2020 Formulary List of Covered Drugs

Health Partners Medicare Special (HMO SNP)

Health Partners Plans

Health Partners Medicare Special (HMO SNP) 2020 Formulary

(List of Covered Drugs)

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

Formulary ID 00020500, Version 17

This formulary was updated on 11/1/2020. For more recent information or other questions, please contact Health Partners Medicare at 1-866-901-8000 or, for TTY users, 1-877-454-8477, 24 hours a day, seven days a week, or visit www.HPPMedicare.com.

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

When this drug list (formulary) refers to "we," "us," or "our," it means 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 11/1/2020. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the first and last 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, 2021, 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 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 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 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?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- New generic drugs. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Health Partners Medicare Special Formulary?"
- Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- Other changes. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Health Partners Medicare Special Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

This formulary is current as of 11/1/2020. To get updated information about the drugs covered by Health Partners Medicare Special, please contact us. Our contact information also appears on the first and last pages.

Our print formulary will be updated, either by reprinting or through the use of formulary update 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, Other." If you know what your drug is used for, look for the category name in the list that begins on page 103. 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 110. The Index provides an alphabetical list of all the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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 360 tablets per prescription for Endocet, 5-325 mg. 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 first and last 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?" below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact us at 1-866-901-8000 (TTY 1-877-454-8477) 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 cover a formulary drug at a lower cost-sharing level if this drug is not on the Specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, 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, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor 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. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

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 first and last 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 110.

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

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.
NDS	Non-Extended Day Supply	The Non-Extended Day Supply file must only contain drugs NOT available as an extended day supply. In addition, drugs from tiers that cover all drugs as an extended day supply must not be included on the Non-Extended Day Supply file.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
butalbital-asa-caffeine	1-Covered	PA
butalbital-aspirin-caffeine 50-325-40 mg cap	1-Covered	PA
celecoxib (50 mg cap, 100 mg cap, 200 mg cap, 400 mg cap)	1-Covered	
diclofenac potassium	1-Covered	
diclofenac sodium (1.5 % solution, 25 mg tab dr, 50 mg tab dr, 75 mg tab dr)	1-Covered	
diclofenac sodium er	1-Covered	
diclofenac-misoprostol	1-Covered	
diflunisal 500 mg tab	1-Covered	
ec-naproxen	1-Covered	
etodolac (200 mg cap, 300 mg cap, 400 mg tab, 500 mg tab)	1-Covered	
fenoprofen calcium (400 mg cap, 600 mg tab)	1-Covered	
flurbiprofen (50 mg tab, 100 mg tab)	1-Covered	
ibu	1-Covered	
ibuprofen (100 mg/5ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)	1-Covered	
indomethacin (25 mg cap, 50 mg cap)	1-Covered	PA
indomethacin er	1-Covered	PA
ketoprofen er	1-Covered	QL (30 PER 30 DAYS)
meclofenamate sodium (50 mg cap, 100 mg cap)	1-Covered	
mefenamic acid 250 mg cap	1-Covered	
meloxicam 15 mg tab	1-Covered	QL (30 PER 30 DAYS)
meloxicam 7.5 mg tab	1-Covered	QL (60 PER 30 DAYS)
nabumetone (500 mg tab, 750 mg tab)	1-Covered	
naproxen (125 mg/5ml suspension, 250 mg tab, 375 mg tab, 500 mg tab)	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 dr	1-Covered	
naproxen sodium (275 mg tab, 550 mg tab)	1-Covered	
naproxen sodium er	1-Covered	
oxaprozin	1-Covered	
piroxicam (10 mg cap, 20 mg cap)	1-Covered	
relafen	1-Covered	
sulindac (150 mg tab, 200 mg tab)	1-Covered	
tolmetin sodium (400 mg cap, 600 mg tab)	1-Covered	
OPIOID ANALGESICS, LONG-ACTING		
fentanyl	1-Covered	QL (10 PER 30 DAYS)
methadone hcl (5 mg tab, 5 mg/5ml solution, 10 mg tab, 10 mg/5ml solution)	1-Covered	
morphine sulfate er (er 10 mg cap er, er 20 mg cap er, er 30 mg cap er, er 40 mg cap er, er 50 mg cap er, er 60 mg cap er, er 80 mg cap er, er 100 mg cap er)	1-Covered	QL (60 PER 30 DAYS)
morphine sulfate er (er 15 mg tab er, er 30 mg tab er, er 60 mg tab er, er 100 mg tab er, er 200 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
NUCYNTA ER (ER 100 MG TAB ER, ER 200 MG TAB ER, ER 250 MG TAB ER)	1-Covered	PA, QL (60 PER 30 DAYS)
NUCYNTA ER 150 MG TAB ER 12H	1-Covered	PA, QL (90 PER 30 DAYS)
NUCYNTA ER 50 MG TAB ER 12H	1-Covered	PA, QL (120 PER 30 DAYS)
oxycodone hcl er	1-Covered	PA, QL (60 PER 30 DAYS)
OXYCONTIN	1-Covered	PA, QL (60 PER 30 DAYS)
oxymorphone hcl er	1-Covered	PA, QL (60 PER 30 DAYS)
tramadol hcl er (er 100 mg cap er, er 100 mg tab er, er 200 mg tab er, er 200 mg cap er, er 300 mg tab er, er 300 mg cap er)	1-Covered	QL (30 PER 30 DAYS)
tramadol hcl er (biphasic)	1-Covered	QL (30 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
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine 120-12 mg/5ml solution	1-Covered	
acetaminophen-codeine 300-15 mg tab	1-Covered	QL (390 PER 30 DAYS)
acetaminophen-codeine 300-30 mg tab	1-Covered	QL (360 PER 30 DAYS)
acetaminophen-codeine 300-60 mg tab	1-Covered	QL (180 PER 30 DAYS)
acetaminophen-codeine #2	1-Covered	QL (390 PER 30 DAYS)
acetaminophen-codeine #3	1-Covered	QL (360 PER 30 DAYS)
acetaminophen-codeine #4	1-Covered	QL (180 PER 30 DAYS)
ascomp-codeine	1-Covered	PA
butalbital-apap-caff-cod 50-325-40-30 mg cap	1-Covered	PA
butalbital-asa-caff-codeine	1-Covered	PA
butorphanol tartrate 10 mg/ml solution	1-Covered	
duramorph	1-Covered	
endocet (5-325 mg tab, 10-325 mg tab)	1-Covered	QL (360 PER 30 DAYS)
endocet 2.5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
endocet 7.5-325 mg tab	1-Covered	
fentanyl citrate (200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)	1-Covered	PA
hydrocodone-acetaminophen (2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml)	1-Covered	
hydrocodone-acetaminophen 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
hydrocodone-acetaminophen 5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
hydrocodone-acetaminophen 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
hydrocodone-ibuprofen (5-200 mg tab, 10-200 mg tab)	1-Covered	
hydrocodone-ibuprofen 7.5-200 mg tab	1-Covered	QL (150 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)	1-Covered	
lorcet	1-Covered	QL (360 PER 30 DAYS)
lorcet hd	1-Covered	QL (180 PER 30 DAYS)
lorcet plus	1-Covered	QL (240 PER 30 DAYS)
morphine sulfate (10 mg/5ml solution, 15 mg tab, 20 mg/5ml solution, 30 mg tab)	1-Covered	
morphine sulfate (concentrate)	1-Covered	
morphine sulfate (pf) ((pf) 0.5 mg/ml, (pf) 1 mg/ml, (pf) 2 mg/ml, (pf) 4 mg/ml, (pf) 8 mg/ml, (pf) 10 mg/ml)	1-Covered	
oxycodone hcl (5 mg tab, 5 mg cap, 5 mg/5ml solution, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab, 100 mg/5ml conc)	1-Covered	
oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab, 10-325 mg tab)	1-Covered	QL (360 PER 30 DAYS)
oxycodone-acetaminophen 7.5-325 mg tab	1-Covered	
oxycodone-aspirin	1-Covered	
oxycodone-ibuprofen	1-Covered	
oxymorphone hcl	1-Covered	
pentazocine-naloxone hcl	1-Covered	QL (360 PER 30 DAYS)
tramadol hcl 100 mg tab	1-Covered	QL (120 PER 30 DAYS)
tramadol hcl 50 mg tab	1-Covered	
tramadol-acetaminophen	1-Covered	QL (240 PER 30 DAYS)
ANESTHETICS		
LOCAL ANESTHETICS		
glydo	1-Covered	
lidocaine 5 % patch	1-Covered	PA, QL (90 PER 30 DAYS)
lidocaine 5 % ointment	1-Covered	QL (106.32 PER 30 DAYS)
lidocaine hcl urethral/mucosal (urethral/mucosal 2 % gel, urethral/mucosal 2 % prsyr)	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
lidocaine viscous hcl	1-Covered	
lidocaine-prilocaine	1-Covered	
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	1-Covered	
disulfiram (250 mg tab, 500 mg tab)	1-Covered	
naltrexone hcl 50 mg tab	1-Covered	
VIVITROL	1-Covered	NDS (Non-Extended Day Supply)
OPIOID DEPENDENCE TREATMENTS		
buprenorphine hcl 2 mg sl tab	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl 8 mg sl tab	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 12-3 mg)	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 8-2 mg film	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab	1-Covered	QL (120 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 8-2 mg sl tab	1-Covered	QL (90 PER 30 DAYS)
LUCEMYRA	1-Covered	PA, QL (16 PER DAY)
OPIOID REVERSAL AGENTS		
naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/10ml solution)	1-Covered	
NARCAN	1-Covered	
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det)	1-Covered	QL (60 PER 30 DAYS)
CHANTIX	1-Covered	
CHANTIX CONTINUING MONTH PAK	1-Covered	
CHANTIX STARTING MONTH PAK	1-Covered	
NICOTROL	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NICOTROL NS	1-Covered	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate 500 mg/2ml solution	1-Covered	
gentak	1-Covered	
gentamicin in saline (gentamicsale 0.8-0.9 mg/ml-%, gentamicsale 1-0.9 mg/ml-%, gentamicsale 1.2-0.9 mg/ml-%, gentamicsale 1.6-0.9 mg/ml-%)	1-Covered	
gentamicin sulfate (0.1 % ointment, 0.1 % cream, 0.3 % solution, 40 mg/ml solution)	1-Covered	
neomycin sulfate 500 mg tab	1-Covered	
paromomycin sulfate 250 mg cap	1-Covered	
streptomycin sulfate 1 gm recon soln	1-Covered	
tobramycin 0.3 % solution	1-Covered	
tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)	1-Covered	
ANTIBACTERIALS, OTHER		
bacitracin 500 unit/gm ointment	1-Covered	
benzoyl peroxide-erythromycin	1-Covered	
clindacin etz	1-Covered	
clindacin-p	1-Covered	
clindamycin hcl (75 mg cap, 150 mg cap, 300 mg cap)	1-Covered	
clindamycin palmitate hcl	1-Covered	
clindamycin phosphate (1 % swab, 1 % lotion, 1 % gel, 1 % solution, 2 % cream, 9 gm/60ml solution, 300 mg/2ml solution, 600 mg/4ml solution, 900 mg/6ml solution, 9000 mg/60ml solution)	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
clindamycin phosphate in d5w	1-Covered	
colistimethate sodium (cba)	1-Covered	
daptomycin 500 mg recon soln	1-Covered	NDS (Non-Extended Day Supply)
daptomycin 350 mg recon soln	1-Covered	NDS (Non-Extended Day Supply)
linezolid 100 mg/5ml recon susp	1-Covered	QL (1800 PER 30 DAYS)
linezolid 600 mg/300ml solution	1-Covered	
linezolid 600 mg tab	1-Covered	QL (60 PER 30 DAYS)
methenamine hippurate	1-Covered	
metronidazole (0.75 % gel, 250 mg tab, 375 mg cap, 500 mg tab)	1-Covered	
metronidazole in nacl 0.74% iv soln 500 mg/100ml	1-Covered	
metronidazole in nacl 0.79% iv soln 500 mg/100ml	1-Covered	
MONUROL	1-Covered	
mupirocin 2 % ointment	1-Covered	
mupirocin calcium	1-Covered	
nitrofurantoin	1-Covered	
nitrofurantoin macrocrystal (25 mg cap, 100 mg cap)	1-Covered	
nitrofurantoin macrocrystal 50 mg cap	1-Covered	QL (112 PER 30 DAYS)
nitrofurantoin monohyd macro	1-Covered	
polymyxin b sulfate 500000 unit recon soln	1-Covered	
TIGECYCLINE	1-Covered	
trimethoprim 100 mg tab	1-Covered	
vancomycin hcl 125 mg cap	1-Covered	QL (120 PER 30 DAYS)
vancomycin hcl 250 mg cap	1-Covered	QL (240 PER 30 DAYS)
vancomycin hcl (1 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln, 750 mg soln)	1-Covered	
vandazole	1-Covered	
XIFAXAN 200 MG TAB	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
XIFAXAN 550 MG TAB	1-Covered	PA, NDS (Non-Extended Day Supply)
BETA-LACTAM, CEPHALOSPORINS		
cefaclor (250 mg cap, 500 mg cap)	1-Covered	
CEFACLOR ER	1-Covered	
cefadroxil (1 gm tab, 250 mg/5ml recon susp, 500 mg/5ml recon susp, 500 mg cap)	1-Covered	
cefazolin sodium (1 gm soln, 10 gm soln, 100 gm soln, 300 gm soln, 500 mg soln)	1-Covered	
cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)	1-Covered	
cefepime hcl (1 gm soln, 2 gm soln)	1-Covered	
cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)	1-Covered	
cefotetan disodium (1 gm soln, 2 gm soln)	1-Covered	
cefoxitin sodium	1-Covered	
cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg/5ml recon susp, 100 mg tab, 200 mg tab)	1-Covered	
cefprozil (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg tab, 500 mg tab)	1-Covered	
ceftazidime (1 gm soln, 2 gm soln, 6 gm soln)	1-Covered	
ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln)	1-Covered	
cefuroxime axetil	1-Covered	
cefuroxime sodium	1-Covered	
cephalexin (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 500 mg cap)	1-Covered	
SUPRAX 400 MG CAP	1-Covered	
tazicef (1 gm soln, 2 gm soln, 6 gm soln)	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
TEFLARO	1-Covered	
BETA-LACTAM, OTHER		
AZACTAM 2 GM RECON SOLN	1-Covered	
aztreonam 1 gm recon soln	1-Covered	
ertapenem sodium	1-Covered	
imipenem-cilastatin	1-Covered	
meropenem	1-Covered	
BETA-LACTAM, PENICILLINS		
amoxicillin (125 mg chew tab, 125 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 250 mg chew tab, 400 mg/5ml recon susp, 500 mg tab, 500 mg cap, 875 mg tab)	1-Covered	
amoxicillin-pot clavulanate (200-28.5 mg/5ml recon susp, 200-28.5 mg chew tab, 250-62.5 mg/5ml recon susp, 250-125 mg tab, 400-57 mg/5ml recon susp, 400-57 mg chew tab, 500-125 mg tab, 600-42.9 mg/5ml recon susp, 875-125 mg tab)	1-Covered	
amoxicillin-pot clavulanate er	1-Covered	
ampicillin 500 mg cap	1-Covered	
ampicillin sodium (1 gm soln, 10 gm soln, 125 mg soln)	1-Covered	
ampicillin-sulbactam sodium	1-Covered	
BICILLIN L-A	1-Covered	
dicloxacillin sodium	1-Covered	
nafcillin sodium (1 gm soln, 2 gm soln)	1-Covered	
NAFCILLIN SODIUM 10 GM RECON SOLN	1-Covered	
oxacillin sodium	1-Covered	
OXACILLIN SODIUM IN DEXTROSE	1-Covered	
PENICILLIN G POT IN DEXTROSE (PENICILL40000 UNIT/ML, PENICILL60000 UNIT/ML)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
penicillin g potassium	1-Covered	
PENICILLIN G PROCAINE	1-Covered	
penicillin g sodium	1-Covered	
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, 250 mg tab, 500 mg tab)	1-Covered	
pfizerpen	1-Covered	
piperacillin sod-tazobactam so	1-Covered	
MACROLIDES		
AZASITE	1-Covered	
azithromycin (1 gm packet, 100 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg tab, 500 mg recon soln, 500 mg tab, 600 mg tab)	1-Covered	
clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)	1-Covered	
clarithromycin er	1-Covered	
e.e.s. 400	1-Covered	
ery-tab	1-Covered	
ERYTHROCIN LACTOBIONATE	1-Covered	
erythromycin (2 % solution, 2 % gel, 5 mg/gm ointment, 250 mg tab dr, 333 mg tab dr, 500 mg tab dr)	1-Covered	
erythromycin base (250 mg tab dr, 250 mg tab, 250 mg cp dr part, 333 mg tab dr, 500 mg tab, 500 mg tab dr)	1-Covered	
erythromycin ethylsuccinate (200 mg/5ml recon susp, 400 mg/5ml recon susp, 400 mg tab)	1-Covered	
QUINOLONES		
CIPRO 500 MG/5ML (10%) RECON SUSP	1-Covered	
ciprofloxacin 500 mg/5ml (10%) recon susp	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ciprofloxacin hcl (0.2 % solution, 0.3 % solution, 100 mg tab, 250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
ciprofloxacin in d5w 200 mg/100ml solution	1-Covered	
gatifloxacin 0.5 % solution	1-Covered	
levofloxacin (0.5 % solution, 250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
levofloxacin 25 mg/ml oral solution	1-Covered	
levofloxacin in d5w (500 mg/100ml, 750 mg/150ml)	1-Covered	
levofloxacin iv soln 25 mg/ml	1-Covered	
moxifloxacin hcl (0.5 % solution, 400 mg/250ml solution, 400 mg tab)	1-Covered	
moxifloxacin hcl (2x day)	1-Covered	
moxifloxacin hcl in nacl	1-Covered	
ofloxacin (0.3 % solution, 300 mg tab, 400 mg tab)	1-Covered	
SULFONAMIDES		
SILVADENE	1-Covered	
silver sulfadiazine 1 % cream	1-Covered	
ssd	1-Covered	
sulfacetamide sodium (10 % ointment, 10 % solution)	1-Covered	
sulfacetamide sodium (acne)	1-Covered	
SULFADIAZINE 500 MG TAB	1-Covered	
sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)	1-Covered	
TETRACYCLINES		
demeclocycline hcl	1-Covered	
doxy 100	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxycycline hyclate (20 mg tab, 50 mg cap, 50 mg tab dr, 75 mg tab dr, 75 mg tab, 100 mg recon soln, 100 mg tab, 100 mg tab dr, 100 mg cap, 150 mg tab dr, 150 mg tab, 200 mg tab dr)	1-Covered	
doxycycline monohydrate (25 mg/5ml recon susp, 50 mg tab, 50 mg cap, 75 mg cap, 75 mg tab, 100 mg tab, 100 mg cap, 150 mg tab)	1-Covered	
minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)	1-Covered	
mondoxyne nl	1-Covered	
morgidox	1-Covered	
okebo	1-Covered	
soloxide	1-Covered	
tetracycline hcl (250 mg cap, 500 mg cap)	1-Covered	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT 50 MG/5ML SOLUTION	1-Covered	
BRIVIACT (10 MG TAB, 10 MG/ML SOLUTION, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
EPIDIOLEX	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
FINTEPLA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)	1-Covered	
levetiracetam er	1-Covered	
levetiracetam in nacl	1-Covered	
NAYZILAM	1-Covered	PA - FOR NEW STARTS ONLY
roweepra	1-Covered	
roweepra xr	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SPRITAM	1-Covered	
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN	1-Covered	
ethosuximide (250 mg/5ml solution, 250 mg cap)	1-Covered	
zonisamide (25 mg cap, 50 mg cap, 100 mg cap)	1-Covered	
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam 2.5 mg/ml suspension	1-Covered	QL (480 PER 30 DAYS)
clobazam (10 mg tab, 20 mg tab)	1-Covered	QL (60 PER 30 DAYS)
DIASTAT ACUDIAL	1-Covered	
DIASTAT PEDIATRIC	1-Covered	
diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)	1-Covered	
divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)	1-Covered	
divalproex sodium er	1-Covered	
gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)	1-Covered	
GRALISE	1-Covered	
GRALISE STARTER	1-Covered	
phenobarbital (15 mg tab, 16.2 mg tab, 20 mg/5ml elixir, 20 mg/5ml solution, 30 mg tab, 32.4 mg tab, 60 mg tab, 64.8 mg tab, 97.2 mg tab, 100 mg tab)	1-Covered	
primidone (50 mg tab, 250 mg tab)	1-Covered	
SYMPAZAN	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
tiagabine hcl	1-Covered	
valproate sodium (100 mg/ml, 250 mg/5ml, 500 mg/5ml)	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
valproic acid (250 mg cap, 250 mg/5ml solution)	1-Covered	
VALTOCO 10 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 15 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 20 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 5 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigabatrin (500 mg tab, 500 mg packet)	1-Covered	NDS (Non-Extended Day Supply)
vigadrone	1-Covered	NDS (Non-Extended Day Supply)
GLUTAMATE REDUCING AGENTS		
felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)	1-Covered	
FYCOMPA (0.5 MG/ML SUSPENSION, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	
LAMICTAL XR (21 X 25 MG 7 X 50 MG, 25 50 100 MG, 50 100 200 MG)	1-Covered	
lamotrigine (5 mg chew tab, 25 mg tab, 25 & 50 & 100 mg kit, 25 mg chew tab, 25 mg tab disp, 50 mg tab disp, 100 mg tab disp, 100 mg tab, 150 mg tab, 200 mg tab, 200 mg tab disp)	1-Covered	
lamotrigine er	1-Covered	
lamotrigine starter kit-blue	1-Covered	
lamotrigine starter kit-green	1-Covered	
lamotrigine starter kit-orange	1-Covered	
subvenite	1-Covered	
subvenite starter kit-blue	1-Covered	
subvenite starter kit-green	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
subvenite starter kit-orange	1-Covered	
topiramate (15 mg cap, 25 mg cap)	1-Covered	
topiramate (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	QL (180 PER 30 DAYS)
topiramate 200 mg tab	1-Covered	QL (120 PER 30 DAYS)
topiramate er	1-Covered	
TROKENDI XR	1-Covered	
XCOPRI (14 X 50 MG & 14 X100 MG TAB THPK, 14 X 150 MG & 14 X200 MG TAB THPK, 50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	1-Covered	
XCOPRI (250 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
XCOPRI (350 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
SODIUM CHANNEL AGENTS		
APTIOM	1-Covered	NDS (Non-Extended Day Supply)
BANZEL (40 MG/ML SUSPENSION, 200 MG TAB, 400 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)	1-Covered	
carbamazepine er (er 100 mg tab er, er 100 mg cap er, er 200 mg tab er, er 200 mg cap er, er 300 mg cap er, er 400 mg tab er)	1-Covered	
DILANTIN 30 MG CAP	1-Covered	
epitol	1-Covered	
fosphenytoin sodium	1-Covered	
oxcarbazepine (150 mg tab, 300 mg/5ml suspension, 300 mg tab, 600 mg tab)	1-Covered	
OXTELLAR XR	1-Covered	
PEGANONE	1-Covered	
phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
phenytoin infatabs	1-Covered	
phenytoin sodium 50 mg/ml solution	1-Covered	
phenytoin sodium extended	1-Covered	
VIMPAT (10 MG/ML SOLUTION, 50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG/20ML SOLUTION, 200 MG TAB)	1-Covered	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
ergoloid mesylates 1 mg tab	1-Covered	PA
CHOLINESTERASE INHIBITORS		
donepezil hcl 23 mg tab	1-Covered	
donepezil hcl (5 mg tab, 5 mg tab disp, 10 mg tab, 10 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
galantamine hydrobromide (4 mg tab, 4 mg/ml solution, 8 mg tab, 12 mg tab)	1-Covered	
galantamine hydrobromide er	1-Covered	
NAMZARIC (7 & 14 & 21 &28 -10 MG CP24 THPK, 7-10 MG CAP ER 24H, 14-10 MG CAP ER 24H, 21-10 MG CAP ER 24H, 28-10 MG CAP ER 24H)	1-Covered	
rivastigmine	1-Covered	QL (30 PER 30 DAYS)
rivastigmine tartrate	1-Covered	QL (60 PER 30 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (2 mg/ml solution, 10 mg/5ml solution, 28 x 5 mg & 21 x 10 mg tab)	1-Covered	
memantine hcl (5 mg tab, 10 mg tab)	1-Covered	QL (60 PER 30 DAYS)
memantine hcl er	1-Covered	QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
APLENZIN	1-Covered	NDS (Non-Extended Day Supply)
bupropion hcl (75 mg tab, 100 mg tab)	1-Covered	QL (120 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bupropion hcl er (sr)	1-Covered	QL (60 PER 30 DAYS)
bupropion hcl er (xl) (er (xl) 300 mg tab er, er (xl) 450 mg tab er)	1-Covered	QL (30 PER 30 DAYS)
bupropion hcl er (xl) 150 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
chlordiazepoxide-amitriptyline	1-Covered	
mirtazapine (15 mg tab, 15 mg tab disp)	1-Covered	QL (90 PER 30 DAYS)
mirtazapine (30 mg tab disp, 30 mg tab)	1-Covered	QL (60 PER 30 DAYS)
mirtazapine (7.5 mg tab, 45 mg tab disp, 45 mg tab)	1-Covered	QL (30 PER 30 DAYS)
olanzapine-fluoxetine hcl	1-Covered	
perphenazine-amitriptyline	1-Covered	
MONOAMINE OXIDASE INHIBITORS		
EMSAM	1-Covered	
MARPLAN	1-Covered	
phenelzine sulfate 15 mg tab	1-Covered	
tranylcypromine sulfate	1-Covered	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
citalopram hydrobromide 10 mg/5ml solution	1-Covered	
citalopram hydrobromide (20 mg tab, 40 mg tab)	1-Covered	QL (45 PER 30 DAYS)
citalopram hydrobromide 10 mg tab	1-Covered	QL (90 PER 30 DAYS)
DESVENLAFAXINE ER	1-Covered	
desvenlafaxine succinate er	1-Covered	
escitalopram oxalate 5 mg/5ml solution	1-Covered	QL (600 PER 30 DAYS)
escitalopram oxalate 10 mg tab	1-Covered	QL (45 PER 30 DAYS)
escitalopram oxalate 20 mg tab	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg tab	1-Covered	QL (90 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FETZIMA	1-Covered	
FETZIMA TITRATION	1-Covered	
fluoxetine hcl 40 mg cap	1-Covered	QL (60 PER 30 DAYS)
fluoxetine hcl 90 mg cap dr	1-Covered	QL (4 PER 28 DAYS)
fluoxetine hcl 20 mg/5ml solution	1-Covered	
fluoxetine hcl (10 mg tab, 10 mg cap)	1-Covered	QL (90 PER 30 DAYS)
fluoxetine hcl (20 mg cap, 20 mg tab)	1-Covered	QL (120 PER 30 DAYS)
fluoxetine hcl 60 mg tab	1-Covered	QL (30 PER 30 DAYS)
fluoxetine hcl (pmdd) 10 mg tab	1-Covered	QL (90 PER 30 DAYS)
fluoxetine hcl (pmdd) 20 mg tab	1-Covered	QL (120 PER 30 DAYS)
fluvoxamine maleate	1-Covered	QL (90 PER 30 DAYS)
fluvoxamine maleate er	1-Covered	
maprotiline hcl	1-Covered	
nefazodone hcl (50 mg tab, 100 mg tab, 250 mg tab)	1-Covered	QL (60 PER 30 DAYS)
nefazodone hcl 150 mg tab	1-Covered	QL (120 PER 30 DAYS)
nefazodone hcl 200 mg tab	1-Covered	QL (90 PER 30 DAYS)
paroxetine hcl	1-Covered	
paroxetine hcl er	1-Covered	
paroxetine mesylate	1-Covered	
PAXIL 10 MG/5ML SUSPENSION	1-Covered	
PEXEVA	1-Covered	
sertraline hcl 20 mg/ml conc	1-Covered	QL (300 PER 30 DAYS)
sertraline hcl (25 mg tab, 50 mg tab)	1-Covered	QL (90 PER 30 DAYS)
sertraline hcl 100 mg tab	1-Covered	QL (60 PER 30 DAYS)
trazodone hcl (50 mg tab, 100 mg tab, 150 mg tab, 300 mg tab)	1-Covered	
TRINTELLIX	1-Covered	
venlafaxine hcl	1-Covered	
venlafaxine hcl er (er 150 mg tab er, er 150 mg cap er)	1-Covered	QL (60 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
venlafaxine hcl er (er 37.5 mg cap er, er 37.5 mg tab er, er 75 mg cap er, er 75 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
venlafaxine hcl er 225 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
VIIBRYD	1-Covered	
VIIBRYD STARTER PACK	1-Covered	
TRICYCLICS		
amitriptyline hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)	1-Covered	
amoxapine	1-Covered	
clomipramine hcl (25 mg cap, 50 mg cap, 75 mg cap)	1-Covered	
desipramine hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)	1-Covered	
doxepin hcl (10 mg/ml conc, 10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)	1-Covered	
imipramine hcl (10 mg tab, 25 mg tab, 50 mg tab)	1-Covered	
imipramine pamoate	1-Covered	
nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)	1-Covered	
protriptyline hcl	1-Covered	
trimipramine maleate (25 mg cap, 50 mg cap)	1-Covered	QL (180 PER 30 DAYS)
trimipramine maleate 100 mg cap	1-Covered	QL (90 PER 30 DAYS)
ANTIEMETICS		
ANTIEMETICS, OTHER		
compro	1-Covered	
meclizine hcl (12.5 mg tab, 25 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
metoclopramide hcl (5 mg/5ml solution, 5 mg tab disp, 5 mg tab, 10 mg tab disp, 10 mg/10ml solution, 10 mg tab)	1-Covered	
perphenazine (2 mg tab, 4 mg tab, 8 mg tab, 16 mg tab)	1-Covered	
phenadoz	1-Covered	
prochlorperazine	1-Covered	
prochlorperazine edisylate (10 mg/2ml, 50 mg/10ml)	1-Covered	
prochlorperazine maleate (5 mg tab, 10 mg tab)	1-Covered	
promethazine hcl (12.5 mg, 25 mg)	1-Covered	
promethazine hcl 50 mg tab	1-Covered	PA
promethegan	1-Covered	
scopolamine	1-Covered	
EMETOGENIC THERAPY ADJUNCTS		
aprepitant	1-Covered	PA - TO CONFIRM PART D COVERAGE
dronabinol	1-Covered	PA
EMEND 125 MG/5ML RECON SUSP	1-Covered	PA - TO CONFIRM PART D COVERAGE
granisetron hcl 1 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
ondansetron 4 mg tab disp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron 8 mg tab disp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl 4 mg/5ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl 24 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (30 PER 30 DAYS)
ondansetron hcl 4 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron hcl 8 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl inj 4 mg/2ml	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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 50 mg recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
caspofungin acetate	1-Covered	
ciclodan	1-Covered	
ciclopirox (0.77 % gel, 1 % shampoo, 8 % solution)	1-Covered	
ciclopirox olamine (0.77 % suspension, 0.77 % cream)	1-Covered	
clotrimazole (1 % cream, 1 % solution, 10 mg troche)	1-Covered	
econazole nitrate 1 % cream	1-Covered	
fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	
fluconazole in sodium chloride (200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%)	1-Covered	
flucytosine (250 mg cap, 500 mg cap)	1-Covered	
griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)	1-Covered	
griseofulvin ultramicrosize	1-Covered	
GYNAZOLE-1	1-Covered	
itraconazole (10 mg/ml solution, 100 mg cap)	1-Covered	
ketoconazole (2 % cream, 2 % shampoo, 200 mg tab)	1-Covered	
naftifine hcl (1 %, 2 %)	1-Covered	
NATACYN	1-Covered	
NOXAFIL (40 MG/ML SUSPENSION, 100 MG TAB DR)	1-Covered	NDS (Non-Extended Day Supply)
nyamyc	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nystatin (100000 unit/gm ointment, 100000 unit/ml suspension, 100000 unit/gm cream, 100000 unit/gm powder, 500000 unit tab)	1-Covered	
nystatin-triamcinolone (100000-0.1 unit/gm-% ointment, 100000-0.1 unit/gm-% cream)	1-Covered	
nystop	1-Covered	
oxiconazole nitrate	1-Covered	
posaconazole	1-Covered	NDS (Non-Extended Day Supply)
terbinafine hcl 250 mg tab	1-Covered	QL (30 PER 30 DAYS)
terconazole (0.4 % cream, 0.8 % cream, 80 mg suppos)	1-Covered	
voriconazole (40 mg/ml recon susp, 50 mg tab, 200 mg tab, 200 mg recon soln)	1-Covered	
ANTIGOUT AGENTS		
allopurinol (100 mg tab, 300 mg tab)	1-Covered	
colchicine (0.6 mg tab, 0.6 mg cap)	1-Covered	
colchicine-probenecid	1-Covered	
febuxostat	1-Covered	ST
probenecid	1-Covered	
ULORIC	1-Covered	ST
ANTIMIGRAINE AGENTS		
ANTIMIGRAINE AGENTS, OTHER		
AIMOVIG	1-Covered	PA, QL (1 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN A-INJ	1-Covered	PA, QL (1.5 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN PRSYR	1-Covered	PA, QL (1.5 PER 28 DAYS)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	1-Covered	PA
EMGALITY (300 MG DOSE)	1-Covered	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ERGOT ALKALOIDS		
dihydroergotamine mesylate 4 mg/ml solution	1-Covered	
ergotamine-caffeine	1-Covered	
SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS		
almotriptan malate	1-Covered	QL (9 PER 30 DAYS)
frovatriptan succinate	1-Covered	
naratriptan hcl	1-Covered	QL (9 PER 30 DAYS)
rizatriptan benzoate (5 mg tab, 5 mg tab disp, 10 mg tab disp, 10 mg tab)	1-Covered	
sumatriptan (5 mg/act, 20 mg/act)	1-Covered	
sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml soln prsyr, 6 mg/0.5ml solution)	1-Covered	
sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	QL (9 PER 30 DAYS)
sumatriptan succinate refill	1-Covered	
zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)	1-Covered	QL (9 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
GUANIDINE HCL	1-Covered	
pyridostigmine bromide (30 mg tab, 60 mg tab, 60 mg/5ml solution)	1-Covered	
pyridostigmine bromide er	1-Covered	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone (25 mg tab, 100 mg tab)	1-Covered	
rifabutin	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
ANTITUBERCULARS		
ethambutol hcl (100 mg tab, 400 mg tab)	1-Covered	
isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)	1-Covered	
PASER	1-Covered	
PRETOMANID	1-Covered	
PRIFTIN	1-Covered	
pyrazinamide 500 mg tab	1-Covered	
rifampin (150 mg cap, 300 mg cap, 600 mg recon soln)	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)
cyclophosphamide (25 mg cap, 50 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE (10 MG CAP, 40 MG CAP, 100 MG CAP)	1-Covered	
IFEX 3 GM RECON SOLN	1-Covered	
ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution, 3 gm recon soln)	1-Covered	
LEUKERAN	1-Covered	
MATULANE	1-Covered	NDS (Non-Extended Day Supply)
melphalan hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TREANDA	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
VALCHLOR	1-Covered	NDS (Non-Extended Day Supply)
YONDELIS	1-Covered	NDS (Non-Extended Day Supply)
ANTIANDROGENS		
abiraterone acetate	1-Covered	NDS (Non-Extended Day Supply)
bicalutamide	1-Covered	QL (30 PER 30 DAYS)
ERLEADA	1-Covered	NDS (Non-Extended Day Supply)
flutamide	1-Covered	
nilutamide	1-Covered	NDS (Non-Extended Day Supply)
NUBEQA	1-Covered	NDS (Non-Extended Day Supply)
XTANDI	1-Covered	NDS (Non-Extended Day Supply)
YONSA	1-Covered	NDS (Non-Extended Day Supply)
ZYTIGA 500 MG TAB	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	
FASLODEX	1-Covered	NDS (Non-Extended Day Supply)
SOLTAMOX	1-Covered	
tamoxifen citrate (10 mg tab, 20 mg tab)	1-Covered	
toremifene citrate	1-Covered	
ANTIMETABOLITES		
adrucil	1-Covered	PA - TO CONFIRM PART D COVERAGE
ALIMTA	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)
clofarabine	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
cytarabine	1-Covered	PA - TO CONFIRM PART D COVERAGE
cytarabine (pf)	1-Covered	PA - TO CONFIRM PART D COVERAGE
DROXIA	1-Covered	
fluorouracil (1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
fluorouracil (2 % solution, 5 % solution, 5 % cream)	1-Covered	
FOLOTYN 40 MG/2ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
gemcitabine hcl 1 gm recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
hydroxyurea 500 mg cap	1-Covered	
mercaptopurine 50 mg tab	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	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
adriamycin 2 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
ALUNBRIG (30 MG TAB, 90 MG TAB, 90 & 180 MG TAB THPK, 180 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
ARRANON	1-Covered	NDS (Non-Extended Day Supply)
arsenic trioxide 10 mg/10ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
AYVAKIT	1-Covered	NDS (Non-Extended Day Supply)
azacitidine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BALVERSA	1-Covered	NDS (Non-Extended Day Supply)
bleomycin sulfate 30 unit recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
BORTEZOMIB	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BRUKINSA	1-Covered	NDS (Non-Extended Day Supply)
carboplatin	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cisplatin	1-Covered	PA - TO CONFIRM PART D COVERAGE
COPIKTRA	1-Covered	NDS (Non-Extended Day Supply)
dacarbazine 200 mg recon soln	1-Covered	
dactinomycin	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
daunorubicin hcl 20 mg/4ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
decitabine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
docetaxel (20 mg/ml conc, 20 mg/2ml solution, 80 mg/4ml conc, 80 mg/8ml solution, 160 mg/16ml solution, 160 mg/8ml conc, 200 mg/10ml conc)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
doxorubicin hcl 2 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
doxorubicin hcl liposomal	1-Covered	PA - TO CONFIRM PART D COVERAGE
epirubicin hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
ERWINAZE	1-Covered	NDS (Non-Extended Day Supply)
fludarabine phosphate 50 mg recon soln	1-Covered	
HALAVEN	1-Covered	NDS (Non-Extended Day Supply)
idarubicin hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IDHIFA	1-Covered	NDS (Non-Extended Day Supply)
INQOVI	1-Covered	NDS (Non-Extended Day Supply)
INREBIC	1-Covered	NDS (Non-Extended Day Supply)
ISTODAX (OVERFILL)	1-Covered	NDS (Non-Extended Day Supply)
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab, 50 mg recon soln, 100 mg recon soln, 200 mg recon soln, 350 mg recon soln, 500 mg recon soln)	1-Covered	
levoleucovorin calcium 50 mg recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
levoleucovorin calcium pf 175 mg/17.5ml solution	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
levoleucovorin calcium pf 250 mg/25ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
LONSURF	1-Covered	NDS (Non-Extended Day Supply)
LYSODREN	1-Covered	NDS (Non-Extended Day Supply)
mitomycin (5 mg soln, 20 mg soln, 40 mg soln)	1-Covered	
mitoxantrone hcl	1-Covered	
mutamycin	1-Covered	
NINLARO	1-Covered	NDS (Non-Extended Day Supply)
paclitaxel (30 mg/5ml, 100 mg/16.7ml, 150 mg/25ml, 300 mg/50ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
paraplatin (50 mg/5ml, 150 mg/15ml, 450 mg/45ml, 600 mg/60ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
PEMAZYRE	1-Covered	NDS (Non-Extended Day Supply)
PROLEUKIN	1-Covered	NDS (Non-Extended Day Supply)
QINLOCK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
RETEVMO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ROMIDEPSIN 10 MG RECON SOLN	1-Covered	NDS (Non-Extended Day Supply)
ROZLYTREK	1-Covered	NDS (Non-Extended Day Supply)
RUBRACA	1-Covered	NDS (Non-Extended Day Supply)
RYDAPT	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)
TABRECTA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TAZVERIK	1-Covered	NDS (Non-Extended Day Supply)
TIBSOVO	1-Covered	NDS (Non-Extended Day Supply)
TRISENOX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TURALIO	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VELCADE	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
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
vinorelbine tartrate 50 mg/5ml solution	1-Covered	
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VIZIMPRO	1-Covered	NDS (Non-Extended Day Supply)
VYXEOS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
XOSPATA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (100 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (40 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (40 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (60 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (60 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (80 MG ONCE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (80 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ZANOSAR	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZOLINZA	1-Covered	NDS (Non-Extended Day Supply)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole 1 mg tab	1-Covered	QL (30 PER 30 DAYS)
exemestane	1-Covered	
letrozole 2.5 mg tab	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENZYME INHIBITORS		
etoposide (1 gm/50ml, 100 mg/5ml, 500 mg/25ml)	1-Covered	
irinotecan hcl 100 mg/5ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
PIQRAY (200 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
PIQRAY (250 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
PIQRAY (300 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
toposar	1-Covered	
topotecan hcl 4 mg recon soln	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)
ALIQOPA	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)
BELEODAQ	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BOSULIF	1-Covered	NDS (Non-Extended Day Supply)
BRAFTOVI 75 MG CAP	1-Covered	NDS (Non-Extended Day Supply)
CABOMETYX	1-Covered	NDS (Non-Extended Day Supply)
CALQUENCE	1-Covered	NDS (Non-Extended Day Supply)
CAPRELSA	1-Covered	NDS (Non-Extended Day Supply)
COMETRIQ (100 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
COMETRIQ (140 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
COMETRIQ (60 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
COTELLIC	1-Covered	NDS (Non-Extended Day Supply)
DAURISMO	1-Covered	NDS (Non-Extended Day Supply)
ERIVEDGE	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
erlotinib hcl	1-Covered	NDS (Non-Extended Day Supply)
everolimus (2.5 mg tab, 5 mg tab, 7.5 mg tab)	1-Covered	NDS (Non-Extended Day Supply)
FARYDAK	1-Covered	NDS (Non-Extended Day Supply)
GILOTRIF	1-Covered	NDS (Non-Extended Day Supply)
HERCEPTIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IBRANCE (75 MG TAB, 75 MG CAP, 100 MG CAP, 100 MG TAB, 125 MG TAB, 125 MG CAP)	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 (70 MG CAP, 140 MG TAB, 140 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
INLYTA	1-Covered	NDS (Non-Extended Day Supply)
IRESSA	1-Covered	NDS (Non-Extended Day Supply)
JAKAFI	1-Covered	NDS (Non-Extended Day Supply)
JEVTANA	1-Covered	NDS (Non-Extended Day Supply)
KISQALI (200 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KISQALI (400 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KISQALI (600 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KISQALI FEMARA (400 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KISQALI FEMARA (600 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KISQALI FEMARA(200 MG DOSE)	1-Covered	NDS (Non-Extended Day Supply)
KOSELUGO	1-Covered	NDS (Non-Extended Day Supply)
KYPROLIS (30 MG SOLN, 60 MG SOLN)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LENVIMA (10 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (12 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (14 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (18 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (20 MG DAILY DOSE)	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
LENVIMA (24 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (4 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LENVIMA (8 MG DAILY DOSE)	1-Covered	NDS (Non-Extended Day Supply)
LORBRENA	1-Covered	NDS (Non-Extended Day Supply)
LYNPARZA	1-Covered	NDS (Non-Extended Day Supply)
MEKINIST	1-Covered	NDS (Non-Extended Day Supply)
MEKTOVI	1-Covered	NDS (Non-Extended Day Supply)
NERLYNX	1-Covered	NDS (Non-Extended Day Supply)
NEXAVAR	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
ODOMZO	1-Covered	NDS (Non-Extended Day Supply)
oxaliplatin (100 mg/20ml solution, 100 mg recon soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
SPRYCEL	1-Covered	NDS (Non-Extended Day Supply)
STIVARGA	1-Covered	NDS (Non-Extended Day Supply)
SUTENT (25 MG CAP, 50 MG CAP)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SUTENT 12.5 MG CAP	1-Covered	QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
SUTENT 37.5 MG CAP	1-Covered	NDS (Non-Extended Day Supply)
TAFINLAR	1-Covered	NDS (Non-Extended Day Supply)
TAGRISSO	1-Covered	NDS (Non-Extended Day Supply)
TALZENNA	1-Covered	NDS (Non-Extended Day Supply)
TASIGNA	1-Covered	NDS (Non-Extended Day Supply)
TUKYSA	1-Covered	NDS (Non-Extended Day Supply)
TYKERB	1-Covered	NDS (Non-Extended Day Supply)
VENCLEXTA (10 MG TAB, 50 MG TAB)	1-Covered	
VENCLEXTA 100 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
VENCLEXTA STARTING PACK	1-Covered	
VERZENIO	1-Covered	NDS (Non-Extended Day Supply)
VOTRIENT	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XALKORI	1-Covered	NDS (Non-Extended Day Supply)
ZALTRAP 100 MG/4ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
ZEJULA	1-Covered	NDS (Non-Extended Day Supply)
ZELBORAF	1-Covered	NDS (Non-Extended Day Supply)
ZYDELIG	1-Covered	NDS (Non-Extended Day Supply)
ZYKADIA (150 MG TAB, 150 MG CAP)	1-Covered	NDS (Non-Extended Day Supply)
MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE		
AVASTIN	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)
DARZALEX	1-Covered	NDS (Non-Extended Day Supply)
EMPLICITI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ERBITUX 100 MG/50ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
IMFINZI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KADCYLA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KEYTRUDA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LARTRUVO	1-Covered	NDS (Non-Extended Day Supply)
MYLOTARG	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
OPDIVO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
PERJETA	1-Covered	NDS (Non-Extended Day Supply)
RITUXAN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
RITUXAN HYCELA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TECENTRIQ 1200 MG/20ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VECTIBIX 100 MG/5ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
YERVOY 50 MG/10ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
RETINOIDS		
bexarotene	1-Covered	NDS (Non-Extended Day Supply)
PANRETIN	1-Covered	NDS (Non-Extended Day Supply)
TARGRETIN 1 % GEL	1-Covered	
tretinoin 10 mg cap	1-Covered	NDS (Non-Extended Day Supply)
TREATMENT ADJUNCTS		
dexrazoxane hcl 250 mg recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
mesna	1-Covered	
MESNEX 400 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
ANTIPARASITICS		
ANTIHELMINTHICS		
albendazole 200 mg tab	1-Covered	
ivermectin 3 mg tab	1-Covered	
praziquantel 600 mg tab	1-Covered	
ANTIPROTOZOALS		
ALINIA (100 MG/5ML RECON SUSP, 500 MG TAB)	1-Covered	
atovaquone 750 mg/5ml suspension	1-Covered	
atovaquone-proguanil hcl	1-Covered	
BENZNIDAZOLE	1-Covered	
chloroquine phosphate (250 mg tab, 500 mg tab)	1-Covered	
COARTEM	1-Covered	
DARAPRIM	1-Covered	NDS (Non-Extended Day Supply)
hydroxychloroquine sulfate 200 mg tab	1-Covered	
mefloquine hcl	1-Covered	
NEBUPENT	1-Covered	PA - TO CONFIRM PART D COVERAGE
PENTAM	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pentamidine isethionate 300 mg inject soln	1-Covered	
pentamidine isethionate for nebulization soln 300 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
primaquine phosphate	1-Covered	
pyrimethamine 25 mg tab	1-Covered	NDS (Non-Extended Day Supply)
quinine sulfate 324 mg cap	1-Covered	
PEDICULICIDES/SCABICIDES		
lindane	1-Covered	
malathion	1-Covered	
permethrin 5 % cream	1-Covered	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	
trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)	1-Covered	
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl (50 mg/5ml syrup, 100 mg tab, 100 mg cap)	1-Covered	
carbidopa-levodopa-entacapone	1-Covered	
entacapone	1-Covered	
tolcapone	1-Covered	NDS (Non-Extended Day Supply)
DOPAMINE AGONISTS		
APOKYN	1-Covered	NDS (Non-Extended Day Supply)
bromocriptine mesylate (2.5 mg tab, 5 mg cap)	1-Covered	
NEUPRO	1-Covered	
pramipexole dihydrochloride	1-Covered	
pramipexole dihydrochloride er	1-Covered	
ropinirole hcl	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ropinirole hcl er	1-Covered	
DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa 25 mg tab	1-Covered	
carbidopa-levodopa (10-100 mg tab disp, 10-100 mg tab, 25-100 mg tab disp, 25-250 mg tab, 25-250 mg tab disp, 25-100 mg tab)	1-Covered	
carbidopa-levodopa er	1-Covered	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate	1-Covered	
selegiline hcl (5 mg cap, 5 mg tab)	1-Covered	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (10 mg tab, 25 mg tab, 25 mg/ml solution, 50 mg tab, 50 mg/2ml solution, 100 mg tab, 200 mg tab)	1-Covered	
fluphenazine decanoate 25 mg/ml solution	1-Covered	
fluphenazine hcl (1 mg tab, 2.5 mg tab, 2.5 mg/5ml elixir, 2.5 mg/ml solution, 5 mg/ml conc, 5 mg tab, 10 mg tab)	1-Covered	
haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
haloperidol decanoate (50 mg/ml, 100 mg/ml)	1-Covered	
haloperidol lactate (2 mg/ml conc, 5 mg/ml solution)	1-Covered	
loxapine succinate	1-Covered	
molindone hcl	1-Covered	
pimozide	1-Covered	
thioridazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	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
thiothixene	1-Covered	
trifluoperazine hcl	1-Covered	
2ND GENERATION/ATYPICAL		
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG SRER, 400 MG PRSYR)	1-Covered	NDS (Non-Extended Day Supply)
ABILIFY MYCITE (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 30 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ABILIFY MYCITE 2 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab, 15 mg tab disp, 20 mg tab, 30 mg tab)	1-Covered	
ARISTADA	1-Covered	NDS (Non-Extended Day Supply)
ARISTADA INITIO	1-Covered	QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply)
CAPLYTA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB)	1-Covered	
FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
FANAPT TITRATION PACK	1-Covered	
GEODON 20 MG RECON SOLN	1-Covered	
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	1-Covered	QL (0.75 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	1-Covered	QL (1.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	1-Covered	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	1-Covered	QL (0.5 PER 28 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
INVEGA TRINZA 273 MG/0.875ML SUSP PRSYR	1-Covered	QL (0.88 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 410 MG/1.315ML SUSP PRSYR	1-Covered	QL (1.32 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	1-Covered	QL (1.75 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 819 MG/2.625ML SUSP PRSYR	1-Covered	QL (2.62 PER 84 DAYS), NDS (Non-Extended Day Supply)
LATUDA	1-Covered	NDS (Non-Extended Day Supply)
NUPLAZID (10 MG TAB, 34 MG CAP)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
olanzapine (2.5 mg tab, 5 mg tab disp, 5 mg tab, 7.5 mg tab, 10 mg tab disp, 10 mg tab, 10 mg recon soln, 15 mg tab, 15 mg tab disp, 20 mg tab, 20 mg tab disp)	1-Covered	
paliperidone er 1.5 mg tab er 24h	1-Covered	QL (240 PER 30 DAYS)
paliperidone er 3 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
paliperidone er 6 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
paliperidone er 9 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
PERSERIS	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
quetiapine fumarate (300 mg tab, 400 mg tab)	1-Covered	QL (60 PER 30 DAYS)
quetiapine fumarate (50 mg tab, 100 mg tab, 200 mg tab)	1-Covered	QL (90 PER 30 DAYS)
quetiapine fumarate 25 mg tab	1-Covered	QL (120 PER 30 DAYS)
quetiapine fumarate er	1-Covered	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
RISPERDAL CONSTA (12.5 MG, 25 MG)	1-Covered	
RISPERDAL CONSTA (37.5 MG, 50 MG)	1-Covered	NDS (Non-Extended Day Supply)
risperidone 1 mg/ml solution	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
risperidone (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 1 mg tab, 2 mg tab, 2 mg tab disp, 3 mg tab, 4 mg tab disp, 4 mg tab)	1-Covered	QL (60 PER 30 DAYS)
risperidone 0.5 mg tab disp	1-Covered	QL (120 PER 30 DAYS)
risperidone 1 mg tab disp	1-Covered	QL (30 PER 30 DAYS)
risperidone 3 mg tab disp	1-Covered	QL (90 PER 30 DAYS)
risperidone m-tab (2 mg tab disp, 4 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
risperidone m-tab 0.5 mg tab disp	1-Covered	QL (120 PER 30 DAYS)
risperidone m-tab 1 mg tab disp	1-Covered	QL (30 PER 30 DAYS)
risperidone m-tab 3 mg tab disp	1-Covered	QL (90 PER 30 DAYS)
SAPHRIS	1-Covered	
SECUADO	1-Covered	QL (30 PER 30 DAYS)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	1-Covered	NDS (Non-Extended Day Supply)
VRAYLAR 1.5 & 3 MG CAP THPK	1-Covered	
ziprasidone hcl	1-Covered	QL (60 PER 30 DAYS)
ziprasidone mesylate	1-Covered	
ZYPREXA RELPREVV	1-Covered	
TREATMENT-RESISTANT		
clozapine 100 mg tab	1-Covered	QL (270 PER 30 DAYS)
clozapine 200 mg tab	1-Covered	QL (120 PER 30 DAYS)
clozapine 25 mg tab	1-Covered	QL (90 PER 30 DAYS)
clozapine 50 mg tab	1-Covered	QL (60 PER 30 DAYS)
clozapine (12.5 mg tab disp, 25 mg tab disp, 100 mg tab disp, 150 mg tab disp, 200 mg tab disp)	1-Covered	
VERSACLOZ	1-Covered	
ANTISPASTICITY AGENTS		
baclofen (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BOTOX	1-Covered	PA
dantrolene sodium (25 mg cap, 50 mg cap, 100 mg cap)	1-Covered	
tizanidine hcl (2 mg tab, 4 mg tab)	1-Covered	
XEOMIN	1-Covered	PA
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
valganciclovir hcl (50 mg/ml recon soln, 450 mg tab)	1-Covered	
ZIRGAN	1-Covered	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	1-Covered	
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	QL (600 PER 30 DAYS)
entecavir	1-Covered	
EPIVIR HBV 5 MG/ML SOLUTION	1-Covered	
lamivudine 100 mg tab	1-Covered	
ANTI-HEPATITIS C (HCV) AGENTS, DIRECT ACTING AGENTS		
LEDIPASVIR-SOFOSBUVIR	1-Covered	PA, NDS (Non-Extended Day Supply)
SOFOSBUVIR-VELPATASVIR	1-Covered	PA, NDS (Non-Extended Day Supply)
ZEPATIER	1-Covered	PA, NDS (Non-Extended Day Supply)
ANTI-HEPATITIS C (HCV) AGENTS, OTHER		
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	1-Covered	NDS (Non-Extended Day Supply)
PEGASYS	1-Covered	NDS (Non-Extended Day Supply)
PEGASYS PROCLICK	1-Covered	NDS (Non-Extended Day Supply)
REBETOL 40 MG/ML SOLUTION	1-Covered	
ribavirin (200 mg cap, 200 mg tab)	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
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
GENVOYA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB, 100 MG PACKET)	1-Covered	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS HD	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
STRIBILD	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY (25 MG TAB, 50 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY 10 MG TAB	1-Covered	QL (60 PER 30 DAYS)
TIVICAY PD	1-Covered	QL (180 PER 30 DAYS)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
ATRIPLA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
COMPLERA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DELSTRIGO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EDURANT	1-Covered	QL (30 PER 30 DAYS)
efavirenz 200 mg cap	1-Covered	QL (90 PER 30 DAYS)
efavirenz 50 mg cap	1-Covered	QL (240 PER 30 DAYS)
efavirenz 600 mg tab	1-Covered	QL (30 PER 30 DAYS)
efavirenz-emtricitab-tenofovir	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
efavirenz-lamivudine-tenofovir	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
INTELENCE (100 MG TAB, 200 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
INTELENCE 25 MG TAB	1-Covered	QL (120 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nevirapine 50 mg/5ml suspension	1-Covered	
nevirapine 200 mg tab	1-Covered	QL (60 PER 30 DAYS)
nevirapine er 100 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
nevirapine er 400 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
ODEFSEY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PIFELTRO	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
RESCRIPTOR 200 MG TAB	1-Covered	QL (180 PER 30 DAYS)
SYMFI	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYMFI LO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate 20 mg/ml solution	1-Covered	
abacavir sulfate 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
abacavir sulfate-lamivudine	1-Covered	QL (30 PER 30 DAYS)
abacavir-lamivudine-zidovudine	1-Covered	QL (60 PER 30 DAYS)
CIMDUO	1-Covered	QL (30 PER 30 DAYS)
didanosine (250 mg cap dr, 400 mg cap dr)	1-Covered	QL (30 PER 30 DAYS)
didanosine 200 mg cap dr	1-Covered	QL (60 PER 30 DAYS)
emtricitabine	1-Covered	QL (30 PER 30 DAYS)
emtricitabine-tenofovir df	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EMTRIVA 200 MG CAP	1-Covered	QL (30 PER 30 DAYS)
EMTRIVA 10 MG/ML SOLUTION	1-Covered	
lamivudine 10 mg/ml solution	1-Covered	
lamivudine 150 mg tab	1-Covered	QL (60 PER 30 DAYS)
lamivudine 300 mg tab	1-Covered	QL (30 PER 30 DAYS)
lamivudine-zidovudine	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
stavudine (15 mg cap, 20 mg cap)	1-Covered	QL (120 PER 30 DAYS)
stavudine (30 mg cap, 40 mg cap)	1-Covered	QL (60 PER 30 DAYS)
TEMIXYS	1-Covered	QL (30 PER 30 DAYS)
tenofovir disoproxil fumarate	1-Covered	QL (30 PER 30 DAYS)
TRUVADA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIDEX	1-Covered	
VIDEX EC 125 MG CAP DR	1-Covered	QL (60 PER 30 DAYS)
VIREAD 40 MG/GM POWDER	1-Covered	
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
zidovudine 100 mg cap	1-Covered	QL (180 PER 30 DAYS)
zidovudine 50 mg/5ml syrup	1-Covered	
zidovudine 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
ANTI-HIV AGENTS, OTHER		
DESCOVY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DOVATO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
FUZEON	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
JULUCA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
RUKOBIA	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SELZENTRY (150 MG TAB, 300 MG TAB)	1-Covered	QL (120 PER 30 DAYS)
SELZENTRY (20 MG/ML SOLUTION, 25 MG TAB, 75 MG TAB)	1-Covered	
TRIUMEQ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TROGARZO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TYBOST	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-HIV AGENTS, PROTEASE INHIBITORS		
APTIVUS 250 MG CAP	1-Covered	QL (120 PER 30 DAYS)
APTIVUS 100 MG/ML SOLUTION	1-Covered	QL (300 PER 30 DAYS)
atazanavir sulfate (150 mg cap, 200 mg cap)	1-Covered	QL (60 PER 30 DAYS)
atazanavir sulfate 300 mg cap	1-Covered	QL (30 PER 30 DAYS)
CRIXIVAN	1-Covered	
EVOTAZ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
fosamprenavir calcium	1-Covered	
INVIRASE 500 MG TAB	1-Covered	
KALETRA (100-25 MG TAB, 200-50 MG TAB)	1-Covered	
LEXIVA 50 MG/ML SUSPENSION	1-Covered	
lopinavir-ritonavir	1-Covered	
NORVIR 100 MG PACKET	1-Covered	QL (360 PER 30 DAYS)
NORVIR 80 MG/ML SOLUTION	1-Covered	
PREZCOBIX	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREZISTA 100 MG/ML SUSPENSION	1-Covered	NDS (Non-Extended Day Supply)
PREZISTA 150 MG TAB	1-Covered	
PREZISTA 600 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
PREZISTA 75 MG TAB	1-Covered	QL (240 PER 30 DAYS)
PREZISTA 800 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
REYATAZ 50 MG PACKET	1-Covered	
ritonavir	1-Covered	QL (360 PER 30 DAYS)
SYMTUZA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIRACEPT 250 MG TAB	1-Covered	QL (270 PER 30 DAYS)
VIRACEPT 625 MG TAB	1-Covered	QL (120 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate (6 mg/ml recon susp, 30 mg cap, 45 mg cap, 75 mg cap)	1-Covered	
RELENZA DISKHALER	1-Covered	
rimantadine hcl	1-Covered	
ANTIHERPETIC AGENTS		
acyclovir (5 % ointment, 200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab)	1-Covered	
acyclovir sodium 50 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
famciclovir (125 mg tab, 250 mg tab, 500 mg tab)	1-Covered	QL (90 PER 30 DAYS)
trifluridine 1 % solution	1-Covered	
valacyclovir hcl (1 gm tab, 500 mg tab)	1-Covered	QL (120 PER 30 DAYS)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl (5 mg tab, 7.5 mg tab, 10 mg tab, 15 mg tab, 30 mg tab)	1-Covered	
meprobamate	1-Covered	
BENZODIAZEPINES		
alprazolam (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp)	1-Covered	QL (120 PER 30 DAYS)
alprazolam (1 mg tab disp, 1 mg tab, 2 mg tab disp, 2 mg tab)	1-Covered	QL (150 PER 30 DAYS)
alprazolam er (er 0.5 mg tab er, er 1 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
alprazolam er (er 2 mg tab er, er 3 mg tab er)	1-Covered	QL (60 PER 30 DAYS)
ALPRAZOLAM INTENSOL	1-Covered	QL (300 PER 30 DAYS)
alprazolam xr (0.5 mg tab er, 1 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
alprazolam xr (2 mg tab er, 3 mg tab er)	1-Covered	QL (60 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
chlordiazepoxide hcl 10 mg cap	1-Covered	QL (300 PER 30 DAYS)
chlordiazepoxide hcl 25 mg cap	1-Covered	QL (360 PER 30 DAYS)
chlordiazepoxide hcl 5 mg cap	1-Covered	QL (240 PER 30 DAYS)
clonazepam (0.125 mg tab disp, 0.25 mg tab disp, 0.5 mg tab disp, 0.5 mg tab, 1 mg tab disp, 1 mg tab, 2 mg tab, 2 mg tab disp)	1-Covered	
clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)	1-Covered	QL (90 PER 30 DAYS)
clorazepate dipotassium 15 mg tab	1-Covered	QL (180 PER 30 DAYS)
diazepam 5 mg/ml conc	1-Covered	QL (240 PER 30 DAYS)
diazepam 5 mg/5ml solution	1-Covered	QL (1200 PER 30 DAYS)
diazepam (2 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (120 PER 30 DAYS)
diazepam intensol	1-Covered	QL (240 PER 30 DAYS)
lorazepam (2 mg tab, 2 mg/ml conc)	1-Covered	QL (150 PER 30 DAYS)
lorazepam 0.5 mg tab	1-Covered	QL (600 PER 30 DAYS)
lorazepam 1 mg tab	1-Covered	QL (300 PER 30 DAYS)
lorazepam intensol	1-Covered	QL (150 PER 30 DAYS)
oxazepam	1-Covered	
BIPOLAR AGENTS		
MOOD STABILIZERS		
EQUETRO	1-Covered	
LITHIUM	1-Covered	
lithium carbonate (150 mg cap, 300 mg tab, 300 mg cap, 600 mg cap)	1-Covered	
lithium carbonate er	1-Covered	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	QL (90 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
alogliptin benzoate	1-Covered	QL (30 PER 30 DAYS)
alogliptin-metformin hcl	1-Covered	QL (60 PER 30 DAYS)
alogliptin-pioglitazone	1-Covered	QL (30 PER 30 DAYS)
BYDUREON 2 MG PEN	1-Covered	QL (4 PER 28 DAYS)
BYDUREON BCISE	1-Covered	QL (3.4 PER 28 DAYS)
BYETTA 10 MCG PEN	1-Covered	QL (2.4 PER 30 DAYS)
BYETTA 5 MCG PEN	1-Covered	QL (1.2 PER 30 DAYS)
CYCLOSET	1-Covered	
glimepiride	1-Covered	
glipizide (5 mg tab, 10 mg tab)	1-Covered	QL (120 PER 30 DAYS)
glipizide er 10 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tab er 24h	1-Covered	
glipizide er 5 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
glipizide xl 10 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
glipizide xl 2.5 mg tab er 24h	1-Covered	
glipizide xl 5 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
glipizide-metformin hcl	1-Covered	QL (120 PER 30 DAYS)
glyburide (1.25 mg tab, 2.5 mg tab, 5 mg tab)	1-Covered	QL (120 PER 30 DAYS)
glyburide micronized	1-Covered	QL (60 PER 30 DAYS)
glyburide-metformin	1-Covered	QL (120 PER 30 DAYS)
GLYXAMBI	1-Covered	QL (30 PER 30 DAYS)
INVOKAMET (50-1000 MG TAB, 150-1000 MG TAB, 150-500 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
INVOKAMET 50-500 MG TAB	1-Covered	QL (120 PER 30 DAYS)
INVOKAMET XR (50-1000 MG TAB ER, 150-1000 MG TAB ER, 150-500 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
INVOKAMET XR 50-500 MG TAB ER 24H	1-Covered	QL (120 PER 30 DAYS)
INVOKANA	1-Covered	QL (30 PER 30 DAYS)
JANUMET	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
JANUMET XR (50-1000 MG TAB ER, 50-500 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
JANUVIA	1-Covered	QL (30 PER 30 DAYS)
JARDIANCE	1-Covered	QL (30 PER 30 DAYS)
JENTADUETO	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
metformin hcl 1000 mg tab	1-Covered	QL (75 PER 30 DAYS)
metformin hcl 500 mg tab	1-Covered	QL (150 PER 30 DAYS)
metformin hcl 850 mg tab	1-Covered	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
miglitol	1-Covered	
nateglinide 120 mg tab	1-Covered	QL (90 PER 30 DAYS)
nateglinide 60 mg tab	1-Covered	QL (180 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE)	1-Covered	QL (1.5 PER 28 DAYS)
OZEMPIC (1 MG/DOSE)	1-Covered	QL (3 PER 28 DAYS)
pioglitazone hcl	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-glimepiride	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-metformin hcl	1-Covered	QL (90 PER 30 DAYS)
repaglinide (0.5 mg tab, 1 mg tab)	1-Covered	QL (120 PER 30 DAYS)
repaglinide 2 mg tab	1-Covered	QL (240 PER 30 DAYS)
repaglinide-metformin hcl	1-Covered	QL (150 PER 30 DAYS)
SYMLINPEN 120	1-Covered	QL (10.8 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYMLINPEN 60	1-Covered	QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYNJARDY (5-1000 MG TAB, 12.5-500 MG TAB, 12.5-1000 MG TAB)	1-Covered	QL (60 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
SYNJARDY 5-500 MG TAB	1-Covered	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER, 10-1000 MG TAB ER, 12.5-1000 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
tolbutamide	1-Covered	QL (180 PER 30 DAYS)
TRADJENTA	1-Covered	QL (30 PER 30 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN, 1.5 MG/0.5ML SOLN)	1-Covered	QL (2 PER 28 DAYS)
VICTOZA	1-Covered	QL (9 PER 30 DAYS)
GLYCEMIC AGENTS		
GLUCAGEN HYPOKIT	1-Covered	
GLUCAGON EMERGENCY (1 MG KIT, 1 MG/ML RECON SOLN)	1-Covered	
PROGLYCEM	1-Covered	
INSULINS		
AFREZZA (4 & 8 & 12, 4, 8, 12, 90 X 4 & 90X8, 90 X 8 & 90X12)	1-Covered	
HUMALOG 100 UNIT/ML SOLN CART	1-Covered	QL (45 PER 30 DAYS)
HUMALOG 100 UNIT/ML SOLUTION	1-Covered	QL (40 PER 30 DAYS)
HUMALOG JUNIOR KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMALOG KWIKPEN 100 UNIT/ML SOLN PEN	1-Covered	QL (45 PER 30 DAYS)
HUMALOG KWIKPEN 200 UNIT/ML SOLN PEN	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)

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
HUMULIN N KWIKPEN	1-Covered	QL (45 PER 30 DAYS)
HUMULIN R	1-Covered	QL (40 PER 30 DAYS)
HUMULIN R U-500 (CONCENTRATED)	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)
LEVEMIR FLEXTOUCH	1-Covered	QL (45 PER 30 DAYS)
LYUMJEV	1-Covered	QL (40 PER 30 DAYS)
LYUMJEV KWIKPEN 100 UNIT/ML SOLN PEN	1-Covered	QL (45 PER 30 DAYS)
LYUMJEV KWIKPEN 200 UNIT/ML SOLN PEN	1-Covered	
NOVOLIN 70/30 (70-30) 100 UNIT/ML SUSPENSION (BRAND RELION NOT COVERED)	1-Covered	QL (40 PER 30 DAYS)
NOVOLIN 70/30 FLEXPEN (70-30) 100 UNIT/ML SUSP PEN (BRAND RELION NOT COVERED)	1-Covered	QL (45 PER 30 DAYS)
NOVOLIN N 100 UNIT/ML SUSPENSION (BRAND RELION NOT COVERED)	1-Covered	QL (40 PER 30 DAYS)
NOVOLIN N FLEXPEN 100 UNIT/ML SUSP PEN (BRAND RELION NOT COVERED)	1-Covered	QL (45 PER 30 DAYS)
NOVOLIN R 100 UNIT/ML SOLUTION (BRAND RELION NOT COVERED)	1-Covered	QL (40 PER 30 DAYS)
NOVOLIN R FLEXPEN 100 UNIT/ML SOLN PEN (BRAND RELION NOT COVERED)	1-Covered	QL (45 PER 30 DAYS)
NOVOLOG	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)
NOVOLOG PENFILL	1-Covered	QL (45 PER 30 DAYS)
TOUJEO MAX SOLOSTAR	1-Covered	QL (18 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
TOUJEO SOLOSTAR	1-Covered	QL (13.5 PER 30 DAYS)
TRESIBA	1-Covered	QL (40 PER 30 DAYS)
TRESIBA FLEXTOUCH 100 UNIT/ML SOLN PEN	1-Covered	QL (45 PER 30 DAYS)
TRESIBA FLEXTOUCH 200 UNIT/ML SOLN PEN	1-Covered	QL (27 PER 30 DAYS)
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS		
ANTICOAGULANTS		
ELIQUIS 2.5 MG TAB	1-Covered	QL (60 PER 30 DAYS)
ELIQUIS 5 MG TAB	1-Covered	
ELIQUIS DVT/PE STARTER PACK	1-Covered	
enoxaparin sodium (30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml, 100 mg/ml, 120 mg/0.8ml, 150 mg/ml)	1-Covered	
fondaparinux sodium	1-Covered	
heparin sodium (porcine) ((porcine) 1000 unit/ml, (porcine) 5000 unit/ml, (porcine) 10000 unit/ml, (porcine) 20000 unit/ml)	1-Covered	
jantoven	1-Covered	
PRADAXA	1-Covered	
warfarin sodium (1 mg tab, 2 mg tab, 2.5 mg tab, 3 mg tab, 4 mg tab, 5 mg tab, 6 mg tab, 7.5 mg tab, 10 mg tab)	1-Covered	
XARELTO	1-Covered	
XARELTO STARTER PACK	1-Covered	
ZONTIVITY	1-Covered	
BLOOD FORMATION MODIFIERS		
anagrelide hcl	1-Covered	
FULPHILA	1-Covered	PA, NDS (Non-Extended Day Supply)
GRANIX (300 MCG/ML SOLUTION, 300 MCG/0.5ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR)	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
LEUKINE	1-Covered	NDS (Non-Extended Day Supply)
NEULASTA	1-Covered	PA, NDS (Non-Extended Day Supply)
NEULASTA ONPRO	1-Covered	PA, NDS (Non-Extended Day Supply)
NEUPOGEN (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION)	1-Covered	PA, NDS (Non-Extended Day Supply)
NIVESTYM (300 MCG/0.5ML SOLN PRSYR, 300 MCG/ML SOLUTION, 480 MCG/0.8ML SOLN PRSYR, 480 MCG/1.6ML SOLUTION)	1-Covered	PA, NDS (Non-Extended Day Supply)
PROCRIT	1-Covered	PA - TO CONFIRM PART D COVERAGE
PROMACTA (12.5 MG PACKET, 12.5 MG TAB, 25 MG PACKET, 25 MG TAB, 50 MG TAB, 75 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
RETACRIT	1-Covered	PA - TO CONFIRM PART D COVERAGE
UDENYCA	1-Covered	PA, NDS (Non-Extended Day Supply)
ZARXIO	1-Covered	PA, NDS (Non-Extended Day Supply)
ZIEXTENZO	1-Covered	PA, NDS (Non-Extended Day Supply)
HEMOSTASIS AGENTS		
tranexamic acid 650 mg tab	1-Covered	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er	1-Covered	QL (90 PER 30 DAYS)
BRILINTA	1-Covered	
cilostazol	1-Covered	
clopidogrel bisulfate 75 mg tab	1-Covered	QL (120 PER 30 DAYS)
dipyridamole (25 mg tab, 50 mg tab, 75 mg tab)	1-Covered	PA
prasugrel hcl	1-Covered	
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	1-Covered	QL (4 PER 28 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clonidine hcl (0.1 mg tab, 0.2 mg tab, 0.3 mg tab)	1-Covered	
guanfacine hcl	1-Covered	PA
methyldopa	1-Covered	PA
midodrine hcl	1-Covered	
NORTHERA	1-Covered	NDS (Non-Extended Day Supply)
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin mesylate (1 mg tab, 2 mg tab, 4 mg tab, 8 mg tab)	1-Covered	QL (60 PER 30 DAYS)
phenoxybenzamine hcl 10 mg cap	1-Covered	NDS (Non-Extended Day Supply)
prazosin hcl (1 mg cap, 2 mg cap, 5 mg cap)	1-Covered	
terazosin hcl	1-Covered	QL (60 PER 30 DAYS)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1-Covered	
irbesartan (75 mg tab, 300 mg tab)	1-Covered	QL (30 PER 30 DAYS)
irbesartan 150 mg tab	1-Covered	QL (60 PER 30 DAYS)
losartan potassium (25 mg tab, 50 mg tab)	1-Covered	QL (90 PER 30 DAYS)
losartan potassium 100 mg tab	1-Covered	QL (30 PER 30 DAYS)
olmesartan medoxomil (5 mg tab, 20 mg tab, 40 mg tab)	1-Covered	
telmisartan	1-Covered	
valsartan	1-Covered	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
captopril (12.5 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
fosinopril sodium	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lisinopril (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (90 PER 30 DAYS)
lisinopril (20 mg tab, 30 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
moexipril hcl	1-Covered	
perindopril erbumine	1-Covered	
quinapril hcl	1-Covered	QL (60 PER 30 DAYS)
ramipril	1-Covered	QL (60 PER 30 DAYS)
trandolapril	1-Covered	
ANTIARRHYTHMICS		
amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)	1-Covered	
disopyramide phosphate	1-Covered	PA
dofetilide	1-Covered	
flecainide acetate	1-Covered	
mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)	1-Covered	
MULTAQ	1-Covered	
pacerone	1-Covered	
propafenone hcl	1-Covered	
propafenone hcl er	1-Covered	
quinidine gluconate er	1-Covered	
quinidine sulfate (200 mg tab, 300 mg tab)	1-Covered	
sorine	1-Covered	
sotalol hcl	1-Covered	
sotalol hcl (af)	1-Covered	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl (200 mg cap, 400 mg cap)	1-Covered	
atenolol (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
betaxolol hcl (10 mg tab, 20 mg tab)	1-Covered	
bisoprolol fumarate	1-Covered	
carvedilol	1-Covered	
carvedilol phosphate er	1-Covered	QL (30 PER 30 DAYS)
labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)	1-Covered	
metoprolol succinate er (er 25 mg tab er, er 50 mg tab er, er 100 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
metoprolol succinate er 200 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)	1-Covered	
nadolol (20 mg tab, 40 mg tab, 80 mg tab)	1-Covered	
pindolol	1-Covered	
propranolol hcl (10 mg tab, 20 mg/5ml solution, 20 mg tab, 40 mg/5ml solution, 40 mg tab, 60 mg tab, 80 mg tab)	1-Covered	
propranolol hcl er	1-Covered	
timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
amlodipine besylate 2.5 mg tab	1-Covered	QL (90 PER 30 DAYS)
amlodipine besylate 5 mg tab	1-Covered	QL (60 PER 30 DAYS)
cartia xt	1-Covered	
dilt-xr	1-Covered	
diltiazem cd	1-Covered	
diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)	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
diltiazem hcl er (er 60 mg cap er 12h, er 90 mg cap er 12h, er 120 mg cap er 24h, er 120 mg cap er 12h, er 180 mg cap er 24h, er 240 mg cap er 24h)	1-Covered	
diltiazem hcl er beads	1-Covered	
diltiazem hcl er coated beads (er 120 mg cap er, er 180 mg cap er, er 180 mg tab er, er 240 mg cap er, er 240 mg tab er, er 300 mg cap er, er 300 mg tab er, er 360 mg tab er, er 360 mg cap er, er 420 mg tab er)	1-Covered	
felodipine er	1-Covered	QL (30 PER 30 DAYS)
isradipine	1-Covered	
matzim la	1-Covered	
nicardipine hcl (20 mg cap, 30 mg cap)	1-Covered	
nifedipine (10 mg cap, 20 mg cap)	1-Covered	PA
nifedipine er	1-Covered	QL (60 PER 30 DAYS)
nifedipine er osmotic release	1-Covered	QL (60 PER 30 DAYS)
nimodipine 30 mg cap	1-Covered	
nisoldipine er	1-Covered	QL (30 PER 30 DAYS)
taztia xt	1-Covered	
tiadylt er	1-Covered	
verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)	1-Covered	
verapamil hcl er (er 100 mg cap er 24h, er 120 mg tab er, er 180 mg tab er, er 200 mg cap er 24h, er 240 mg tab er, er 300 mg cap er 24h, er 360 mg cap er 24h)	1-Covered	
verapamil hcl er (er 120 mg cap er, er 180 mg cap er, er 240 mg cap er)	1-Covered	QL (60 PER 30 DAYS)
CARDIOVASCULAR AGENTS, OTHER		
aliskiren fumarate	1-Covered	QL (30 PER 30 DAYS)
amiloride-hydrochlorothiazide	1-Covered	
amlodipine besy-benazepril hcl	1-Covered	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amlodipine besylate-valsartan	1-Covered	
amlodipine-atorvastatin	1-Covered	
amlodipine-olmesartan	1-Covered	
amlodipine-valsartan-hctz	1-Covered	
atenolol-chlorthalidone	1-Covered	
benazepril-hydrochlorothiazide	1-Covered	
bisoprolol-hydrochlorothiazide	1-Covered	
candesartan cilexetil-hctz	1-Covered	
captopril-hydrochlorothiazide	1-Covered	
CORLANOR 5 MG/5ML SOLUTION	1-Covered	QL (450 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
DEMSER	1-Covered	NDS (Non-Extended Day Supply)
digitek	1-Covered	
digox	1-Covered	
digoxin (0.05 mg/ml solution, 125 mcg tab, 250 mcg tab)	1-Covered	
DUTOPROL	1-Covered	
enalapril-hydrochlorothiazide	1-Covered	
ENTRESTO	1-Covered	QL (60 PER 30 DAYS)
fosinopril sodium-hctz	1-Covered	
irbesartan-hydrochlorothiazide	1-Covered	QL (30 PER 30 DAYS)
LANOXIN (62.5 MCG TAB, 125 MCG TAB, 250 MCG TAB)	1-Covered	
lisinopril-hydrochlorothiazide	1-Covered	
losartan potassium-hctz (100-12.5 mg tab, 100-25 mg tab)	1-Covered	QL (30 PER 30 DAYS)
losartan potassium-hctz 50-12.5 mg tab	1-Covered	QL (60 PER 30 DAYS)
methyldopa-hydrochlorothiazide	1-Covered	PA
metoprolol-hydrochlorothiazide	1-Covered	
olmesartan medoxomil-hctz	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
olmesartan-amlodipine-hctz	1-Covered	
pentoxifylline er	1-Covered	
propranolol-hctz	1-Covered	
quinapril-hydrochlorothiazide	1-Covered	
ranolazine er	1-Covered	
spironolactone-hctz	1-Covered	
telmisartan-amlodipine	1-Covered	
telmisartan-hctz	1-Covered	
trandolapril-verapamil hcl er	1-Covered	
triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)	1-Covered	
valsartan-hydrochlorothiazide	1-Covered	QL (30 PER 30 DAYS)
VECAMYL	1-Covered	NDS (Non-Extended Day Supply)
DIURETICS, CARBONIC ANHYDRASE INHIBITORS		
acetazolamide (125 mg tab, 250 mg tab)	1-Covered	
acetazolamide er	1-Covered	
KEVEYIS	1-Covered	NDS (Non-Extended Day Supply)
DIURETICS, LOOP		
bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	
ethacrynic acid	1-Covered	
furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)	1-Covered	
torsemide	1-Covered	
DIURETICS, POTASSIUM-SPARING		
amiloride hcl 5 mg tab	1-Covered	
eplerenone	1-Covered	
spironolactone (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
triamterene (50 mg cap, 100 mg cap)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURETICS, THIAZIDE		
chlorothiazide (250 mg tab, 500 mg tab)	1-Covered	
chlorthalidone	1-Covered	
DIURIL	1-Covered	
hydrochlorothiazide (12.5 mg tab, 12.5 mg cap, 25 mg tab, 50 mg tab)	1-Covered	
indapamide	1-Covered	
methyclothiazide	1-Covered	
metolazone	1-Covered	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 120 mg tab, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)	1-Covered	QL (30 PER 30 DAYS)
fenofibrate (50 mg cap, 150 mg cap)	1-Covered	
fenofibrate 40 mg tab	1-Covered	QL (90 PER 30 DAYS)
fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)	1-Covered	QL (30 PER 30 DAYS)
fenofibric acid (35 mg tab, 45 mg cap dr, 105 mg tab, 135 mg cap dr)	1-Covered	
gemfibrozil 600 mg tab	1-Covered	QL (60 PER 30 DAYS)
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium (10 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
atorvastatin calcium 20 mg tab	1-Covered	QL (90 PER 30 DAYS)
atorvastatin calcium 80 mg tab	1-Covered	QL (30 PER 30 DAYS)
LIVALO	1-Covered	ST, QL (30 PER 30 DAYS)
lovastatin (10 mg tab, 20 mg tab)	1-Covered	QL (30 PER 30 DAYS)
lovastatin 40 mg tab	1-Covered	QL (60 PER 30 DAYS)
pravastatin sodium	1-Covered	QL (30 PER 30 DAYS)
rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rosuvastatin calcium 40 mg tab	1-Covered	QL (30 PER 30 DAYS)
simvastatin (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)	1-Covered	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
cholestyramine (4 gm packet, 4 gm/dose powder)	1-Covered	
cholestyramine light (4 gm packet, 4 gm/dose powder)	1-Covered	
colesevelam hcl (3.75 gm packet, 625 mg tab)	1-Covered	
colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)	1-Covered	
ezetimibe	1-Covered	QL (30 PER 30 DAYS)
ezetimibe-simvastatin	1-Covered	QL (30 PER 30 DAYS)
JUXTAPID	1-Covered	PA, NDS (Non-Extended Day Supply)
niacin er (antihyperlipidemic)	1-Covered	
omega-3-acid ethyl esters	1-Covered	
PRALUENT (75 MG/ML SOLN, 150 MG/ML SOLN)	1-Covered	PA, QL (2 PER 28 DAYS)
prevalite (4 gm packet, 4 gm/dose powder)	1-Covered	
REPATHA	1-Covered	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	1-Covered	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	1-Covered	PA, QL (3 PER 28 DAYS)
VASCEPA	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
minoxidil (2.5 mg tab, 10 mg tab)	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
GONITRO	1-Covered	
isosorbide dinitrate	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
isosorbide mononitrate	1-Covered	
isosorbide mononitrate er	1-Covered	
minitran	1-Covered	
NITRO-BID	1-Covered	
NITRO-DUR (0.3 MG/HR, 0.8 MG/HR)	1-Covered	
nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg/hr patch 24hr, 0.4 mg sl tab, 0.4 mg/spray solution, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)	1-Covered	
NITROSTAT	1-Covered	
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
amphetamine-dextroamphet er	1-Covered	QL (30 PER 30 DAYS)
amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)	1-Covered	QL (90 PER 30 DAYS)
amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)	1-Covered	QL (120 PER 30 DAYS)
amphetamine-dextroamphetamine 30 mg tab	1-Covered	QL (60 PER 30 DAYS)
dextroamphetamine sulfate (5 mg tab, 10 mg tab)	1-Covered	
dextroamphetamine sulfate er	1-Covered	
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)	1-Covered	QL (60 PER 30 DAYS)
atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)	1-Covered	QL (30 PER 30 DAYS)
atomoxetine hcl 18 mg cap	1-Covered	QL (120 PER 30 DAYS)
clonidine hcl er	1-Covered	
dexmethylphenidate hcl	1-Covered	QL (60 PER 30 DAYS)
guanfacine hcl er	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
metadate er	1-Covered	
methylphenidate hcl (2.5 mg chew tab, 5 mg chew tab, 5 mg/5ml solution, 10 mg/5ml solution, 10 mg chew tab)	1-Covered	
methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	QL (90 PER 30 DAYS)
methylphenidate hcl er 20 mg tab er	1-Covered	
methylphenidate hcl er (er 18 mg tab er, er 18 mg tab er 24h, er 27 mg tab er, er 27 mg tab er 24h, er 54 mg tab er, er 54 mg tab er 24h)	1-Covered	QL (30 PER 30 DAYS)
methylphenidate hcl er (er 36 mg tab er 24h, er 36 mg tab er)	1-Covered	QL (60 PER 30 DAYS)
methylphenidate hcl er (la) 60 mg cap er 24h	1-Covered	
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO	1-Covered	PA, NDS (Non-Extended Day Supply)
butalbital-acetaminophen 50-325 mg tab	1-Covered	PA
butalbital-apap	1-Covered	PA
butalbital-apap-caffeine (50-325-40 mg cap, 50-325-40 mg tab)	1-Covered	PA
esgic 50-325-40 mg cap	1-Covered	PA
HORIZANT 300 MG TAB ER	1-Covered	
INGREZZA (40 MG CAP, 80 MG CAP)	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
INGREZZA 40 & 80 MG CAP THPK	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
NUEDEXTA	1-Covered	PA, QL (60 PER 30 DAYS)
riluzole	1-Covered	
tencon	1-Covered	PA
tetrabenazine	1-Covered	PA, NDS (Non-Extended Day Supply)
zebutal	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
FIBROMYALGIA AGENTS		
DRIZALMA SPRINKLE	1-Covered	
duloxetine hcl (20 mg dr, 30 mg dr, 40 mg dr, 60 mg dr)	1-Covered	
LYRICA CR (82.5 MG TAB ER, 165 MG TAB ER)	1-Covered	PA, QL (90 PER 30 DAYS)
LYRICA CR 330 MG TAB ER 24H	1-Covered	PA, QL (60 PER 30 DAYS)
pregabalin (225 mg cap, 300 mg cap)	1-Covered	QL (60 PER 30 DAYS)
pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)	1-Covered	QL (90 PER 30 DAYS)
pregabalin 20 mg/ml solution	1-Covered	
SAVELLA	1-Covered	
SAVELLA TITRATION PACK	1-Covered	
MULTIPLE SCLEROSIS AGENTS		
AUBAGIO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
AVONEX PEN	1-Covered	NDS (Non-Extended Day Supply)
AVONEX PREFILLED	1-Covered	NDS (Non-Extended Day Supply)
BETASERON	1-Covered	NDS (Non-Extended Day Supply)
dalfampridine er	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
GILENYA 0.5 MG CAP	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
glatiramer acetate 20 mg/ml soln prsyr	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
glatiramer acetate 40 mg/ml soln prsyr	1-Covered	QL (12 PER 28 DAYS), NDS (Non-Extended Day Supply)
glatopa 20 mg/ml soln prsyr	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
glatopa 40 mg/ml soln prsyr	1-Covered	QL (12 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAVENCLAD (10 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
MAVENCLAD (4 TABS)	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
MAVENCLAD (5 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
MAVENCLAD (6 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
MAVENCLAD (7 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
MAVENCLAD (8 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
MAVENCLAD (9 TABS)	1-Covered	PA, NDS (Non-Extended Day Supply)
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	1-Covered	NDS (Non-Extended Day Supply)
PLEGRIDY STARTER PACK (63 94 MCG/0.5ML SOLN PRSYR, 63 94 MCG/0.5ML SOLN PEN)	1-Covered	NDS (Non-Extended Day Supply)
TECFIDERA (120 & 240 MG MISC, 120 MG CAP DR, 240 MG CAP DR)	1-Covered	NDS (Non-Extended Day Supply)
DENTAL AND ORAL AGENTS		
cevimeline hcl	1-Covered	
chlorhexidine gluconate 0.12 % solution	1-Covered	
oralone	1-Covered	
paroex	1-Covered	
periogard	1-Covered	
pilocarpine hcl (5 mg tab, 7.5 mg tab)	1-Covered	
triamcinolone acetonide 0.1 % paste	1-Covered	
DERMATOLOGICAL AGENTS		
acitretin	1-Covered	
adapalene (0.1 % cream, 0.1 % gel, 0.3 % gel)	1-Covered	PA
ammonium lactate (12 % lotion, 12 % cream)	1-Covered	
amnesteem	1-Covered	
avita (0.025 % cream, 0.025 % gel)	1-Covered	PA
calcipotriene (0.005 % cream, 0.005 % ointment, 0.005 % solution)	1-Covered	
calcipotriene-betameth diprop 0.005-0.064 % ointment	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
calcitrene	1-Covered	
calcitriol 3 mcg/gm ointment	1-Covered	
claravis	1-Covered	
clindamycin phos-benzoyl perox (1-5 % gel, 1.2-5 % gel)	1-Covered	
clotrimazole-betamethasone (1-0.05 % lotion, 1-0.05 % cream)	1-Covered	
COSENTYX	1-Covered	PA, NDS (Non-Extended Day Supply)
COSENTYX (300 MG DOSE)	1-Covered	PA, NDS (Non-Extended Day Supply)
COSENTYX SENSOREADY (300 MG)	1-Covered	PA, NDS (Non-Extended Day Supply)
COSENTYX SENSOREADY PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
diclofenac sodium 1 % gel	1-Covered	
doxepin hcl 5 % cream	1-Covered	
DUPIXENT (200 MG/1.14ML SOLN PRSYR, 300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
fluorouracil 0.5 % cream	1-Covered	
hydrocortisone (perianal) 1 % cream	1-Covered	
imiquimod 5 % cream	1-Covered	
isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)	1-Covered	
metronidazole (0.75 % cream, 0.75 % lotion, 1 % gel)	1-Covered	
MICORT-HC	1-Covered	
myorisan	1-Covered	
pimecrolimus	1-Covered	
podofilox 0.5 % solution	1-Covered	
procto-pak	1-Covered	
RECTIV	1-Covered	
REGRANEX	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SANTYL	1-Covered	QL (90 PER 30 DAYS)
selenium sulfide 2.5 % lotion	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
STELARA (45 MG/0.5ML SOLUTION, 45 MG/0.5ML SOLN PRSYR, 90 MG/ML SOLN PRSYR, 130 MG/26ML SOLUTION)	1-Covered	PA, NDS (Non-Extended Day Supply)
tacrolimus (0.03 %, 0.1 %)	1-Covered	
tazarotene 0.1 % cream	1-Covered	
TAZORAC (0.05 % GEL, 0.05 % CREAM, 0.1 % GEL)	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	PA
zenatane	1-Covered	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
AMINOSYN II	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMINOSYN-PF 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (2.75/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/10)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/15)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/20)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINOLIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
dextrose (5 %, 10 %)	1-Covered	
dextrose-nacl (2.5-0.45 %, 5-0.3 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.9 %, 5-0.45 %, 10-0.45 %, 10-0.2 %)	1-Covered	
ENDARI	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fluoritab (1.1 (0.5 f) mg tab, 2.2 (1 f) mg tab)	1-Covered	
FREAMINE III	1-Covered	PA - TO CONFIRM PART D COVERAGE
INTRALIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
K-TAB	1-Covered	
kcl in dextrose-nacl (10-5-0.45 meq/l-%-%, 20-5-0.225 meq/l-%-%, 20-5-0.33 meq/l-%-%, 20-5-0.9 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%)	1-Covered	
KCL-LACTATED RINGERS-D5W	1-Covered	
klor-con (8 tab er, 20 packet)	1-Covered	
klor-con 10	1-Covered	
klor-con m10	1-Covered	
klor-con m15	1-Covered	
klor-con m20	1-Covered	
klor-con sprinkle	1-Covered	
ludent	1-Covered	
magnesium sulfate 50 % solution	1-Covered	
NORMOSOL-M IN D5W	1-Covered	
NORMOSOL-R	1-Covered	
NORMOSOL-R IN D5W	1-Covered	
NORMOSOL-R PH 7.4	1-Covered	
NUTRILIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
PLASMA-LYTE 148	1-Covered	
PLASMA-LYTE A	1-Covered	
potassium chloride (2 meq/ml solution, 10 meq/100ml solution, 20 meq packet, 20 meq/100ml solution, 20 meq/15ml (10%) solution, 40 meq/100ml solution, 40 meq/15ml (20%) solution)	1-Covered	
potassium chloride crys 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
potassium chloride er (er 8 tab er, er 8 cap er, er 10 tab er, er 10 cap er, er 20 tab er)	1-Covered	
potassium chloride in dextrose	1-Covered	
potassium chloride in nacl (20-0.9 meq/l-%, 20-0.45 meq/l-%, 40-0.9 meq/l-%)	1-Covered	
potassium chloride proamp	1-Covered	
PREMASOL 10 % SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
sodium chloride (0.45 %, 0.9 %, 3 %, 5 %)	1-Covered	
sodium chloride (pf)	1-Covered	
sodium fluoride (0.55 (0.25 f) mg tab, 1.1 (0.5 f) mg tab, 2.2 (1 f) mg tab)	1-Covered	
TPN ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE	1-Covered	PA - TO CONFIRM PART D COVERAGE
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET	1-Covered	
clovique	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
deferasirox (90 mg tab, 125 mg tab sol, 180 mg tab, 250 mg tab sol, 360 mg tab, 500 mg tab sol)	1-Covered	PA, NDS (Non-Extended Day Supply)
deferasirox granules	1-Covered	PA, NDS (Non-Extended Day Supply)
EXJADE	1-Covered	PA, NDS (Non-Extended Day Supply)
FERRIPROX (100 MG/ML SOLUTION, 500 MG TAB, 1000 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
FERRIPROX TWICE-A-DAY	1-Covered	NDS (Non-Extended Day Supply)
JADENU	1-Covered	PA, NDS (Non-Extended Day Supply)
JADENU SPRINKLE	1-Covered	PA, NDS (Non-Extended Day Supply)
kionex (15gm/60mlsuspension, powder)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sodium polystyrene sulfonate (15 gm/60ml suspension, 30 gm/120ml suspension, 50 gm/200ml suspension, powder)	1-Covered	
sps	1-Covered	
trientine hcl	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
PHOSPHATE BINDERS		
calcium acetate 667 mg tab	1-Covered	
calcium acetate (phos binder) (binder) 667 mg tab, binder) 667 mg cap)	1-Covered	
FOSRENOL (750 MG, 1000 MG)	1-Covered	
lanthanum carbonate	1-Covered	
sevelamer carbonate 800 mg tab	1-Covered	
VELTASSA	1-Covered	
VITAMINS		
BAL-CARE DHA	1-Covered	
C-NATE DHA	1-Covered	
CITRANATAL 90 DHA	1-Covered	
CITRANATAL B-CALM	1-Covered	
CITRANATAL BLOOM	1-Covered	
CITRANATAL HARMONY	1-Covered	
CITRANATAL MEDLEY	1-Covered	
CITRANATAL RX	1-Covered	
COMPLETENATE	1-Covered	
CONCEPT DHA	1-Covered	
CONCEPT OB	1-Covered	
DOTHELLE DHA	1-Covered	
DUET DHA 400	1-Covered	
DUET DHA BALANCED	1-Covered	
elite-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
ENBRACE HR	1-Covered	
FOLIVANE-OB	1-Covered	
M-NATAL PLUS	1-Covered	
MARNATAL-F	1-Covered	
NATACHEW	1-Covered	
NEONATAL COMPLETE	1-Covered	
NEONATAL PLUS	1-Covered	
NESTABS	1-Covered	
NESTABS ONE	1-Covered	
NIVA-PLUS	1-Covered	
O-CAL PRENATAL	1-Covered	
OB COMPLETE	1-Covered	
OB COMPLETE ONE	1-Covered	
OB COMPLETE PETITE	1-Covered	
OB COMPLETE PREMIER	1-Covered	
OB COMPLETE/DHA	1-Covered	
ONE VITE WOMENS PLUS	1-Covered	
PNV FOLIC ACID + IRON	1-Covered	
PNV PRENATAL PLUS MULTIVITAMIN	1-Covered	
PNV TABS 29-1	1-Covered	
pnv-dha	1-Covered	
PNV-DHA+DOCUSATE	1-Covered	
PNV-OMEGA	1-Covered	
PNV-SELECT	1-Covered	
PRENAISSANCE	1-Covered	
PRENAISSANCE PLUS	1-Covered	
PRENATA	1-Covered	
PRENATAL	1-Covered	
PRENATAL 19 (19 29-1 MG TAB, 19 CHEW TAB, 19 29-1 MG CHEW TAB)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRENATAL PLUS IRON	1-Covered	
PRENATAL VITAMIN PLUS LOW IRON	1-Covered	
PRENATE	1-Covered	
PRENATE AM	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	
PRENATRIX	1-Covered	
PRENATVITE COMPLETE	1-Covered	
PRENATVITE PLUS	1-Covered	
PREPLUS	1-Covered	
PRETAB	1-Covered	
PRIMACARE	1-Covered	
PROVIDA OB	1-Covered	
RULAVITE DHA	1-Covered	
SE-NATAL 19 (19 29-1 MG CHEW TAB, 19 29-1 MG TAB)	1-Covered	
SELECT-OB	1-Covered	
TARON-C DHA	1-Covered	
TARON-PREX	1-Covered	
THRIVITE RX	1-Covered	
TRICARE	1-Covered	
TRICARE PRENATAL DHA ONE 27-1-500 MG CAP	1-Covered	
TRINATAL RX 1	1-Covered	
TRISTART DHA	1-Covered	
TRISTART ONE	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIRT-C DHA	1-Covered	
VIRT-NATE DHA	1-Covered	
VIRT-PN DHA	1-Covered	
VIRT-PN PLUS	1-Covered	
VITAFOL FE+	1-Covered	
VITAFOL GUMMIES	1-Covered	
VITAFOL ULTRA	1-Covered	
VITAFOL-NANO	1-Covered	
VITAFOL-OB	1-Covered	
VITAFOL-ONE	1-Covered	
VITAMEDMD ONE RX/QUATREFOLIC	1-Covered	
VOL-PLUS	1-Covered	
VP-PNV-DHA	1-Covered	
WESTAB PLUS	1-Covered	
WESTGEL DHA	1-Covered	
ZATEAN-PN DHA	1-Covered	
ZATEAN-PN PLUS	1-Covered	
GASTROINTESTINAL AGENTS		
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)	1-Covered	
glycopyrrolate (1 mg tab, 2 mg tab)	1-Covered	
methscopolamine bromide (2.5 mg tab, 5 mg tab)	1-Covered	
propantheline bromide 15 mg tab	1-Covered	
GASTROINTESTINAL AGENTS, OTHER		
amoxicill-clarithro-lansopraz	1-Covered	
cromolyn sodium 100 mg/5ml conc	1-Covered	
diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GATTEX	1-Covered	NDS (Non-Extended Day Supply)
loperamide hcl 2 mg cap	1-Covered	
MYALEPT	1-Covered	PA, NDS (Non-Extended Day Supply)
RELISTOR (12 MG/0.6ML SOLUTION, 150 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
ursodiol (250 mg tab, 300 mg cap, 500 mg tab)	1-Covered	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine (200 mg tab, 300 mg tab, 400 mg tab, 800 mg tab)	1-Covered	
cimetidine hcl	1-Covered	
famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)	1-Covered	
IRRITABLE BOWEL SYNDROME AGENTS		
alosetron hcl	1-Covered	
LINZESS	1-Covered	QL (30 PER 30 DAYS)
VIBERZI	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
LAXATIVES		
COLYTE WITH FLAVOR PACKS	1-Covered	
constulose	1-Covered	
enulose	1-Covered	
gavilyte-c	1-Covered	
gavilyte-g	1-Covered	
gavilyte-n with flavor pack	1-Covered	
generlac	1-Covered	
GOLYTELY (227.1 GM SOLN, 236 GM SOLN)	1-Covered	
KRISTALOSE	1-Covered	
lactulose (10 gm packet, 10 gm/15ml solution, 20 gm/30ml solution)	1-Covered	
lactulose encephalopathy	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MOVIPREP	1-Covered	
NULYTELY LEMON-LIME	1-Covered	
NULYTELY WITH FLAVOR PACKS	1-Covered	
peg 3350-kcl-na bicarb-nacl	1-Covered	
peg 3350/electrolytes	1-Covered	
peg-3350/electrolytes	1-Covered	
SUPREP BOWEL PREP KIT	1-Covered	
trilyte	1-Covered	
PROTECTANTS		
CARAFATE 1 GM/10ML SUSPENSION	1-Covered	
misoprostol (100 mcg tab, 200 mcg tab)	1-Covered	
sucralfate (1 gm/10ml suspension, 1 gm tab)	1-Covered	
PROTON PUMP INHIBITORS		
esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
lansoprazole (15 mg cap dr, 30 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
pantoprazole sodium (20 mg tab dr, 40 mg tab dr)	1-Covered	QL (60 PER 30 DAYS)
rabeprazole sodium 20 mg tab dr	1-Covered	
GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ARALAST NP	1-Covered	NDS (Non-Extended Day Supply)
CARBAGLU	1-Covered	NDS (Non-Extended Day Supply)
CREON	1-Covered	
CYSTADANE	1-Covered	
CYSTAGON	1-Covered	
GLASSIA	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
KUVAN (100 MG TAB SOL, 100 MG PACKET, 500 MG PACKET)	1-Covered	NDS (Non-Extended Day Supply)
miglustat	1-Covered	NDS (Non-Extended Day Supply)
NITYR	1-Covered	NDS (Non-Extended Day Supply)
OCALIVA	1-Covered	PA, NDS (Non-Extended Day Supply)
PANCREAZE	1-Covered	
PERTZYE	1-Covered	
PROLASTIN-C (1000 MG/20ML SOLUTION, 1000 MG RECON SOLN)	1-Covered	NDS (Non-Extended Day Supply)
RAVICTI	1-Covered	PA, NDS (Non-Extended Day Supply)
sodium phenylbutyrate 500 mg tab	1-Covered	NDS (Non-Extended Day Supply)
ZEMAIRA	1-Covered	NDS (Non-Extended Day Supply)
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin hydrobromide er	1-Covered	
flavoxate hcl	1-Covered	
MYRBETRIQ	1-Covered	
oxybutynin chloride 5 mg/5ml syrup	1-Covered	
oxybutynin chloride 5 mg tab	1-Covered	QL (120 PER 30 DAYS)
oxybutynin chloride er	1-Covered	QL (60 PER 30 DAYS)
solifenacin succinate	1-Covered	
tolterodine tartrate	1-Covered	
tolterodine tartrate er	1-Covered	QL (30 PER 30 DAYS)
trospium chloride	1-Covered	
trospium chloride er	1-Covered	
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	1-Covered	
dutasteride 0.5 mg cap	1-Covered	QL (30 PER 30 DAYS)
dutasteride-tamsulosin hcl	1-Covered	QL (30 PER 30 DAYS)
finasteride 5 mg tab	1-Covered	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
silodosin	1-Covered	QL (30 PER 30 DAYS)
tamsulosin hcl	1-Covered	
GENITOURINARY AGENTS, OTHER		
bethanechol chloride (5 mg tab, 10 mg tab, 25 mg tab, 50 mg tab)	1-Covered	
DEPEN TITRATABS	1-Covered	NDS (Non-Extended Day Supply)
ELMIRON	1-Covered	
penicillamine 250 mg tab	1-Covered	NDS (Non-Extended Day Supply)
potassium citrate er	1-Covered	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR	1-Covered	PA, NDS (Non-Extended Day Supply)
ala-cort	1-Covered	
alclometasone dipropionate (0.05 % cream, 0.05 % ointment)	1-Covered	
amcinonide (0.1 % cream, 0.1 % lotion, 0.1 % ointment)	1-Covered	
betamethasone dipropionate (0.05 % lotion, 0.05 % ointment, 0.05 % cream)	1-Covered	
betamethasone dipropionate aug (0.05 % cream, 0.05 % ointment, 0.05 % lotion, 0.05 % gel)	1-Covered	
betamethasone valerate (0.1 % cream, 0.1 % ointment, 0.1 % lotion, 0.12 % foam)	1-Covered	
CAPEX	1-Covered	
clobetasol prop emollient base	1-Covered	
clobetasol propionate (0.05 % solution, 0.05 % lotion, 0.05 % shampoo, 0.05 % ointment, 0.05 % foam, 0.05 % gel, 0.05 % cream, 0.05 % liquid)	1-Covered	
clobetasol propionate e	1-Covered	
clobetasol propionate emulsion	1-Covered	
clodan	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
cortisone acetate 25 mg tab	1-Covered	
decadron (0.5 mg/5ml elixir, 0.5 mg tab, 0.75 mg tab, 4 mg tab, 6 mg tab)	1-Covered	
desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)	1-Covered	
desoximetasone (0.05 % ointment, 0.05 % cream, 0.05 % gel, 0.25 % cream, 0.25 % ointment)	1-Covered	
dexamethasone (0.5 mg tab, 0.5 mg/5ml elixir, 0.5 mg/5ml solution, 0.75 mg tab, 1 mg tab, 1.5 mg tab, 2 mg tab, 4 mg tab, 6 mg tab)	1-Covered	
DEXAMETHASONE INTENSOL	1-Covered	
dexamethasone sod phosphate pf 10 mg/ml solution	1-Covered	
dexamethasone sodium phosphate (4 mg/ml, 10 mg/ml, 20 mg/5ml, 100 mg/10ml, 120 mg/30ml)	1-Covered	
diflorasone diacetate (0.05 % cream, 0.05 % ointment)	1-Covered	
EMFLAZA (6 MG TAB, 18 MG TAB, 22.75 MG/ML SUSPENSION, 30 MG TAB, 36 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
fludrocortisone acetate 0.1 mg tab	1-Covered	
fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % ointment, 0.025 % cream)	1-Covered	
fluocinolone acetonide body	1-Covered	
fluocinolone acetonide scalp	1-Covered	
fluocinonide (0.05 % cream, 0.05 % solution, 0.05 % gel, 0.05 % ointment)	1-Covered	
fluocinonide emulsified base	1-Covered	
flurandrenolide (0.05 % lotion, 0.05 % cream, 0.05 % ointment)	1-Covered	
fluticasone propionate (0.005 % ointment, 0.05 % cream, 0.05 % lotion)	1-Covered	
halobetasol propionate (0.05 % ointment, 0.05 % 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
hydrocortisone (1 % cream, 1 % ointment, 2.5 % lotion, 2.5 % ointment, 2.5 % cream, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
hydrocortisone (perianal) 2.5 % cream	1-Covered	
hydrocortisone butyrate (0.1 % ointment, 0.1 % solution)	1-Covered	
hydrocortisone valerate (0.2 % ointment, 0.2 % cream)	1-Covered	
KORLYM	1-Covered	NDS (Non-Extended Day Supply)
methylprednisolone (4 mg tab thpk, 4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)	1-Covered	
methylprednisolone acetate 40 mg/ml suspension	1-Covered	
methylprednisolone sodium succ 1000 mg recon soln	1-Covered	
mometasone furoate (0.1 % solution, 0.1 % ointment, 0.1 % cream)	1-Covered	
nolix (0.05 % lotion, 0.05 % cream)	1-Covered	
prednisolone (15 mg/5ml syrup, 15 mg/5ml solution)	1-Covered	
prednisolone sodium phosphate (6.7 (5 base) mg/5ml solution, 10 mg/5ml solution, 10 mg tab disp, 15 mg/5ml solution, 15 mg tab disp, 20 mg/5ml solution, 25 mg/5ml solution, 30 mg tab disp)	1-Covered	
prednisone (1 mg tab, 2.5 mg tab, 5 mg/5ml solution, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 5 mg tab, 10 mg (48) tab thpk, 10 mg (21) tab thpk, 10 mg tab, 20 mg tab, 50 mg tab)	1-Covered	
PREDNISONE INTENSOL	1-Covered	
procto-med hc	1-Covered	
proctosol hc	1-Covered	
proctozone-hc	1-Covered	
tovet	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
triamcinolone acetonide (0.025 % ointment, 0.025 % cream, 0.025 % lotion, 0.1 % lotion, 0.1 % cream, 0.1 % ointment, 0.147 mg/gm aero soln, 0.5 % cream, 0.5 % ointment)	1-Covered	
triderm	1-Covered	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
desmopressin ace spray refrig	1-Covered	QL (15 PER 30 DAYS)
desmopressin acetate (0.1 mg tab, 0.2 mg tab)	1-Covered	
desmopressin acetate spray	1-Covered	QL (15 PER 30 DAYS)
INCRELEX	1-Covered	NDS (Non-Extended Day Supply)
NORDITROPIN FLEXPRO	1-Covered	PA, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
ANADROL-50	1-Covered	NDS (Non-Extended Day Supply)
oxandrolone 10 mg tab	1-Covered	QL (60 PER 30 DAYS)
oxandrolone 2.5 mg tab	1-Covered	QL (240 PER 30 DAYS)
ANDROGENS		
danazol (50 mg cap, 100 mg cap, 200 mg cap)	1-Covered	
methyltestosterone 10 mg cap	1-Covered	
testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)	1-Covered	PA, QL (300 PER 30 DAYS)
testosterone cypionate	1-Covered	
testosterone enanthate	1-Covered	
testosterone td gel pump 20.25 mg/act (1.62%)	1-Covered	PA, QL (150 PER 30 DAYS)
ESTROGENS		
afirmelle	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
altavera	1-Covered	
alyacen 1/35	1-Covered	
alyacen 7/7/7	1-Covered	
amabelz	1-Covered	
amethia lo	1-Covered	
apri	1-Covered	
aubra	1-Covered	
aubra eq	1-Covered	
aurovela 1.5/30	1-Covered	
aurovela 1/20	1-Covered	
aurovela fe 1.5/30	1-Covered	
aurovela fe 1/20	1-Covered	
aviane	1-Covered	
ayuna	1-Covered	
azurette	1-Covered	
bekyree	1-Covered	
blisovi fe 1.5/30	1-Covered	
blisovi fe 1/20	1-Covered	
camrese lo	1-Covered	
caziant	1-Covered	
chateal	1-Covered	
chateal eq	1-Covered	
cryselle-28	1-Covered	
cyclafem 1/35	1-Covered	
cyclafem 7/7/7	1-Covered	
cyred	1-Covered	
cyred eq	1-Covered	
dasetta 1/35	1-Covered	
dasetta 7/7/7	1-Covered	
delyla	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
desogestrel-ethinyl estradiol	1-Covered	
dotti	1-Covered	
drospirenone-ethinyl estradiol 3-0.03 mg tab	1-Covered	
elinest	1-Covered	
eluryng	1-Covered	QL (1 PER 28 DAYS)
emoquette	1-Covered	
enskyce	1-Covered	
estarylla	1-Covered	
estradiol (0.025 mg/24hr patch tw, 0.025 mg/24hr patch wk, 0.0375 mg/24hr patch tw, 0.0375 mg/24hr patch wk, 0.05 mg/24hr patch tw, 0.05 mg/24hr patch wk, 0.06 mg/24hr patch wk, 0.075 mg/24hr patch tw, 0.075 mg/24hr patch wk, 0.1 mg/gm cream, 0.1 mg/24hr patch tw, 0.1 mg/24hr patch wk, 0.5 mg tab, 1 mg tab, 2 mg tab, 10 mcg tab)	1-Covered	
estradiol-norethindrone acet	1-Covered	
ethynodiol diac-eth estradiol	1-Covered	
etonogestrel-ethinyl estradiol	1-Covered	QL (1 PER 28 DAYS)
falmina	1-Covered	
femynor	1-Covered	
hailey 1.5/30	1-Covered	
hailey fe 1.5/30	1-Covered	
hailey fe 1/20	1-Covered	
introvale	1-Covered	
isibloom	1-Covered	
jolessa	1-Covered	
juleber	1-Covered	
junel 1.5/30	1-Covered	
junel 1/20	1-Covered	
junel fe 1.5/30	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
junel fe 1/20	1-Covered	
kalliga	1-Covered	
kariva	1-Covered	
kelnor 1/35	1-Covered	
kelnor 1/50	1-Covered	
kimidess	1-Covered	
kurvelo	1-Covered	
larin 1.5/30	1-Covered	
larin 1/20	1-Covered	
larin fe 1.5/30	1-Covered	
larin fe 1/20	1-Covered	
larissia	1-Covered	
lessina	1-Covered	
levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)	1-Covered	
levonorgestrel-ethinyl estrad (0.1-20 tab, 0.15-30 tab)	1-Covered	
levora 0.15/30 (28)	1-Covered	
lillow	1-Covered	
lojaimiess	1-Covered	
lopreeza	1-Covered	
low-ogestrel	1-Covered	
lutera	1-Covered	
marlissa	1-Covered	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB)	1-Covered	
microgestin 1.5/30	1-Covered	
microgestin 1/20	1-Covered	
microgestin fe 1.5/30	1-Covered	
microgestin fe 1/20	1-Covered	
mili	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
mimvey	1-Covered	
mimvey lo	1-Covered	
mono-linyah	1-Covered	
necon 0.5/35 (28)	1-Covered	
norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)	1-Covered	
norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab	1-Covered	
norethindrone acet-ethinyl est (1-20 tab, 1.5-30 tab)	1-Covered	
norgestim-eth estrad triphasic 0.18/0.215/0.25 mg-35 mcg tab	1-Covered	
norgestimate-eth estradiol	1-Covered	
nortrel 0.5/35 (28)	1-Covered	
nortrel 1/35 (21)	1-Covered	
nortrel 1/35 (28)	1-Covered	
nortrel 7/7/7	1-Covered	
NUVARING	1-Covered	QL (1 PER 28 DAYS)
ocella	1-Covered	
ogestrel	1-Covered	
orsythia	1-Covered	
pimtrea	1-Covered	
pirmella 1/35	1-Covered	
pirmella 7/7/7	1-Covered	
portia-28	1-Covered	
PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG/GM CREAM, 0.625 MG TAB, 0.9 MG TAB, 1.25 MG TAB)	1-Covered	
PREMPHASE	1-Covered	
PREMPRO	1-Covered	QL (30 PER 30 DAYS)
previfem	1-Covered	
quasense	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
reclipsen	1-Covered	
setlakin	1-Covered	
simliya	1-Covered	
sprintec 28	1-Covered	
sronyx	1-Covered	
syeda	1-Covered	
tarina fe 1/20	1-Covered	
tarina fe 1/20 eq	1-Covered	
tilia fe	1-Covered	
tri femynor	1-Covered	
tri-estarylla	1-Covered	
tri-legest fe	1-Covered	
tri-linyah	1-Covered	
tri-mili	1-Covered	
tri-previfem	1-Covered	
tri-sprintec	1-Covered	
tri-vylibra	1-Covered	
velivet	1-Covered	
vienva	1-Covered	
viorele	1-Covered	
volnea	1-Covered	
vylibra	1-Covered	
wera	1-Covered	
wymzya fe	1-Covered	
xulane	1-Covered	
yuvafem	1-Covered	
zarah	1-Covered	
zovia 1/35e (28)	1-Covered	
zumandimine	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROGESTINS		
camila	1-Covered	
deblitane	1-Covered	
DEPO-PROVERA 400 MG/ML SUSPENSION	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
errin	1-Covered	
heather	1-Covered	
incassia	1-Covered	
jencycla	1-Covered	
jolivette	1-Covered	
lyza	1-Covered	
medroxyprogesterone acetate (150 mg/ml suspension, 150 mg/ml susp prsyr)	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 tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension)	1-Covered	
nora-be	1-Covered	
norethindrone 0.35 mg tab	1-Covered	
norethindrone acetate 5 mg tab	1-Covered	
norlyda	1-Covered	
norlyroc	1-Covered	
progesterone micronized (100 mg cap, 200 mg cap)	1-Covered	
sharobel	1-Covered	
tulana	1-Covered	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
DUAVEE	1-Covered	
raloxifene hcl	1-Covered	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
euthyrox	1-Covered	
levo-t	1-Covered	
levothyroxine sodium (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab, 300 mcg tab)	1-Covered	
levoxyl	1-Covered	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	1-Covered	
SYNTHROID	1-Covered	
THYROLAR-2	1-Covered	
unithroid	1-Covered	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
BYNFEZIA PEN	1-Covered	PA
cabergoline	1-Covered	
ELIGARD	1-Covered	PA - TO CONFIRM PART D COVERAGE
FENSOLVI (6 MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	1-Covered	PA - TO CONFIRM PART D COVERAGE
leuprolide acetate 1 mg/0.2ml kit	1-Covered	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (1-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (3-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (4-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (6-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (1-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (3-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
octreotide acetate	1-Covered	
SIGNIFOR	1-Covered	NDS (Non-Extended Day Supply)
SOMATULINE DEPOT	1-Covered	NDS (Non-Extended Day Supply)
SOMAVERT	1-Covered	NDS (Non-Extended Day Supply)
SYNAREL	1-Covered	NDS (Non-Extended Day Supply)
TRELSTAR	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TRELSTAR MIXJECT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole (5 mg tab, 10 mg tab)	1-Covered	
propylthiouracil 50 mg tab	1-Covered	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
CINRYZE	1-Covered	NDS (Non-Extended Day Supply)
icatibant acetate	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 50 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE
AZATHIOPRINE SODIUM	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 25 MG RECON SOLN, 50 MG/ML SOLN PRSYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL MINI	1-Covered	PA, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENBREL SURECLICK	1-Covered	PA, NDS (Non-Extended Day Supply)
ENVARSUS XR	1-Covered	PA - TO CONFIRM PART D COVERAGE
everolimus (0.5 mg tab, 0.75 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
everolimus 0.25 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE
gengraf (25 mg cap, 100 mg/ml solution, 100 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
HUMIRA	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEDIATRIC CROHNS START	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-CD/UC/HS STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-PS/UV/ADOL HS START	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 2.5 mg tab	1-Covered	
methotrexate sodium (1 gm recon soln, 2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution)	1-Covered	
methotrexate sodium (pf) ((pf) 1 gm/40ml, (pf) 50 mg/2ml, (pf) 250 mg/10ml)	1-Covered	
mycophenolate mofetil (200 mg/ml recon susp, 250 mg cap, 500 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
NULOJIX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ORENCIA (50 MG/0.4ML SOLN, 87.5 MG/0.7ML SOLN, 125 MG/ML SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
ORENCIA CLICKJECT	1-Covered	PA, NDS (Non-Extended Day Supply)
OTREXUP (10 MG/0.4ML SOLN, 12.5 MG/0.4ML SOLN, 15 MG/0.4ML SOLN, 17.5 MG/0.4ML SOLN, 20 MG/0.4ML SOLN, 22.5 MG/0.4ML SOLN, 25 MG/0.4ML SOLN)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROGRAF (0.2 MG, 1 MG)	1-Covered	PA - TO CONFIRM PART D COVERAGE
RASUVO (7.5 MG/0.15ML SOLN, 10 MG/0.2ML SOLN, 12.5 MG/0.25ML SOLN, 15 MG/0.3ML SOLN, 17.5 MG/0.35ML SOLN, 20 MG/0.4ML SOLN, 22.5 MG/0.45ML SOLN, 25 MG/0.5ML SOLN, 30 MG/0.6ML SOLN)	1-Covered	
RENFLEXIS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
SANDIMMUNE 100 MG/ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
SIMULECT 20 MG RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
sirolimus (0.5 mg tab, 1 mg tab, 1 mg/ml solution, 2 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE
tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
temsirolimus	1-Covered	NDS (Non-Extended Day Supply)
TREXALL	1-Covered	
XATMEP	1-Covered	
XELJANZ	1-Covered	PA, NDS (Non-Extended Day Supply)
XELJANZ XR	1-Covered	PA, NDS (Non-Extended Day Supply)
ZORTRESS (0.5 MG TAB, 0.75 MG TAB, 1 MG TAB)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ZORTRESS 0.25 MG TAB	1-Covered	PA - TO CONFIRM PART D COVERAGE
IMMUNIZING AGENTS, PASSIVE		
ATGAM	1-Covered	NDS (Non-Extended Day Supply)
BIVIGAM 5 GM/50ML SOLUTION	1-Covered	PA, NDS (Non-Extended Day Supply)
FLEBOGAMMA DIF	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD S/D LESS IGA	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAKED	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAPLEX	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMUNEX-C (1 GM/10ML, 2.5 GM/25ML, 5 GM/50ML, 10 GM/100ML, 20 GM/200ML)	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
OCTAGAM	1-Covered	PA, NDS (Non-Extended Day Supply)
PANZYGA	1-Covered	PA, NDS (Non-Extended Day Supply)
PRIVIGEN	1-Covered	PA, NDS (Non-Extended Day Supply)
THYMOGLOBULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IMMUNOMODULATORS		
ACTEMRA 162 MG/0.9ML SOLN PRSYR	1-Covered	PA, NDS (Non-Extended Day Supply)
ACTEMRA ACTPEN	1-Covered	PA, NDS (Non-Extended Day Supply)
ACTIMMUNE	1-Covered	PA, NDS (Non-Extended Day Supply)
ARCALYST	1-Covered	NDS (Non-Extended Day Supply)
BENLYSTA (200 MG/ML SOLN PRSYR, 200 MG/ML SOLN A-INJ)	1-Covered	NDS (Non-Extended Day Supply)
leflunomide 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
leflunomide 20 mg tab	1-Covered	QL (150 PER 30 DAYS)
ORALAIR	1-Covered	
ORALAIR ADULT SAMPLE KIT	1-Covered	
ORALAIR ADULT STARTER PACK	1-Covered	
RIDAURA	1-Covered	
SYLVANT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VACCINES		
ACTHIB	1-Covered	
ADACEL	1-Covered	
BCG VACCINE	1-Covered	
BEXSERO	1-Covered	
BOOSTRIX	1-Covered	
DAPTACEL	1-Covered	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Covered	
ENGERIX-B	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9 (9SUSPPRSYR, 9SUSPENSION)	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
HAVRIX	1-Covered	
HIBERIX	1-Covered	
IMOVAX RABIES	1-Covered	
INFANRIX	1-Covered	
IPOL	1-Covered	
IXIARO	1-Covered	
KINRIX	1-Covered	
M-M-R II	1-Covered	
MENACTRA	1-Covered	
MENVEO	1-Covered	
PEDIARIX	1-Covered	
PEDVAX HIB	1-Covered	
PROQUAD	1-Covered	
QUADRACEL	1-Covered	
RABAVERT	1-Covered	
RECOMBIVAX HB	1-Covered	PA - TO CONFIRM PART D COVERAGE
ROTARIX	1-Covered	
ROTATEQ	1-Covered	
SHINGRIX	1-Covered	
TDVAX	1-Covered	
TENIVAC	1-Covered	
TRUMENBA	1-Covered	
TWINRIX 720-20 ELU-MCG/ML SUSP PRSYR	1-Covered	
TYPHIM VI	1-Covered	
VAQTA	1-Covered	
VARIVAX	1-Covered	
VARIZIG	1-Covered	
YF-VAX	1-Covered	
ZOSTAVAX	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
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
APRISO	1-Covered	
balsalazide disodium	1-Covered	
mesalamine (1.2 gm tab dr, 4 gm enema, 400 mg cap dr, 800 mg tab dr)	1-Covered	
mesalamine er	1-Covered	
mesalamine-cleanser	1-Covered	
GLUCOCORTICOIDS		
budesonide 3 mg cp dr part	1-Covered	
budesonide er	1-Covered	
colocort	1-Covered	
hydrocortisone 100 mg/60ml enema	1-Covered	
SULFONAMIDES		
sulfasalazine (500 mg tab dr, 500 mg tab)	1-Covered	
METABOLIC BONE DISEASE AGENTS		
alendronate sodium 70 mg/75ml solution	1-Covered	
alendronate sodium (35 mg tab, 70 mg tab)	1-Covered	QL (4 PER 28 DAYS)
alendronate sodium (5 mg tab, 10 mg tab, 40 mg tab)	1-Covered	QL (30 PER 30 DAYS)
calcitonin (salmon)	1-Covered	
calcitriol (0.25 mcg cap, 0.5 mcg cap, 1 mcg/ml solution)	1-Covered	
cinacalcet hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
doxercalciferol (0.5 mcg cap, 1 mcg cap, 2.5 mcg cap)	1-Covered	
FORTEO	1-Covered	PA, NDS (Non-Extended Day Supply)
ibandronate sodium 150 mg tab	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
NATPARA	1-Covered	NDS (Non-Extended Day Supply)
PROLIA	1-Covered	
risedronate sodium (5 mg tab, 30 mg tab, 35 mg tab dr, 35 mg tab, 150 mg tab)	1-Covered	
XGEVA	1-Covered	NDS (Non-Extended Day Supply)
zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)	1-Covered	PA - TO CONFIRM PART D COVERAGE
MISCELLANEOUS THERAPEUTIC AGENTS		
GAUZE PADS & DRESSINGS - PADS 2 X 2	1-Covered	
INSULIN PEN NEEDLE	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	
ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD	1-Covered	
NEEDLES, INSULIN DISP., SAFETY	1-Covered	
sterile water for irrigation	1-Covered	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
ak-poly-bac	1-Covered	
ATROPINE SULFATE 1 % SOLUTION	1-Covered	
bacitra-neomycin-polymyxin-hc	1-Covered	
bacitracin-polymyxin b	1-Covered	
BLEPHAMIDE	1-Covered	
BLEPHAMIDE S.O.P.	1-Covered	
cyclopentolate hcl (0.5 %, 1 %, 2 %)	1-Covered	
CYSTARAN	1-Covered	
ISOPTO ATROPINE	1-Covered	
neo-polycin	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
neo-polycin hc	1-Covered	
neomycin-bacitracin zn-polymyx	1-Covered	
neomycin-polymyxin-dexameth (3.5-10000-0.1suspension, 3.5-10000-0.1ointment)	1-Covered	
neomycin-polymyxin-gramicidin	1-Covered	
neomycin-polymyxin-hc 3.5-10000-1 suspension	1-Covered	
OXERVATE	1-Covered	PA, NDS (Non-Extended Day Supply)
polycin	1-Covered	
polymyxin b-trimethoprim	1-Covered	
proparacaine hcl 0.5 % solution	1-Covered	
RESTASIS	1-Covered	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	1-Covered	QL (60 PER 30 DAYS)
sulfacetamide-prednisolone	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	
tobramycin-dexamethasone	1-Covered	
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRIL	1-Covered	
ALOMIDE	1-Covered	
azelastine hcl 0.05 % solution	1-Covered	
cromolyn sodium 4 % solution	1-Covered	
epinastine hcl	1-Covered	
olopatadine hcl 0.1 % solution	1-Covered	QL (10 PER 30 DAYS)
olopatadine hcl 0.2 % solution	1-Covered	
OPHTHALMIC ANTI-INFLAMMATORIES		
ALREX	1-Covered	
bromfenac sodium (once-daily)	1-Covered	
dexamethasone sodium phosphate 0.1 % solution	1-Covered	
diclofenac sodium 0.1 % solution	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
DUREZOL	1-Covered	
FLAREX	1-Covered	
fluorometholone	1-Covered	
flurbiprofen sodium	1-Covered	
FML	1-Covered	
ILEVRO	1-Covered	
ketorolac tromethamine (0.4 %, 0.5 %)	1-Covered	
loteprednol etabonate	1-Covered	
PRED MILD	1-Covered	
prednisolone acetate 1 % suspension	1-Covered	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
PROLENSA	1-Covered	
OPHTHALMIC ANTIGLAUCOMA AGENTS		
ALPHAGAN P 0.1 % SOLUTION	1-Covered	
apraclonidine hcl	1-Covered	
AZOPT	1-Covered	
betaxolol hcl 0.5 % solution	1-Covered	
brimonidine tartrate (0.15 %, 0.2 %)	1-Covered	
carteolol hcl	1-Covered	
COMBIGAN	1-Covered	
dorzolamide hcl 2 % solution	1-Covered	QL (10 PER 18 DAYS)
dorzolamide hcl-timolol mal	1-Covered	QL (10 PER 18 DAYS)
dorzolamide hcl-timolol mal pf	1-Covered	
levobunolol hcl	1-Covered	
methazolamide (25 mg tab, 50 mg tab)	1-Covered	
pilocarpine hcl (1 %, 2 %, 4 %)	1-Covered	
RHOPRESSA	1-Covered	
SIMBRINZA	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
timolol maleate (0.25 % gel f soln, 0.25 % solution, 0.5 % solution, 0.5 % gel f soln, 0.5 % (daily) solution)	1-Covered	
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost 0.03 % ophth solution	1-Covered	
latanoprost 0.005 % solution	1-Covered	QL (5 PER 30 DAYS)
LUMIGAN	1-Covered	
TRAVATAN Z	1-Covered	QL (10 PER 30 DAYS)
travoprost (bak free)	1-Covered	QL (10 PER 30 DAYS)
OTIC AGENTS		
acetic acid 2 % solution	1-Covered	
CIPRODEX	1-Covered	
flac	1-Covered	
fluocinolone acetonide 0.01 % oil	1-Covered	
hydrocortisone-acetic acid	1-Covered	
neomycin-polymyxin-hc (1 %, 3.5-10000-1)	1-Covered	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
budesonide 0.25 mg/2ml suspension	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (240 PER 30 DAYS)
budesonide 0.5 mg/2ml suspension	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (120 PER 30 DAYS)
budesonide 1 mg/2ml suspension	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
FLOVENT DISKUS	1-Covered	QL (80 PER 30 DAYS)
FLOVENT HFA (110 MCG/ACT, 220 MCG/ACT)	1-Covered	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	1-Covered	QL (22 PER 30 DAYS)
flunisolide 25 mcg/act (0.025%) solution	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
fluticasone propionate 50 mcg/act suspension	1-Covered	QL (16 PER 30 DAYS)
mometasone furoate 50 mcg/act suspension	1-Covered	
PULMICORT FLEXHALER	1-Covered	
QVAR REDIHALER	1-Covered	QL (21.2 PER 30 DAYS)
ANTIHISTAMINES		
azelastine hcl (0.1 %, 0.15 %, 137 mcg/spray)	1-Covered	
cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)	1-Covered	
desloratadine (2.5 mg tab disp, 5 mg tab, 5 mg tab disp)	1-Covered	
diphenhydramine hcl 50 mg/ml solution	1-Covered	
hydroxyzine hcl (10 mg/5ml syrup, 10 mg tab, 25 mg tab, 50 mg tab)	1-Covered	
hydroxyzine pamoate (25 mg cap, 50 mg cap, 100 mg cap)	1-Covered	
levocetirizine dihydrochloride (2.5 mg/5ml solution, 5 mg tab)	1-Covered	
olopatadine hcl 0.6 % solution	1-Covered	
promethazine hcl (6.25 mg/5ml solution, 6.25 mg/5ml syrup, 12.5 mg tab, 25 mg tab)	1-Covered	PA
ANTILEUKOTRIENES		
montelukast sodium (4 mg chew tab, 4 mg packet, 5 mg chew tab, 10 mg tab)	1-Covered	QL (30 PER 30 DAYS)
zafirlukast 10 mg tab	1-Covered	QL (120 PER 30 DAYS)
zafirlukast 20 mg tab	1-Covered	QL (60 PER 30 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	1-Covered	
INCRUSE ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
ipratropium bromide (0.03 %, 0.06 %)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ipratropium bromide 0.02 % solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
SPIRIVA HANDIHALER	1-Covered	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
TUDORZA PRESSAIR	1-Covered	
BRONCHODILATORS, SYMPATHOMIMETIC		
albuterol sulfate (0.63 mg/3ml soln, 1.25 mg/3ml soln, 2.5 mg/0.5ml soln, (2.5 mg/3ml) 0.083% soln, (5 mg/ml) 0.5% soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)	1-Covered	
albuterol sulfate er	1-Covered	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)	1-Covered	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)	1-Covered	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)	1-Covered	
epinephrine (0.15 mg/0.15ml soln, 0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)	1-Covered	
EPIPEN 2-PAK	1-Covered	
EPIPEN JR 2-PAK	1-Covered	
levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/3ml soln, 1.25 mg/0.5ml soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
levalbuterol tartrate	1-Covered	
metaproterenol sulfate 10 mg/5ml syrup	1-Covered	
SEREVENT DISKUS	1-Covered	QL (60 PER 30 DAYS)
STRIVERDI RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	1-Covered	
CYSTIC FIBROSIS AGENTS		
CAYSTON	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
KALYDECO (25 MG PACKET, 50 MG PACKET, 75 MG PACKET, 150 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
ORKAMBI (100-125 MG TAB, 100-125 MG PACKET, 150-188 MG PACKET, 200-125 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
PULMOZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TOBI PODHALER	1-Covered	NDS (Non-Extended Day Supply)
MAST CELL STABILIZERS		
cromolyn sodium 20 mg/2ml nebu soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (240 PER 30 DAYS)
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
DALIRESP	1-Covered	
theophylline	1-Covered	
theophylline er (er 300 mg tab er 12h, er 400 mg tab er 24h, er 450 mg tab er 12h, er 600 mg tab er 24h)	1-Covered	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	1-Covered	PA, NDS (Non-Extended Day Supply)
alyq	1-Covered	PA, NDS (Non-Extended Day Supply)
ambrisentan	1-Covered	PA, NDS (Non-Extended Day Supply)
bosentan	1-Covered	PA, NDS (Non-Extended Day Supply)
OPSUMIT	1-Covered	PA, NDS (Non-Extended Day Supply)
sildenafil citrate 10 mg/ml recon susp	1-Covered	PA, NDS (Non-Extended Day Supply)
sildenafil citrate 20 mg tab	1-Covered	PA
tadalafil (pah)	1-Covered	PA, NDS (Non-Extended Day Supply)
TRACLEER 32 MG TAB SOL	1-Covered	PA, NDS (Non-Extended Day Supply)
UPTRAVI (200 & 800 MCG TAB THPK, 200 MCG TAB, 400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB)	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
PULMONARY FIBROSIS AGENTS		
ESBRIET (267 MG CAP, 267 MG TAB, 801 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
OFEV	1-Covered	PA, NDS (Non-Extended Day Supply)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10 %, 20 %)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ADVAIR HFA	1-Covered	QL (12 PER 30 DAYS)
ANORO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
BREO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
COMBIVENT RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
DULERA (100-5 MCG/ACT, 200-5 MCG/ACT)	1-Covered	QL (13 PER 30 DAYS)
DULERA 50-5 MCG/ACT AEROSOL	1-Covered	QL (13 PER 30 DAYS)
fluticasone-salmeterol (100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose)	1-Covered	QL (60 PER 30 DAYS)
fluticasone-salmeterol (55-14 mcg/act, 113-14 mcg/act, 232-14 mcg/act)	1-Covered	
ipratropium-albuterol	1-Covered	PA - TO CONFIRM PART D COVERAGE
promethazine-phenylephrine	1-Covered	PA
STIOLTO RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
SYMBICORT	1-Covered	QL (10.2 PER 30 DAYS)
tobramycin 300 mg/5ml nebu soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TRELEGY ELLIPTA 100-62.5-25 MCG/INH AER POW BA	1-Covered	QL (60 PER 30 DAYS)
wixela inhub	1-Covered	QL (60 PER 30 DAYS)
XOLAIR (75 MG/0.5ML SOLN PRSYR, 150 MG/ML SOLN PRSYR, 150 MG RECON SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
SKELETAL MUSCLE RELAXANTS		
carisoprodol (250 mg tab, 350 mg tab)	1-Covered	PA, QL (120 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
chlorzoxazone 500 mg tab	1-Covered	PA
cyclobenzaprine hcl 10 mg tab	1-Covered	PA, QL (90 PER 30 DAYS)
cyclobenzaprine hcl 5 mg tab	1-Covered	PA, QL (180 PER 30 DAYS)
metaxalone	1-Covered	PA
methocarbamol (500 mg tab, 750 mg tab)	1-Covered	PA
orphenadrine citrate er	1-Covered	PA
vanadom	1-Covered	PA, QL (120 PER 30 DAYS)
SLEEP DISORDER AGENTS		
GABA RECEPTOR MODULATORS		
estazolam	1-Covered	
eszopiclone	1-Covered	PA, QL (30 PER 30 DAYS)
temazepam (15 mg cap, 30 mg cap)	1-Covered	QL (30 PER 30 DAYS)
triazolam 0.125 mg tab	1-Covered	QL (60 PER 30 DAYS)
triazolam 0.25 mg tab	1-Covered	QL (30 PER 30 DAYS)
zaleplon	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate (1.75 mg sl tab, 3.5 mg sl tab, 5 mg tab)	1-Covered	QL (30 PER 30 DAYS)
zolpidem tartrate 10 mg tab	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate er	1-Covered	PA, QL (30 PER 30 DAYS)
SLEEP DISORDERS, OTHER		
armodafinil	1-Covered	PA
doxepin hcl (3 mg tab, 6 mg tab)	1-Covered	
HETLIOZ	1-Covered	PA, NDS (Non-Extended Day Supply)
ramelteon	1-Covered	
SILENOR	1-Covered	
XYREM	1-Covered	PA, NDS (Non-Extended Day Supply)

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This formulary was updated on 11/1/2020. For more recent information or other questions, please contact Health Partners Medicare at 1-866-901-8000 or, for TTY users, 1-877-454-8477, 24 hours a day, seven days a week, or visit www.HPPMedicare.com.

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Health Partners Plans

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- Written information in other formats (large print, audio, accessible electronic formats, other formats)

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- Information written in other languages

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If you believe that Health Partners Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can file a grievance with Health Partners Medicare. You can file a grievance in person or by phone, mail or fax:

Phone: 1-866-901-8000 (TTY 1-877-454-8477)

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

Fax: 215-991-4105

If you need help filing a grievance, Health Partners Medicare Member Relations is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-866-901-8000 (TTY 1-877-454-8477).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-901-8000 (TTY 1-877-454-8477).

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-901-8000 (رقم هاتف الصم والبكم: 1-877-454-8477)

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ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-866-901-8000 (ATS 1-877-454-8477).

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ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-901-8000 (TTY 1-877-454-8477).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-901-8000 (телетайп 1-877-454-8477).

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 1-877-454-8477).

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