calcium acetate (667 mg capsule, 667 mg tablet, 667 mg gelcap)	1-Covered	
ELIPHOS	1-Covered	
FOSRENOL	1-Covered	
RENAGEL	1-Covered	
RENVELA 800 MG TABLET	1-Covered	QL (17 PER 1 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
A-HYDROCORT	1-Covered	
alclometasone dipropionate	1-Covered	
amcinonide (cream, lotion, ointment)	1-Covered	
betamethasone dipropionate (aug crm, aug gel, aug lot, aug oin, crm, lot, oint)	1-Covered	
betamethasone valerate (va 0.1% cream, va 0.1% lotion, valer 0.1% ointm, valer 0.12% foam)	1-Covered	
CAPEX SHAMPOO	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clobetasol emollient 0.05% crm	1-Covered	
clobetasol propionate (gel, ointment, prop foam, prop spray, shampoo, solution, topical lotn)	1-Covered	
cortisone acetate	1-Covered	
desonide (cream, lotion, ointment)	1-Covered	
desoximetasone	1-Covered	
dexamethasone (0.5 mg tablet, 0.5 mg/5 ml elx, 0.5 mg/5 ml liq, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet, 2 mg tablet, 4 mg tablet, 6 mg tablet)	1-Covered	
DEXAMETHASONE INTENSOL	1-Covered	
dexamethasone sodium phosphate (4 mg/ml vial, 4 mg/ml syringe, 10 mg/ml vial, 20 mg/5 ml vial, 100 mg/10 ml vl, 120 mg/30 ml vl)	1-Covered	
diflorasone diacetate	1-Covered	
EMFLAZA (6 MG TABLET, 18 MG TABLET, 22.75 MG/ML ORAL SUSP, 30 MG TABLET, 36 MG TABLET)	1-Covered	PA, NDS (Non-Extended Day Supply)
fludrocortisone acetate	1-Covered	
fluocinolone acetonide (0.01% solution, 0.01% cream, 0.01% body oil, 0.025% cream, 0.025% ointment)	1-Covered	
fluocinonide (gel, ointment, solution)	1-Covered	
fluocinonide emollient	1-Covered	
fluocinonide-e	1-Covered	
flurandrenolide (cream, lotion, ointment)	1-Covered	
fluticasone propionate (0.005% oint, 0.05% cream, 0.05% lotion)	1-Covered	
halobetasol propionate	1-Covered	
hydrocortisone (1% ointment, 1% cream, 2.5% cream, 2.5% ointment, 2.5% lotion, 5 mg tablet, 10 mg tablet, 20 mg tablet)	1-Covered	
hydrocortisone butyrate (oint, soln)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydrocortisone valerate	1-Covered	
KORLYM	1-Covered	NDS (Non-Extended Day Supply)
methylprednisolone	1-Covered	
methylprednisolone acetate	1-Covered	
methylprednisolone sodium succ	1-Covered	
MILLIPRED 5 MG TABLET	1-Covered	
mometasone furoate (cream, oint, soln)	1-Covered	
prednisolone 15 mg/5 ml soln	1-Covered	
prednisolone sodium phos odt	1-Covered	
prednisolone sodium phosphate (5 mg/5 ml soln, 10 mg/5 ml soln, 20 mg/5 ml soln, sod ph 25 mg/5 ml)	1-Covered	
prednisone (1 mg tablet, 2.5 mg tablet, 5 mg tab dose pack, 5 mg tablet, 5 mg/5 ml solution, 10 mg tab dose pack, 10 mg tablet, 20 mg tablet, 50 mg tablet)	1-Covered	
PREDNISONE INTENSOL	1-Covered	
SOLU-CORTEF (250 MG VIAL, 500 MG VIAL, 1,000 MG VIAL)	1-Covered	
SOLU-MEDROL (40 MG VIAL, 500 MG VIAL, 1,000 MG VIAL, 2,000 MG VIAL)	1-Covered	
triamcinolone acetonide (0.025% lotion, 0.025% oint, 0.025% cream, 0.1% ointment, 0.1% cream, 0.1% lotion, 0.147 mg/g spray, 0.5% ointment, 0.5% cream)	1-Covered	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
chorionic gonadotropin	1-Covered	PA
desmopressin acetate (0.01% spray, 0.01% solution, 0.1 mg/ml sol)	1-Covered	QL (15 PER 30 DAYS)
desmopressin acetate (ac 4 mcg/ml vial, ac 4 mcg/ml ampul, acetate 0.1 mg tb, acetate 0.2 mg tb, 40 mcg/10 ml vial)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
H.P. ACTHAR	1-Covered	PA, NDS (Non-Extended Day Supply)
INCRELEX	1-Covered	NDS (Non-Extended Day Supply)
NORDITROPIN FLEXPRO	1-Covered	PA, NDS (Non-Extended Day Supply)
NORDITROPIN NORDIFLEX	1-Covered	PA, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
ANADROL-50	1-Covered	
oxandrolone 10 mg tablet	1-Covered	QL (2 PER 1 DAYS)
oxandrolone 2.5 mg tablet	1-Covered	QL (8 PER 1 DAYS)
ANDROGENS		
ANDROGEL (1.62%(1.25G) GEL PCKT, 1.62% GEL PUMP, 1.62%(2.5G) GEL PCKT)	1-Covered	QL (150 PER 30 DAYS)
danazol	1-Covered	
methyltestosterone	1-Covered	
testosterone (12.5 mg/1.25 gram, 25 mg/2.5 gm pkt, 50 mg/5 gram gel, 50 mg/5 gram pkt)	1-Covered	
testosterone enanthate	1-Covered	
ESTROGENS		
ALYACEN 1-35-28 TABLET	1-Covered	
AMABELZ	1-Covered	
AMETHIA LO	1-Covered	
APRI	1-Covered	
ARANELLE	1-Covered	
AVIANE	1-Covered	
BALZIVA	1-Covered	
CAMRESE LO	1-Covered	
CAZIANT	1-Covered	
CRYSELLE	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CYCLAFEM	1-Covered	
drospirenone-ee 3-0.03 mg tab	1-Covered	
drospirenone-eth estra-levomef	1-Covered	
ENPRESSE	1-Covered	
estradiol	1-Covered	
estropipate	1-Covered	
ethynodiol-ethinyl estradiol	1-Covered	
FEMCON FE	1-Covered	
FEMYNOR	1-Covered	
GILDESS FE 1-20 TABLET	1-Covered	
JUNEL	1-Covered	
JUNEL FE	1-Covered	
KARIVA	1-Covered	
KELNOR 1-35	1-Covered	
LARIN	1-Covered	
LARIN 24 FE	1-Covered	
LARIN FE	1-Covered	
LARISSIA	1-Covered	
LESSINA	1-Covered	
LEVORA-28	1-Covered	
LOW-OGESTREL	1-Covered	
LUTERA	1-Covered	
MENEST	1-Covered	
MICROGESTIN	1-Covered	
MICROGESTIN FE	1-Covered	
MONONESSA	1-Covered	
NECON (0.5-35-28 TABLET, 1-35-28 TABLET, 7-7-7-28 TABLET, 10-11-28 TABLET)	1-Covered	
noret-estr-fe 0.4-0.035(21)-75	1-Covered	
norethind-eth estrad 1-0.02 mg	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
norgestimate-ethinyl estradiol (norg-ee 0.18-0.215-0.25/0.035, norg-ethin estra 0.25-0.035 mg)	1-Covered	
NORTREL	1-Covered	
NUVARING	1-Covered	QL (1 PER 28 DAYS)
OGESTREL	1-Covered	
PORTIA	1-Covered	
PREMARIN (0.3 MG TABLET, 0.45 MG TABLET, 0.625 MG TABLET, 0.9 MG TABLET)	1-Covered	QL (1 PER 1 DAYS)
PREMARIN (25 MG VIAL, VAGINAL CREAM-APPL)	1-Covered	
PREMARIN 1.25 MG TABLET	1-Covered	QL (6 PER 1 DAYS)
PREMPHASE	1-Covered	
PREMPRO	1-Covered	QL (1 PER 1 DAYS)
PREVIFEM	1-Covered	
RECLIPSEN	1-Covered	
SPRINTEC	1-Covered	
SRONYX	1-Covered	
TRI-LEGEST FE	1-Covered	
TRI-LINYAH	1-Covered	
TRI-PREVIFEM	1-Covered	
TRI-SPRINTEC	1-Covered	
TRINESSA	1-Covered	
TRIVORA-28	1-Covered	
VAGIFEM	1-Covered	
VELIVET	1-Covered	
XULANE	1-Covered	
YASMIN 28	1-Covered	
YUVAFEM	1-Covered	
ZARAH	1-Covered	
ZENCHENT	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZOVIA 1-35E	1-Covered	
ZOVIA 1-50E	1-Covered	
PROGESTINS		
DEPO-PROVERA 400 MG/ML VIAL	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
ERRIN	1-Covered	
JOLIVETTE	1-Covered	
medroxyprogesterone 150 mg/ml	1-Covered	QL (1 PER 68 DAYS)
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Covered	
megestrol acetate (20 mg tablet, acet 40 mg/ml susp, 40 mg tablet, acet 400 mg/10 ml, 625 mg/5 ml susp)	1-Covered	
norethindrone	1-Covered	
norethindrone ac (lupaneta)	1-Covered	
norethindrone acetate	1-Covered	
progesterone (100 mg capsule, 200 mg capsule)	1-Covered	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
raloxifene hcl	1-Covered	QL (1 PER 1 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
levothyroxine sodium (25 mcg tablet, 50 mcg tablet, 75 mcg tablet, 88 mcg tablet, 100 mcg tablet, 112 mcg tablet, 125 mcg tablet, 137 mcg tablet, 150 mcg tablet, 175 mcg tablet, 200 mcg tablet, 300 mcg tablet)	1-Covered	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	1-Covered	
SYNTHROID	1-Covered	
THYROLAR-1	1-Covered	
THYROLAR-1/2	1-Covered	
THYROLAR-1/4	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
THYROLAR-2	1-Covered	
THYROLAR-3	1-Covered	
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)		
SENSIPAR	1-Covered	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
cabergoline	1-Covered	
ELIGARD	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (2 X 120 MG, 80 MG)	1-Covered	PA - TO CONFIRM PART D COVERAGE
leuprolide acetate (1 mg/0.2 ml vial, 2wk 1 mg/0.2 ml kit, 2wk 14 mg/2.8 ml kt)	1-Covered	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (LUPANETA)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
octreotide acetate (acet 0.05 mg/ml vl, acet 50 mcg/ml amp, acet 50 mcg/ml vial, acet 100 mcg/ml vl, acet 100 mcg/ml amp, acet 200 mcg/ml vl, acet 500 mcg/ml vl, acet 500 mcg/ml amp, 1,000 mcg/5 ml vial, 1,000 mcg/ml vial, 5,000 mcg/5 ml vial)	1-Covered	
SANDOSTATIN LAR	1-Covered	NDS (Non-Extended Day Supply)
SANDOSTATIN LAR DEPOT	1-Covered	NDS (Non-Extended Day Supply)
SIGNIFOR	1-Covered	NDS (Non-Extended Day Supply)
SIGNIFOR LAR	1-Covered	NDS (Non-Extended Day Supply)
SOMATULINE DEPOT	1-Covered	NDS (Non-Extended Day Supply)
SOMAVERT (10 MG VIAL, 15 MG VIAL, 20 MG VIAL)	1-Covered	NDS (Non-Extended Day Supply)
SYNAREL	1-Covered	
TRELSTAR	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole	1-Covered	
propylthiouracil	1-Covered	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA (HAE) AGENTS		
CINRYZE	1-Covered	LA, NDS (Non-Extended Day Supply)
FIRAZYR	1-Covered	NDS (Non-Extended Day Supply)
IMMUNE SUPPRESSANTS		
ASTAGRAF XL	1-Covered	PA - TO CONFIRM PART D COVERAGE
AZASAN	1-Covered	PA - TO CONFIRM PART D COVERAGE
azathioprine	1-Covered	PA - TO CONFIRM PART D COVERAGE
azathioprine sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
CELLCEPT 500 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine (25 mg capsule, 50 mg/ml ampul, 100 mg capsule, 100 mg/ml soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine modified	1-Covered	PA - TO CONFIRM PART D COVERAGE
ENBREL (25 MG/0.5 ML SYRINGE, 50 MG/ML SYRINGE, 50 MG/ML SURECLICK SYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL 25 MG KIT	1-Covered	PA, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
ENVARSUS XR	1-Covered	PA - TO CONFIRM PART D COVERAGE
HUMIRA (10 MG/0.2 ML, 40 MG/0.8 ML)	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA 20 MG/0.4 ML SYRINGE	1-Covered	PA, QL (2 PER 28 DAYS), NDS (Non-Extended Day Supply)
HUMIRA PEDIATRIC CROHN'S	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN CROHN-UC-HS STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMIRA PEN PSORIASIS-UVEITIS	1-Covered	PA, NDS (Non-Extended Day Supply)
INFLECTRA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KINERET	1-Covered	NDS (Non-Extended Day Supply)
methotrexate (1 gm vial, 2.5 mg tablet, 50 mg/2 ml vial, 100 mg/4 ml vial, 250 mg/10 ml vial)	1-Covered	
methotrexate sodium	1-Covered	
mycophenolate mofetil (200 mg/ml susp, 250 mg capsule, 500 mg vial, 500 mg tablet)	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolic acid	1-Covered	PA - TO CONFIRM PART D COVERAGE
NULOJIX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ORENCIA (125 MG/ML SYRINGE, 250 MG VIAL)	1-Covered	PA, NDS (Non-Extended Day Supply)
ORENCIA CLICKJECT	1-Covered	PA, NDS (Non-Extended Day Supply)
OTREXUP	1-Covered	
PROGRAF 5 MG/ML AMPULE	1-Covered	PA - TO CONFIRM PART D COVERAGE
RAPAMUNE 1 MG/ML ORAL SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
RASUVO	1-Covered	
REMICADE	1-Covered	NDS (Non-Extended Day Supply)
RHEUMATREX	1-Covered	
SANDIMMUNE 100 MG/ML SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE
sirolimus	1-Covered	PA - TO CONFIRM PART D COVERAGE
tacrolimus (0.5 mg capsule, 1 mg capsule, 5 mg capsule)	1-Covered	PA - TO CONFIRM PART D COVERAGE
TREXALL	1-Covered	
ZORTRESS	1-Covered	PA - TO CONFIRM PART D COVERAGE
IMMUNIZING AGENTS, PASSIVE		
ATGAM	1-Covered	NDS (Non-Extended Day Supply)
BIVIGAM	1-Covered	PA - TO CONFIRM PART D COVERAGE
CARIMUNE NF NANOFILTERED	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GAMASTAN S-D	1-Covered	PA - TO CONFIRM PART D COVERAGE
GAMMAGARD LIQUID	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
GAMMAGARD S-D	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
GAMMAPLEX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
GAMUNEX-C	1-Covered	PA - TO CONFIRM PART D COVERAGE
HYPERRAB S-D	1-Covered	
IMOGAM RABIES-HT	1-Covered	
PRIVIGEN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
THYMOGLOBULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VARIZIG 125 UNIT/1.2 ML VIAL	1-Covered	
IMMUNOMODULATORS		
ACTEMRA (80 MG/4 ML VIAL, 200 MG/10 ML VIAL, 400 MG/20 ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ACTEMRA 162 MG/0.9 ML SYRINGE	1-Covered	PA, NDS (Non-Extended Day Supply)
ACTIMMUNE	1-Covered	LA, NDS (Non-Extended Day Supply)
ARCALYST	1-Covered	LA, NDS (Non-Extended Day Supply)
BENLYSTA	1-Covered	NDS (Non-Extended Day Supply)
ILARIS 180 MG VIAL	1-Covered	NDS (Non-Extended Day Supply)
leflunomide 10 mg tablet	1-Covered	QL (1 PER 1 DAYS)
leflunomide 20 mg tablet	1-Covered	QL (5 PER 1 DAYS)
RIDAURA	1-Covered	
SIMULECT 20 MG VIAL	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
SYNAGIS	1-Covered	PA, LA, NDS (Non-Extended Day Supply)
VACCINES		
ACTHIB	1-Covered	
ADACEL TDAP	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bcg vaccine (tice strain)	1-Covered	PA - TO CONFIRM PART D COVERAGE
BEXSERO	1-Covered	
BOOSTRIX TDAP	1-Covered	
CERVARIX	1-Covered	
DAPTACEL DTAP	1-Covered	
diphtheria-tetanus toxoids-ped	1-Covered	
ENGERIX-B 20 MCG/ML SYRN	1-Covered	PA - TO CONFIRM PART D COVERAGE
ENGERIX-B PEDIATRIC-ADOLESCENT	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL	1-Covered	
GARDASIL 9	1-Covered	
HAVRIX (720 UNIT/0.5 ML SYRINGE, 1,440 UNITS/ML VIAL)	1-Covered	
HIBERIX	1-Covered	
IMOVAX RABIES VACCINE	1-Covered	
INFANRIX DTAP VIAL	1-Covered	
IPOL	1-Covered	
IXIARO	1-Covered	
KINRIX	1-Covered	
M-M-R II VACCINE	1-Covered	
MENACTRA	1-Covered	
MENHIBRIX	1-Covered	
MENOMUNE-A-C-Y-W-135	1-Covered	
MENVEO A-C-Y-W-135-DIP	1-Covered	
PEDIARIX	1-Covered	
PEDVAXHIB	1-Covered	
PENTACEL ACTHIB COMPONENT	1-Covered	
PROQUAD	1-Covered	
QUADRACEL DTAP-IPV	1-Covered	
RABAVERT	1-Covered	
RECOMBIVAX HB (5 MCG/0.5 ML SYR, 10 MCG/ML VIAL, 10 MCG/ML SYR, 40 MCG/ML VIAL)	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ROTARIX	1-Covered	
ROTATEQ	1-Covered	
TENIVAC SYRINGE	1-Covered	
tetanus diphtheria toxoids	1-Covered	
TRUMENBA	1-Covered	
TWINRIX VACCINE VIAL	1-Covered	
TYPHIM VI	1-Covered	
VAQTA (25 UNITS/0.5 ML, 50 UNITS/ML)	1-Covered	
VARIVAX VACCINE	1-Covered	
YF-VAX	1-Covered	
ZOSTAVAX	1-Covered	
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
APRISO	1-Covered	
balsalazide disodium	1-Covered	
DELZICOL	1-Covered	
DIPENTUM	1-Covered	NDS (Non-Extended Day Supply)
mesalamine (4 gm/60 ml kit, 800 mg dr tablet)	1-Covered	
PENTASA	1-Covered	QL (8 PER 1 DAYS)
GLUCOCORTICOIDS		
budesonide ec	1-Covered	
hydrocortisone 100 mg/60 ml	1-Covered	
PROCTO-MED HC	1-Covered	
PROCTOSOL-HC	1-Covered	
PROCTOZONE-HC	1-Covered	
UCERIS (2 MG RECTAL FOAM, 9 MG ER TABLET)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SULFONAMIDES		
sulfasalazine	1-Covered	QL (8 PER 1 DAYS)
sulfasalazine dr	1-Covered	
METABOLIC BONE DISEASE AGENTS		
alendronate sod 70 mg/75 ml	1-Covered	
alendronate sodium (35 mg tab, 70 mg tab)	1-Covered	QL (1 PER 7 DAYS)
alendronate sodium (5 mg tablet, 10 mg tab, 40 mg tab)	1-Covered	QL (1 PER 1 DAYS)
ATELVIA	1-Covered	
BINOSTO	1-Covered	
calcitonin-salmon	1-Covered	
calcitriol (0.25 mcg capsule, 0.5 mcg capsule, 1 mcg/ml solution, 1 mcg/ml ampul)	1-Covered	
doxercalciferol (0.5 mcg cap, 1 mcg capsule, 2.5 mcg cap, 4 mcg/2 ml vl, 4 mcg/2 ml amp)	1-Covered	
etidronate disodium	1-Covered	
FORTEO	1-Covered	NDS (Non-Extended Day Supply)
ibandronate 3 mg/3 ml vial	1-Covered	PA - TO CONFIRM PART D COVERAGE
ibandronate sodium 150 mg tab	1-Covered	
MIACALCIN (200 UNIT/ML VIAL, 400 UNIT/2 ML VIAL)	1-Covered	
NATPARA	1-Covered	NDS (Non-Extended Day Supply)
pamidronate disodium (disod 30 mg vial, 30 mg/10 ml vial, 60 mg/10 ml vial, 90 mg/10 ml vial, disod 90 mg vial)	1-Covered	
PROLIA	1-Covered	
risedronate sodium	1-Covered	
risedronate sodium dr	1-Covered	
XGEVA	1-Covered	NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
zoledronic acid 5 mg/100 ml	1-Covered	PA - TO CONFIRM PART D COVERAGE
MISCELLANEOUS THERAPEUTIC AGENTS		
1st tier unifine pentips	1-Covered	
1st tier unifine pentips plus	1-Covered	
advocate pen needle	1-Covered	
advocate pen needles	1-Covered	
alcohol 70% swabs	1-Covered	
alcohol prep pads (, cvs)	1-Covered	
band-aid gauze pads 2"x2"	1-Covered	
bd ultra-fine pen needle	1-Covered	
carefine pen needle	1-Covered	
caretouch alcohol prep pad	1-Covered	
caretouch pen needle	1-Covered	
clickfine	1-Covered	
comfort ez (needle 12mm 29g, needles 4mm 32g, needles 4mm 33g, needles 5mm 31g, needles 5mm 33g, needles 5mm 32g, needles 6mm 32g, needles 6mm 31g, needles 6mm 33g, needles 8mm 31g, needles 8mm 32g, needles 8mm 33g)	1-Covered	
curity guaze pads	1-Covered	
droplet pen needle	1-Covered	
easy comfort pen needles	1-Covered	
easy touch pen needle	1-Covered	
EXONDYS 51	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
fomepizole	1-Covered	
gauze pads & dressings - pads 2 x 2	1-Covered	
healthy accents unifine pentip (4mm 32g, 5mm 31g, 6mm 31g, 8mm 31g)	1-Covered	
incontrol pen needle	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
insulin pen needle	1-Covered	
insulin syringe (0.3 ml 31gx6mm, 1 ml 31gx15/64")	1-Covered	
insulin syringe (disp) u-100 0.3 ml	1-Covered	
insulin syringe (disp) u-100 1 ml	1-Covered	
insulin syringe (disp) u-100 1/2 ml	1-Covered	
insupen	1-Covered	
isopropyl alcohol 0.7 ml/ml medicated pad	1-Covered	
lite touch (29g, 31gx1/4", 31g)	1-Covered	
methylergonovine 0.2 mg tablet	1-Covered	
mini ultra-thin ii	1-Covered	
MYALEPT	1-Covered	PA, NDS (Non-Extended Day Supply)
needles, insulin disp., safety	1-Covered	
novofine	1-Covered	
novofine 32	1-Covered	
novofine plus	1-Covered	
novotwist	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pen needle (eql pen 8mm 31g x 5/16" needle, eql pen needle 6mm 31g, fifty50 pen 31g x 5/16" needle, fifty50 pen needle 32g x 1/4", fifty50 pen 31g x 3/16" needle, fifty50 pen needle 32g x 5/32", gnp clickfine pen ndl 31gx5/16, gnp clickfine pen ndl 31gx1/4", kroger pen needles 29g, kroger pen needles 31g x 5/16", leader pen needle 6mm 31g, live better pen needle 6mm 31g, live better pen needles 8mm, live better pen needles 12mm, ms pen needle 6mm 31g, pen needle 4mm 32g, pen needle 5mm 31g, pen needle 6mm 31g, pen needle 8mm 31g, pen needle 12mm 29g, pen needle 30g x 5/16", pen needle 31g x 1/4", pen needle 31g x 5/16", pen needle 31g x 3/16", pen needle 32g x 5/32", pen needles 8mm 31g, pen needles 12mm 29g, pub pen 8mm 31g needles, pub pen 12mm 29g needles, pub pen needle 6mm 31g, pv pen needle 6mm 31g, pv pen needles 6mm 31g, ra pen needle 31gx3/16", ra pen needle 31gx5/16", relion mini pen 31g x 1/4" ndl, relion pen 29g needle, relion pen 31g needle, relion pen needle 29gx1/2", relion pen needle 31gx5/16", relion pen needle 31gx1/4", relion pen needle 32gx5/32", today's hlt pn needle 12mm 29g, today's hlth pn needle 6mm 31g, today's hlth pn needle 8mm 31g)	1-Covered	
pen needles	1-Covered	
pentips	1-Covered	
pro comfort pen needle	1-Covered	
reli on 31g x 1/4" needles	1-Covered	
relion pen needles	1-Covered	
sterile water for irrigation	1-Covered	
sure comfort (ndl 29gx1/2", 30g needle, 31g needle, ndl 31gx3/16", ndl 31gx5/16", ndl 32gx5/32", ndl 32gx1/4")	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sure-fine pen needles	1-Covered	
techlite pen needle	1-Covered	
topcare clickfine	1-Covered	
trueplus pen needle	1-Covered	
ulticare pen needle	1-Covered	
ultilet pen needle	1-Covered	
ultra-thin ii (29gx1/2", 31gx5/16)	1-Covered	
unifine pentips	1-Covered	
unifine pentips plus	1-Covered	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
atropine 1% eye drops	1-Covered	
bacitracin-polymyxin eye oint	1-Covered	
BLEPHAMIDE	1-Covered	
BLEPHAMIDE S.O.P.	1-Covered	
cyclopentolate hcl	1-Covered	
CYSTARAN	1-Covered	
naphazoline hcl	1-Covered	
neomycin-bacitracin-poly-hc	1-Covered	
neomycin-bacitracin-polymyxin	1-Covered	
neomycin-poly-hc eye drops	1-Covered	
neomycin-polymyxin-dexameth (neomyc-polym-dexamet ointm, neomyc-polym-dexameth drop)	1-Covered	
neomycin-polymyxin-gramicidin	1-Covered	
POLYCIN	1-Covered	
polymyxin b sul-trimethoprim	1-Covered	
proparacaine hcl	1-Covered	
RESTASIS	1-Covered	QL (2 PER 1 DAYS)
sulfacetamide-prednisolone	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TOBRADEX EYE OINTMENT	1-Covered	
tobramycin-dexamethasone	1-Covered	
tropicamide 1% eye drops	1-Covered	
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRIL	1-Covered	
ALOMIDE	1-Covered	
azelastine hcl 0.05% drops	1-Covered	
cromolyn 4% eye drops	1-Covered	
epinastine hcl	1-Covered	
olopatadine hcl 0.1% eye drops	1-Covered	QL (10 PER 30 DAYS)
OPHTHALMIC ANTI-INFLAMMATORIES		
ALREX	1-Covered	
bromfenac sodium	1-Covered	
dexamethasone 0.1% eye drop	1-Covered	
diclofenac 0.1% eye drops	1-Covered	
DUREZOL	1-Covered	
FLAREX	1-Covered	
fluorometholone	1-Covered	
flurbiprofen sodium	1-Covered	
FML FORTE	1-Covered	
FML S.O.P.	1-Covered	
ILEVRO	1-Covered	
ketorolac tromethamine (0.4%, 0.5%)	1-Covered	
PRED MILD	1-Covered	
prednisolone acetate	1-Covered	
prednisolone sod 1% eye drop	1-Covered	
PROLENSA	1-Covered	
VEXOL	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPHTHALMIC ANTIGLAUCOMA AGENTS		
ALPHAGAN P 0.1% DROPS	1-Covered	
apraclonidine hcl	1-Covered	
AZOPT	1-Covered	
betaxolol hcl 0.5% eye drop	1-Covered	
brimonidine tartrate	1-Covered	
carteolol hcl	1-Covered	
dorzolamide hcl	1-Covered	QL (10 PER 18 DAYS)
dorzolamide-timolol	1-Covered	QL (10 PER 18 DAYS)
levobunolol 0.5% eye drops	1-Covered	
methazolamide	1-Covered	
metipranolol	1-Covered	
pilocarpine hcl (1% drops, 2% drops, 4% drops)	1-Covered	
SIMBRINZA	1-Covered	
timolol maleate (0.25% gfs gel-solution, 0.25% gel-solution, 0.25% eye drops, 0.5% eye drops, 0.5% gfs gel-solution, 0.5% gel-solution)	1-Covered	
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost	1-Covered	
latanoprost	1-Covered	QL (5 PER 30 DAYS)
LUMIGAN	1-Covered	
TRAVATAN Z	1-Covered	QL (10 PER 30 DAYS)
travoprost	1-Covered	
OTIC AGENTS		
acetic acid 2% ear solution	1-Covered	
CIPRODEX	1-Covered	
fluocinolone acetonide oil	1-Covered	
hydrocortisone-acetic acid	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
neomycin-polymyxin-hc ear susp	1-Covered	
neomycin-polymyxin-hydrocort	1-Covered	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
AEROSPAN	1-Covered	
ARNUITY ELLIPTA	1-Covered	
budesonide 0.25 mg/2 ml susp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)
budesonide 0.5 mg/2 ml susp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (4 PER 1 DAYS)
budesonide 1 mg/2 ml inh susp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (2 PER 1 DAYS)
budesonide 32 mcg nasal spray	1-Covered	
FLOVENT DISKUS	1-Covered	QL (80 PER 30 DAYS)
FLOVENT HFA	1-Covered	
fluticasone prop 50 mcg spray	1-Covered	QL (16 PER 30 DAYS)
mometasone furoate 50 mcg spry	1-Covered	
PULMICORT FLEXHALER	1-Covered	
QVAR	1-Covered	
ANTIHISTAMINES		
azelastine hcl (0.1% (137 mcg) spry, 0.15% nasal spray)	1-Covered	
carbinoxamine maleate (4 mg/5 ml liquid, maleate 4 mg tab)	1-Covered	PA
clemastine fumarate (0.5 mg/5 ml syrup, fum 2.68 mg tab)	1-Covered	PA
cyproheptadine hcl (2 mg/5 ml syrup, 4 mg tablet, 4 mg/10 ml syrp)	1-Covered	
desloratadine	1-Covered	
diphenhydramine 50 mg/ml vial	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydroxyzine hcl (hcl 10 mg tablet, 10 mg/5 ml syrup, 10 mg/5 ml soln, 25 mg/ml vial, hcl 25 mg tablet, 50 mg/ml vial, 50 mg/25 ml syrup, hcl 50 mg tablet, 100 mg/2 ml vial, 500 mg/10 ml vial)	1-Covered	
hydroxyzine pamoate	1-Covered	
levocetirizine dihydrochloride (2.5 mg/5 ml sol, 5 mg tablet)	1-Covered	
olopatadine 665 mcg nasal spry	1-Covered	
promethazine hcl (25 mg/ml vial, 25 mg/ml ampul, 50 mg/ml vial, 50 mg/ml ampul)	1-Covered	
promethazine hcl (6.25 mg/5 ml syrp, 12.5 mg tablet, 25 mg tablet)	1-Covered	PA
ANTILEUKOTRIENES		
montelukast sodium	1-Covered	QL (1 PER 1 DAYS)
zafirlukast 10 mg tablet	1-Covered	QL (4 PER 1 DAYS)
zafirlukast 20 mg tablet	1-Covered	QL (2 PER 1 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	1-Covered	
INCRUSE ELLIPTA	1-Covered	
ipratropium br 0.02% soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (15 PER 1 DAYS)
ipratropium bromide (0.03%, 0.06%)	1-Covered	
SPIRIVA	1-Covered	
SPIRIVA RESPIMAT	1-Covered	
TUDORZA PRESSAIR	1-Covered	
BRONCHODILATORS, SYMPATHOMIMETIC		
ADRENACLICK	1-Covered	
ADRENALIN	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
albuterol sulfate (sul 0.63 mg/3 ml sol, sul 1.25 mg/3 ml sol, sul 2.5 mg/3 ml soln, 2.5 mg/0.5 ml sol, 5 mg/ml solution, 20 mg/4 ml solution)	1-Covered	PA - TO CONFIRM PART D COVERAGE
albuterol sulfate (sulf 2 mg/5 ml syrup, sulfate 2 mg tab, sulfate 4 mg tab, sulfate er 4 mg tab, sulfate er 8 mg tab)	1-Covered	
epinephrine (0.15 mg auto-injct, 0.3 mg auto-inject)	1-Covered	
EPIPEN 2-PAK	1-Covered	
EPIPEN JR 2-PAK	1-Covered	
levalbuterol concentrate	1-Covered	PA - TO CONFIRM PART D COVERAGE
levalbuterol hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
levalbuterol tartrate hfa	1-Covered	
metaproterenol sulfate (10 mg tablet, 10 mg/5 ml syr, 20 mg tablet)	1-Covered	
PROAIR HFA	1-Covered	
PROAIR RESPICLICK	1-Covered	
PROVENTIL HFA	1-Covered	
SEREVENT DISKUS	1-Covered	QL (2 PER 1 DAYS)
STRIVERDI RESPIMAT	1-Covered	
terbutaline sulfate (2.5 mg tab, 5 mg tab)	1-Covered	
VENTOLIN HFA	1-Covered	QL (36 PER 30 DAYS)
XOPENEX HFA	1-Covered	
CYSTIC FIBROSIS AGENTS		
CAYSTON	1-Covered	NDS (Non-Extended Day Supply)
KALYDECO	1-Covered	PA, NDS (Non-Extended Day Supply)
ORKAMBI	1-Covered	PA, NDS (Non-Extended Day Supply)
TOBI PODHALER	1-Covered	NDS (Non-Extended Day Supply)
tobramycin 300 mg/5 ml ampule	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
aminophylline 250 mg/10 ml vl	1-Covered	
DALIRESP	1-Covered	
ELIXOPHYLLIN	1-Covered	
theophylline (80 mg/15 ml soln, er 400 mg tablet, er 600 mg tablet)	1-Covered	
theophylline anhydrous	1-Covered	
PULMONARY ANTIHYPERTENSIVES		
ADCIRCA	1-Covered	PA
ADEMPAS	1-Covered	NDS (Non-Extended Day Supply)
LETAIRIS	1-Covered	PA, LA, NDS (Non-Extended Day Supply)
OPSUMIT	1-Covered	NDS (Non-Extended Day Supply)
REMODULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
REVATIO 10 MG/ML ORAL SUSP	1-Covered	PA
sildenafil	1-Covered	PA
sildenafil citrate	1-Covered	PA
TRACLEER	1-Covered	PA, LA, NDS (Non-Extended Day Supply)
UPTRAVI	1-Covered	PA, NDS (Non-Extended Day Supply)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10% vial, 20% vial)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ADVAIR DISKUS	1-Covered	
ADVAIR HFA	1-Covered	
ANORO ELLIPTA	1-Covered	
ARALAST NP	1-Covered	NDS (Non-Extended Day Supply)
BREO ELLIPTA	1-Covered	
COMBIVENT RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
cromolyn 20 mg/2 ml neb soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (8 PER 1 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DULERA 100 MCG/5 MCG INHALER	1-Covered	QL (13.3 PER 30 DAYS)
DULERA 200 MCG/5 MCG INHALER	1-Covered	QL (13 PER 30 DAYS)
ESBRIET	1-Covered	PA, NDS (Non-Extended Day Supply)
GLASSIA	1-Covered	NDS (Non-Extended Day Supply)
GRASTEK	1-Covered	
ipratropium-albuterol	1-Covered	PA - TO CONFIRM PART D COVERAGE
OFEV	1-Covered	NDS (Non-Extended Day Supply)
ORALAIR (300 IR STARTER PACK, 300 IR SUBLINGUAL TAB, 300 IR ADULT SAMPLE KT)	1-Covered	
PROLASTIN C	1-Covered	NDS (Non-Extended Day Supply)
promethazine vc	1-Covered	PA
promethazine-phenylephrine	1-Covered	PA
PULMOZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
RAGWITEK	1-Covered	
STIOLTO RESPIMAT	1-Covered	
SYMBICORT	1-Covered	
TYZINE PEDIATRIC 0.05% DROP	1-Covered	
VIRAZOLE	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
XOLAIR	1-Covered	PA, LA, NDS (Non-Extended Day Supply)
ZEMAIRA	1-Covered	NDS (Non-Extended Day Supply)
SKELETAL MUSCLE RELAXANTS		
BOTOX	1-Covered	PA
carisoprodol	1-Covered	QL (4 PER 1 DAYS)
chlorzoxazone	1-Covered	
cyclobenzaprine 10 mg tablet	1-Covered	QL (3 PER 1 DAYS)
cyclobenzaprine 5 mg tablet	1-Covered	QL (6 PER 1 DAYS)
metaxalone 800 mg tablet	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
methocarbamol (500 mg tablet, 750 mg tablet)	1-Covered	
orphenadrine er 100 mg tablet	1-Covered	
SLEEP DISORDER AGENTS		
GABA RECEPTOR MODULATORS		
eszopiclone	1-Covered	PA
temazepam (15 mg capsule, 30 mg capsule)	1-Covered	QL (1 PER 1 DAYS)
triazolam 0.125 mg tablet	1-Covered	QL (2 PER 1 DAYS)
triazolam 0.25 mg tablet	1-Covered	QL (1 PER 1 DAYS)
zaleplon	1-Covered	PA
zolpidem tartrate (1.75 mg tab, 3.5 mg tablet)	1-Covered	
zolpidem tartrate 10 mg tablet	1-Covered	PA, QL (1 PER 1 DAYS)
zolpidem tartrate 5 mg tablet	1-Covered	QL (1 PER 1 DAYS)
zolpidem tartrate er	1-Covered	PA, QL (1 PER 1 DAYS)
SLEEP DISORDERS, OTHER		
armodafinil	1-Covered	PA
HETLIOZ	1-Covered	NDS (Non-Extended Day Supply)
ROZEREM	1-Covered	
SILENOR	1-Covered	
XYREM	1-Covered	NDS (Non-Extended Day Supply)
THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES		
ELECTROLYTE/MINERAL MODIFIERS		
CHEMET	1-Covered	
EXJADE	1-Covered	NDS (Non-Extended Day Supply)
FERRIPROX (100 MG/ML SOLUTION, 500 MG TABLET)	1-Covered	NDS (Non-Extended Day Supply)
KIONEX (15 GM/60 ML SUSPENSION, POWDER)	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sodium polystyrene sulfonate (sod polystyren sulf 15 g/60 ml, sodium polystyrene sulf powder, sps 15 gm/60 ml suspension, sps 30 gm/120 ml enema, sps 50 gm/200 ml enema)	1-Covered	
SPS 15 GM/60 ML SUSPENSION	1-Covered	
SYPRINE	1-Covered	
VELTASSA	1-Covered	
ELECTROLYTE/MINERAL REPLACEMENT		
dextrose 10%-0.2% nacl	1-Covered	
dextrose 10%-0.45% nacl	1-Covered	
dextrose 2.5%-0.45% nacl	1-Covered	
dextrose 5%-0.2% nacl	1-Covered	
dextrose 5%-0.2% nacl-kcl	1-Covered	
dextrose 5%-0.225% nacl	1-Covered	
dextrose 5%-0.225% nacl-kcl	1-Covered	
dextrose 5%-0.3% nacl	1-Covered	
dextrose 5%-0.3% nacl-kcl	1-Covered	
dextrose 5%-0.33% nacl	1-Covered	
dextrose 5%-0.33% nacl-kcl	1-Covered	
dextrose 5%-0.45% nacl	1-Covered	
dextrose 5%-0.45% nacl-kcl	1-Covered	
dextrose 5%-0.9% nacl	1-Covered	
dextrose 5%-1/2ns-kcl	1-Covered	
dextrose 5%-ns-kcl	1-Covered	
dextrose 5%-potassium chloride (20, 40)	1-Covered	
dextrose in lactated ringers	1-Covered	
FLUOR-A-DAY (0.25 MG TAB, 0.5 MG TAB, 1 MG TABLET)	1-Covered	
fluoride	1-Covered	
FLUORITAB (0.5 MG TABLET, 1 MG TABLET)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
K-TAB ER	1-Covered	
kcl 20 meq in d5w-lact ringer	1-Covered	
KLOR-CON 10	1-Covered	
KLOR-CON 8	1-Covered	
KLOR-CON M10	1-Covered	
KLOR-CON M15	1-Covered	
KLOR-CON M20	1-Covered	
KLOR-CON SPRINKLE	1-Covered	
lactated ringers injection	1-Covered	
LUDENT FLUORIDE	1-Covered	
magnesium sulfate 50% syringe	1-Covered	PA - TO CONFIRM PART D COVERAGE
magnesium sulfate 50% vial	1-Covered	
NORMOSOL-M AND DEXTROSE	1-Covered	
NORMOSOL-R AND DEXTROSE	1-Covered	
NORMOSOL-R PH 7.4	1-Covered	
PLASMA-LYTE 148	1-Covered	
PLASMA-LYTE 56 IN DEXTROSE	1-Covered	
PLASMA-LYTE A PH 7.4	1-Covered	
potassium chl-normal saline	1-Covered	
potassium chloride (2 meq/ml vial, 10 meq/5 ml conc, 20 meq/10 ml conc, 30 meq/15 ml conc, 40 meq/20 ml conc)	1-Covered	PA - TO CONFIRM PART D COVERAGE
potassium chloride (er 8 meq capsule, er 8 meq tablet, er 10 meq tablet, 10 meq/50 ml sol, 10% (40 meq/30 ml, 10 meq/100 ml sol, er 10 meq capsule, 10% (20 meq/15 ml, 20 meq packet, 20 meq/50 ml sol, 20% (40 meq/15 ml, er 20 meq tablet, 20 meq/100 ml sol, 40 meq/100 ml sol)	1-Covered	
potassium chloride-nacl	1-Covered	
ringers injection	1-Covered	
ringers irrigation	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sodium chloride (saline 0.45% soln-excel con, saline 0.9% soln-excel cont, sodium chloride 0.45% soln, sodium chloride 0.45% solution, sodium chloride 0.9% 250 ml, sodium chloride 0.9% 50 ml, sodium chloride 0.9% vial, sodium chloride 0.9% solution, sodium chloride 0.9% irrig., sodium chloride 0.9% soln, sodium chloride 0.9% 500 ml, sodium chloride 0.9% 1,000 ml, sodium chloride 0.9% 100 ml, sodium chloride 3% iv soln, sodium chloride 5% iv soln, sodium chloride 50 meq/20 ml, sodium chloride 100 meq/40 ml)	1-Covered	
sodium fluoride (0.5 mg(1.1 mg), 1 mg (2.2 mg))	1-Covered	
sodium lactate	1-Covered	
TPN ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
ACTIVE OB	1-Covered	
AMINOSYN 8.5%-ELECTROLYTES SOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN II	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN II WITH ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
ATABEX EC	1-Covered	
BAL-CARE DHA	1-Covered	
BAL-CARE DHA ESSENTIAL	1-Covered	
C-NATE DHA	1-Covered	
CADEAU DHA	1-Covered	
CALCIUM PNV	1-Covered	
CITRANATAL 90 DHA	1-Covered	
CITRANATAL ASSURE	1-Covered	
CITRANATAL B-CALM	1-Covered	
CITRANATAL DHA	1-Covered	
CITRANATAL HARMONY	1-Covered	
CITRANATAL RX	1-Covered	
CLINIMIX	1-Covered	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CLINIMIX E (4.25%-5%, 5%-20%)	1-Covered	PA - TO CONFIRM PART D COVERAGE
COMPLETE NATAL DHA	1-Covered	
COMPLETENATE	1-Covered	
CONCEPT DHA	1-Covered	
CONCEPT OB	1-Covered	
dextrose 10%-water iv solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
dextrose in water (iv soln, vial)	1-Covered	
DOTHELLE DHA	1-Covered	
DUET DHA 400	1-Covered	
DUET DHA BALANCED	1-Covered	
ELITE OB DHA	1-Covered	
ELITE-OB 400	1-Covered	
ENBRACE HR	1-Covered	
EXTRA-VIRT PLUS DHA	1-Covered	
FOCALGIN 90 DHA	1-Covered	
FOCALGIN CA	1-Covered	
FOLBECAL	1-Covered	
FOLET DHA	1-Covered	
FOLET ONE	1-Covered	
FOLIVANE-OB	1-Covered	
HEMENATAL OB	1-Covered	
HEMENATAL OB + DHA	1-Covered	
INATAL ADVANCE	1-Covered	
INATAL ULTRA	1-Covered	
INFANATE BALANCE	1-Covered	
INFANATE PLUS	1-Covered	
INTRALIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
KOSHER PRENATAL PLUS IRON	1-Covered	
lactated ringers irrigation	1-Covered	
levomefolate dha	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
M-VIT	1-Covered	
MACNATAL CN DHA	1-Covered	
MARNATAL-F	1-Covered	
MAXINATE	1-Covered	
MYNATAL	1-Covered	
MYNATAL ADVANCE	1-Covered	
MYNATAL PLUS	1-Covered	
MYNATAL-Z	1-Covered	
MYNATE 90 PLUS	1-Covered	
NATACHEW	1-Covered	
NATELLE ONE	1-Covered	
NEEVODHA	1-Covered	
NESTABS	1-Covered	
NESTABS ABC	1-Covered	
NESTABS DHA	1-Covered	
NEWGEN	1-Covered	
NEXA PLUS	1-Covered	
NIVA-PLUS	1-Covered	
O-CAL FA	1-Covered	
O-CAL PRENATAL	1-Covered	
OB COMPLETE	1-Covered	
OB COMPLETE GOLD	1-Covered	
OB COMPLETE ONE	1-Covered	
OB COMPLETE PETITE	1-Covered	
OB COMPLETE PREMIER	1-Covered	
OB COMPLETE WITH DHA	1-Covered	
OBSTETRIX DHA	1-Covered	
OBSTETRIX EC	1-Covered	
OBSTETRIX ONE	1-Covered	
OBTREX DHA	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PAIRE OB PLUS DHA	1-Covered	
PNV 29-1	1-Covered	
PNV OB+DHA	1-Covered	
PNV-DHA + DOCUSATE	1-Covered	
pnv-ferrous fumarate-docu-fa	1-Covered	
PNV-OMEGA	1-Covered	
PNV-SELECT	1-Covered	
PNV-TOTAL	1-Covered	
PNV-VP-U	1-Covered	
PR NATAL 400	1-Covered	
PR NATAL 400 EC	1-Covered	
PR NATAL 430	1-Covered	
PR NATAL 430 EC	1-Covered	
PREFERA OB	1-Covered	
PREFERA-OB ONE	1-Covered	
PREFERA-OB PLUS DHA	1-Covered	
PRENA1 CHEW	1-Covered	
PRENA1 PEARL	1-Covered	
PRENA1 TRUE	1-Covered	
PRENAISSANCE	1-Covered	
PRENAISSANCE 90 DHA	1-Covered	
PRENAISSANCE BALANCE	1-Covered	
PRENAISSANCE DHA	1-Covered	
PRENAISSANCE NEXT	1-Covered	
PRENAISSANCE NEXT-B	1-Covered	
PRENAISSANCE PLUS	1-Covered	
PRENAISSANCE PROMISE	1-Covered	
PRENATA	1-Covered	
PRENATABS FA	1-Covered	
PRENATABS RX	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
prenatal 19	1-Covered	
prenatal low iron	1-Covered	
prenatal plus	1-Covered	
prenatal plus-dha	1-Covered	
prenatal vitamin plus low iron	1-Covered	
prenatal-u	1-Covered	
PRENATE AM	1-Covered	
PRENATE CHEWABLE	1-Covered	
PRENATE DHA	1-Covered	
PRENATE ELITE	1-Covered	
PRENATE ENHANCE	1-Covered	
PRENATE ESSENTIAL	1-Covered	
PRENATE MINI	1-Covered	
PRENATE PIXIE	1-Covered	
PRENATE RESTORE	1-Covered	
PRENATE STAR	1-Covered	
PREPLUS	1-Covered	
PREQUE 10	1-Covered	
PRETAB	1-Covered	
PRIMACARE	1-Covered	
PROVIDA DHA	1-Covered	
PROVIDA OB	1-Covered	
PUREFE OB PLUS	1-Covered	
PUREFE PLUS	1-Covered	
R-NATAL OB	1-Covered	
RELNATE DHA	1-Covered	
RULAVITE DHA	1-Covered	
SE-NATAL 19	1-Covered	
SE-TAN DHA	1-Covered	
SELECT-OB	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SELECT-OB + DHA	1-Covered	
TARON-BC	1-Covered	
TARON-C DHA	1-Covered	
TARON-PREX PRENATAL	1-Covered	
THRIVITE 19	1-Covered	
TL FOLATE	1-Covered	
TL-SELECT	1-Covered	
TRAVASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRI-TABS DHA	1-Covered	
TRIADVANCE	1-Covered	
TRICARE	1-Covered	
TRICARE PRENATAL	1-Covered	
TRICARE PRENATAL DHA ONE	1-Covered	
TRINATAL GT	1-Covered	
TRINATAL RX 1	1-Covered	
TRINATE	1-Covered	
TRISTART DHA	1-Covered	
TRIVEEN-DUO DHA	1-Covered	
TRIVEEN-ONE	1-Covered	
TRIVEEN-PRX RNF	1-Covered	
TROPHAMINE	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRUST NATAL DHA	1-Covered	
ULTIMATECARE ONE	1-Covered	
ULTIMATECARE ONE NF	1-Covered	
VEMAVITE-PRX 2	1-Covered	
VENA-BAL DHA	1-Covered	
VINACAL	1-Covered	
VINATE CARE	1-Covered	
VINATE DHA	1-Covered	
VINATE DHA RF	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VINATE GT	1-Covered	
VINATE II	1-Covered	
VINATE ONE	1-Covered	
VINATE PN CARE	1-Covered	
VINATE ULTRA	1-Covered	
VINATE-M	1-Covered	
VIRT NATE	1-Covered	
VIRT-ADVANCE	1-Covered	
VIRT-C DHA	1-Covered	
VIRT-NATE	1-Covered	
VIRT-NATE DHA	1-Covered	
VIRT-PN	1-Covered	
VIRT-PN DHA	1-Covered	
VIRT-PN PLUS	1-Covered	
VIRT-SELECT	1-Covered	
VIRT-VITE GT	1-Covered	
VIRTPREX	1-Covered	
VITAFOL FE+	1-Covered	
VITAFOL GUMMIES	1-Covered	
VITAFOL NANO	1-Covered	
VITAFOL ULTRA	1-Covered	
VITAFOL-OB	1-Covered	
VITAFOL-OB+DHA	1-Covered	
VITAFOL-ONE	1-Covered	
VITAMEDMD ONE RX	1-Covered	
VITAMEDMD PLUS RX	1-Covered	
VITAMEDMD REDICHEW RX	1-Covered	
VITAPEARL	1-Covered	
VITATRUE	1-Covered	
VOL-NATE	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VOL-TAB RX	1-Covered	
VP-CH PLUS	1-Covered	
VP-CH-PNV	1-Covered	
VP-GGR-B6	1-Covered	
VP-HEME OB	1-Covered	
VP-HEME OB + DHA	1-Covered	
VP-HEME ONE	1-Covered	
VP-PNV-DHA	1-Covered	
ZATEAN-CH	1-Covered	
ZATEAN-PN	1-Covered	
ZATEAN-PN DHA	1-Covered	
ZATEAN-PN PLUS	1-Covered	
ZINGIBER	1-Covered	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

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Mail: Attn: Complaints, Grievances & Appeals Unit
Health Partners Medicare
901 Market Street, Suite 500
Philadelphia, PA 19107

Fax: 215-991-4105

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Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.

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French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-901-8000 (ATS: 711).

French Creole Haitian
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-901-8000 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-901-8000 (TTY: 711).

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-901-8000 (TTY: 711).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-901-8000 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-901-8000 (TTY: 711)번으로 전화해 주십시오.

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-901-8000 (TTY: 711).

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-901-8000 (TTY: 711).

Portuguese European
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-901-8000 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-901-8000 (телетайп: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-901-8000 (TTY: 711).

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