



2022 Formulary List of Covered Drugs

**Health Partners Medicare
Prime and Complete (HMO-POS)**

Health Partners 
Medicare

The plan you **need**.
The care you **deserve**.

Health Partners Medicare Prime and Complete (HMO-POS) 2022 Formulary (List of Covered Drugs)

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

Formulary ID 00022492, Version 6

This formulary was updated on 10/5/2021. For more recent information or other questions, please contact Health Partners Medicare Member Relations at 1-866-901-8000 (TTY users should call 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 Prime and Health Partners Medicare Complete.

This document includes a list of the drugs (formulary) for our plan which is current as of 10/5/2021. 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, 2023, and from time to time during the year.

What is the Health Partners Medicare Prime and Complete 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 the 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 find information in the section below titled “How do I request an exception to the Health Partners Medicare Prime and Complete Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, 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 titled “How do I request an exception to the Health Partners Medicare Prime and Complete Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except 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. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 10/5/2021. To get updated information about the drugs covered by Health Partners Medicare Prime and Complete, please contact us. Our contact information appears on the first and last pages.

Our print formulary will be updated by reprinting in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 107. 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 114. 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 Prime and Complete cover 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 Prime and Complete require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, Health Partners Medicare Prime and Complete limit the amount of the drug that our plan will cover. For example, our plan 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 Prime and Complete require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 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 us 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 Prime and Complete 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 our plan does not cover your drug, you have two options:

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

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

- You can ask us to cover 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, unless the drug is 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, our plan 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, we 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, tier or utilization restriction exception. **When you request a formulary, tier or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor 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 Prime or Complete prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Health Partners Medicare Prime or Complete, 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 Prime and Complete's Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Prime and Complete. If you have trouble finding your drug in the list, turn to the Index that begins on page 114.

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 Prime or Complete has any special requirements for coverage of your drug.

The table below shows the cost-sharing for each drug tier shown in this formulary.

Health Partners Medicare Prime and Complete		
Drug Tier	Retail Cost-Sharing (30-day supply)	Mail-Order Cost-Sharing (90-day supply)
1 - Preferred Generics	\$0	\$0
2 - Generic	\$10	\$20
3 - Preferred Brand	\$47	\$94
4 - Non-Preferred Drug	\$100	\$200
5 - Specialty	33%	Not offered

LEGEND

TIER	NAME
1	Preferred Generics
2	Generic
3	Preferred Brands
4	Non-Preferred Drug
5	Specialty

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.

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
<i>butalbital-aspirin-caffeine 50-325-40 mg cap</i>	2-Generic	PA, QL (180 PER 30 DAYS)
<i>cataflam</i>	2-Generic	
<i>celecoxib</i>	2-Generic	
<i>diclofenac potassium 50 mg tab</i>	2-Generic	
<i>diclofenac sodium 1 % gel</i>	4-Non-Preferred Drug	QL (1000 PER 30 DAYS)
<i>diclofenac sodium 1.5 % solution</i>	4-Non-Preferred Drug	QL (300 PER 28 DAYS)
<i>diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)</i>	2-Generic	
<i>diclofenac sodium er</i>	2-Generic	
<i>diclofenac-misoprostol</i>	4-Non-Preferred Drug	
<i>diflunisal</i>	2-Generic	
<i>ec-naproxen</i>	2-Generic	
<i>etodolac (200 mg cap, 300 mg cap, 400 mg tab, 500 mg tab)</i>	2-Generic	
<i>flurbiprofen</i>	2-Generic	
<i>ibu</i>	2-Generic	
<i>ibuprofen (100 mg/5ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)</i>	2-Generic	
<i>indomethacin (25 mg cap, 50 mg cap)</i>	2-Generic	PA
<i>indomethacin er</i>	2-Generic	PA
<i>meloxicam 15 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>meloxicam 7.5 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>nabumetone (500 mg tab, 750 mg tab)</i>	2-Generic	
<i>naproxen (250 mg tab, 375 mg tab, 500 mg tab)</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>naproxen (375 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>naproxen sodium (275 mg tab, 550 mg tab)</i>	2-Generic	
<i>oxaprozin</i>	4-Non-Preferred Drug	
<i>piroxicam (10 mg cap, 20 mg cap)</i>	2-Generic	
<i>relafen</i>	2-Generic	
<i>sulindac (150 mg tab, 200 mg tab)</i>	2-Generic	

OPIOID ANALGESICS, LONG-ACTING

<i>buprenorphine</i>	4-Non-Preferred Drug	QL (4 PER 28 DAYS)
<i>fentanyl</i>	2-Generic	QL (10 PER 30 DAYS)
<i>methadone hcl (5 mg tab, 5 mg/5ml solution, 10 mg tab, 10 mg/5ml solution)</i>	4-Non-Preferred Drug	
<i>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)</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>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)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>tramadol hcl er (er 100 mg tab er, er 200 mg tab er, er 300 mg tab er)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>tramadol hcl er (biphasic)</i>	2-Generic	QL (30 PER 30 DAYS)
XTAMPZA ER	4-Non-Preferred Drug	QL (60 PER 30 DAYS)

OPIOID ANALGESICS, SHORT-ACTING

<i>acetaminophen-codeine 120-12 mg/5ml solution</i>	2-Generic	
<i>acetaminophen-codeine 300-15 mg tab</i>	2-Generic	QL (390 PER 30 DAYS)
<i>acetaminophen-codeine 300-30 mg tab</i>	2-Generic	QL (360 PER 30 DAYS)
<i>acetaminophen-codeine 300-60 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>acetaminophen-codeine #2</i>	2-Generic	QL (390 PER 30 DAYS)
<i>acetaminophen-codeine #3</i>	2-Generic	QL (360 PER 30 DAYS)
<i>acetaminophen-codeine #4</i>	2-Generic	QL (180 PER 30 DAYS)
<i>butalbital-apap-caff-cod 50-325-40-30 mg cap</i>	4-Non-Preferred Drug	PA, QL (180 PER 30 DAYS)
<i>butorphanol tartrate 10 mg/ml solution</i>	4-Non-Preferred Drug	
<i>endocet 10-325 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)
<i>endocet 2.5-325 mg tab</i>	2-Generic	QL (360 PER 30 DAYS)
<i>endocet 5-325 mg tab</i>	2-Generic	QL (360 PER 30 DAYS)
<i>endocet 7.5-325 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)
<i>fentanyl citrate (400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)</i>	5-Specialty	PA
<i>fentanyl citrate 200 mcg loz handle</i>	4-Non-Preferred Drug	PA
<i>hydrocodone-acetaminophen (2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml)</i>	2-Generic	
<i>hydrocodone-acetaminophen 10-325 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)
<i>hydrocodone-acetaminophen 5-325 mg tab</i>	2-Generic	QL (360 PER 30 DAYS)
<i>hydrocodone-acetaminophen 7.5-325 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)
<i>hydrocodone-ibuprofen (5-200 mg tab, 10-200 mg tab)</i>	2-Generic	QL (150 PER 30 DAYS)
<i>hydrocodone-ibuprofen 7.5-200 mg tab</i>	2-Generic	QL (150 PER 30 DAYS)
<i>hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)</i>	2-Generic	
<i>morphine sulfate (10 mg/5ml solution, 15 mg tab, 20 mg/5ml solution, 30 mg tab)</i>	2-Generic	
<i>morphine sulfate (concentrate)</i>	2-Generic	
<i>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)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)</i>	2-Generic	QL (360 PER 30 DAYS)
<i>oxycodone-acetaminophen 10-325 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)
<i>oxycodone-acetaminophen 7.5-325 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)
<i>oxymorphone hcl</i>	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
<i>tramadol hcl 50 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)
<i>tramadol-acetaminophen</i>	2-Generic	QL (240 PER 30 DAYS)

ANESTHETICS

LOCAL ANESTHETICS

<i>glydo</i>	2-Generic	QL (30 PER 30 DAYS)
<i>lidocaine 5 % patch</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>lidocaine 5 % ointment</i>	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
<i>lidocaine hcl urethral/mucosal (urethral/mucosal 2 % gel, urethral/mucosal 2 % prsyr)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>lidocaine viscous hcl</i>	2-Generic	
<i>lidocaine-prilocaine</i>	2-Generic	QL (30 PER 30 DAYS)

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ALCOHOL DETERRENTS/ANTI-CRAVING

<i>acamprosate calcium</i>	2-Generic	
<i>disulfiram</i>	2-Generic	
<i>naltrexone hcl 50 mg tab</i>	2-Generic	
VIVITROL	5-Specialty	

OPIOID DEPENDENCE

<i>buprenorphine hcl 2 mg sl tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>buprenorphine hcl 8 mg sl tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 8-2 mg)</i>	2-Generic	QL (90 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>buprenorphine hcl-naloxone hcl 12-3 mg film</i>	2-Generic	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 8-2 mg sl tab</i>	2-Generic	QL (90 PER 30 DAYS)
LUCEMYRA	4-Non-Preferred Drug	PA, QL (16 PER DAY)
SUBOXONE (2-0.5 MG, 4-1 MG, 8-2 MG)	3-Preferred Brands	QL (90 PER 30 DAYS)
SUBOXONE 12-3 MG FILM	3-Preferred Brands	QL (60 PER 30 DAYS)

OPIOID REVERSAL AGENTS

<i>naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/10ml solution)</i>	1-Preferred Generics	
NARCAN	3-Preferred Brands	

SMOKING CESSATION AGENTS

<i>bupropion hcl er (smoking det)</i>	2-Generic	QL (60 PER 30 DAYS)
CHANTIX	3-Preferred Brands	
CHANTIX CONTINUING MONTH PAK	3-Preferred Brands	
CHANTIX STARTING MONTH PAK	3-Preferred Brands	
NICOTROL	3-Preferred Brands	
NICOTROL NS	3-Preferred Brands	

ANTIBACTERIALS

AMINOGLYCOSIDES

<i>amikacin sulfate</i>	2-Generic	
<i>gentamicin in saline</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>gentamicin sulfate (0.1 % ointment, 0.1 % cream)</i>	2-Generic	
<i>gentamicin sulfate (10 mg/ml, 40 mg/ml)</i>	1-Preferred Generics	
<i>neomycin sulfate 500 mg tab</i>	2-Generic	
<i>paromomycin sulfate 250 mg cap</i>	1-Preferred Generics	
<i>streptomycin sulfate 1 gm recon soln</i>	1-Preferred Generics	
<i>tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)</i>	4-Non-Preferred Drug	
ANTIBACTERIALS, OTHER		
<i>acetic acid 2 % solution</i>	2-Generic	
<i>aztreonam</i>	4-Non-Preferred Drug	
<i>clindacin etz</i>	2-Generic	
<i>clindacin-p</i>	2-Generic	
<i>clindamycin hcl (75 mg cap, 150 mg cap, 300 mg cap)</i>	1-Preferred Generics	
<i>clindamycin palmitate hcl</i>	2-Generic	
<i>clindamycin phosphate (9 gm/60ml, 300 mg/2ml, 600 mg/4ml, 900 mg/6ml, 9000 mg/60ml)</i>	1-Preferred Generics	
<i>clindamycin phosphate (1 % swab, 2 % cream)</i>	2-Generic	
<i>clindamycin phosphate in d5w</i>	1-Preferred Generics	
<i>colistimethate sodium (cba)</i>	1-Preferred Generics	
<i>daptomycin (350 mg recon soln)</i>	5-Specialty	
<i>fosfomycin tromethamine</i>	4-Non-Preferred Drug	
<i>linezolid 100 mg/5ml recon susp</i>	4-Non-Preferred Drug	QL (1800 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>linezolid 600 mg/300ml solution</i>	4-Non-Preferred Drug	
<i>linezolid 600 mg tab</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>methenamine hippurate</i>	2-Generic	
<i>metronidazole (0.75 % gel, 0.75 % cream, 0.75 % lotion, 1 % gel, 250 mg tab, 375 mg cap, 500 mg tab)</i>	2-Generic	
<i>metronidazole in nacl (5-0.79 mg/ml-%, 500-0.79 mg/100ml-%)</i>	4-Non-Preferred Drug	
<i>metronidazole in nacl 0.74% iv soln 500 mg/100ml</i>	4-Non-Preferred Drug	
<i>nitrofurantoin macrocrystal (25 mg cap, 50 mg cap, 100 mg cap)</i>	1-Preferred Generics	
<i>nitrofurantoin monohyd macro</i>	2-Generic	
<i>polymyxin b sulfate 500000 unit recon soln</i>	1-Preferred Generics	
<i>rosadan (0.75 % gel, 0.75 % cream)</i>	2-Generic	
TIGECYCLINE	5-Specialty	
<i>trimethoprim 100 mg tab</i>	1-Preferred Generics	
<i>vancomycin hcl 125 mg cap</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>vancomycin hcl 250 mg cap</i>	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
<i>vancomycin hcl (1 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln, 750 mg soln, 1000 mg soln)</i>	4-Non-Preferred Drug	
<i>vandazole</i>	2-Generic	
XIFAXAN 200 MG TAB	4-Non-Preferred Drug	PA
XIFAXAN 550 MG TAB	5-Specialty	PA
BETA-LACTAM, CEPHALOSPORINS		
<i>cefaclor (250 mg cap, 500 mg cap)</i>	2-Generic	
CEFACLOR ER	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>cefadroxil (1 gm tab, 250 mg/5ml recon susp, 500 mg/5ml recon susp, 500 mg cap)</i>	1-Preferred Generics	
<i>cefazolin sodium (1 gm soln, 10 gm soln, 100 gm soln, 300 gm soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)</i>	2-Generic	
<i>cefepime hcl (1 gm soln, 2 gm soln)</i>	4-Non-Preferred Drug	
<i>cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)</i>	2-Generic	
<i>cefotetan disodium (1 gm soln, 2 gm soln)</i>	4-Non-Preferred Drug	
<i>cefoxitin sodium</i>	4-Non-Preferred Drug	
<i>cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg/5ml recon susp, 100 mg tab, 200 mg tab)</i>	2-Generic	
<i>cefprozil (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg tab, 500 mg tab)</i>	2-Generic	
<i>ceftazidime</i>	4-Non-Preferred Drug	
<i>ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>cefuroxime axetil</i>	2-Generic	
<i>cefuroxime sodium</i>	4-Non-Preferred Drug	
<i>cephalexin (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 500 mg cap)</i>	1-Preferred Generics	
<i>tazicef (1 gm soln, 2 gm soln, 6 gm soln)</i>	4-Non-Preferred Drug	
TEFLARO	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BETA-LACTAM, PENICILLINS		
<i>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)</i>	1-Preferred Generics	
<i>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)</i>	2-Generic	
<i>amoxicillin-pot clavulanate er</i>	2-Generic	
<i>ampicillin</i>	2-Generic	
<i>ampicillin sodium</i>	1-Preferred Generics	
<i>ampicillin-sulbactam sodium</i>	2-Generic	
BICILLIN L-A	3-Preferred Brands	
<i>dicloxacillin sodium</i>	1-Preferred Generics	
<i>nafcillin sodium</i>	2-Generic	
<i>oxacillin sodium</i>	1-Preferred Generics	
OXACILLIN SODIUM IN DEXTROSE	1-Preferred Generics	
PENICILLIN G POT IN DEXTROSE	4-Non-Preferred Drug	
<i>penicillin g potassium</i>	4-Non-Preferred Drug	
PENICILLIN G PROCAINE	4-Non-Preferred Drug	
<i>penicillin g sodium</i>	4-Non-Preferred Drug	
<i>penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, 250 mg tab, 500 mg tab)</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pfizerpen</i>	4-Non-Preferred Drug	
<i>piperacillin sod-tazobactam so</i>	2-Generic	
CARBAPENEMS		
<i>ertapenem sodium</i>	4-Non-Preferred Drug	
<i>imipenem-cilastatin</i>	2-Generic	
<i>meropenem</i>	2-Generic	
MACROLIDES		
<i>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)</i>	1-Preferred Generics	
<i>clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)</i>	2-Generic	
<i>clarithromycin er</i>	2-Generic	
DIFICID (40 MG/ML RECON SUSP, 200 MG TAB)	5-Specialty	
E.E.S. 400	2-Generic	
<i>ery-tab</i>	2-Generic	
ERYTHROCIN LACTOBIONATE	4-Non-Preferred Drug	
<i>erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>erythromycin base (250 mg tab, 250 mg cp dr part, 500 mg tab)</i>	4-Non-Preferred Drug	
<i>erythromycin base (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>erythromycin ethylsuccinate 400 mg tab</i>	2-Generic	
QUINOLONES		
BESIVANCE	3-Preferred Brands	
CILOXAN 0.3 % OINTMENT	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ciprofloxacin hcl 0.3 % solution</i>	2-Generic	
<i>ciprofloxacin hcl (100 mg tab, 250 mg tab, 500 mg tab, 750 mg tab)</i>	1-Preferred Generics	
<i>ciprofloxacin in d5w 200 mg/100ml solution</i>	1-Preferred Generics	
<i>levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)</i>	2-Generic	
<i>levofloxacin 25 mg/ml oral solution</i>	2-Generic	
<i>levofloxacin in d5w (500 mg/100ml, 750 mg/150ml)</i>	1-Preferred Generics	
<i>levofloxacin iv soln 25 mg/ml</i>	1-Preferred Generics	
<i>moxifloxacin hcl 400 mg tab</i>	2-Generic	
<i>moxifloxacin hcl in nacl</i>	1-Preferred Generics	
<i>ofloxacin (300 mg tab, 400 mg tab)</i>	2-Generic	
SULFONAMIDES		
<i>sulfacetamide sodium (acne)</i>	2-Generic	
SULFADIAZINE 500 MG TAB	4-Non-Preferred Drug	
<i>sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)</i>	1-Preferred Generics	
TETRACYCLINES		
<i>demeclocycline hcl</i>	1-Preferred Generics	
<i>doxy 100</i>	4-Non-Preferred Drug	
<i>doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg tab, 100 mg cap)</i>	2-Generic	
<i>doxycycline hyclate 100 mg recon soln</i>	4-Non-Preferred Drug	
<i>doxycycline monohydrate (25 mg/5ml recon susp, 50 mg tab, 50 mg cap, 75 mg tab, 100 mg tab, 100 mg cap, 150 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)</i>	2-Generic	
<i>mondoxylene nl 100 mg cap</i>	2-Generic	
<i>morgidox</i>	2-Generic	
<i>tetracycline hcl (250 mg cap, 500 mg cap)</i>	2-Generic	

ANTICONVULSANTS

ANTICONVULSANTS, OTHER

BRIVIACT (10 MG TAB, 10 MG/ML SOLUTION, 25 MG TAB, 50 MG TAB, 50 MG/5ML SOLUTION, 75 MG TAB, 100 MG TAB)	5-Specialty	
DIACOMIT (250 MG CAP, 250 MG PACKET, 500 MG PACKET, 500 MG CAP)	5-Specialty	
<i>divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>divalproex sodium er</i>	2-Generic	
EPIIDIOLEX	5-Specialty	PA - FOR NEW STARTS ONLY
<i>felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)</i>	4-Non-Preferred Drug	
FINTEPLA	5-Specialty	PA - FOR NEW STARTS ONLY
FYCOMPA (0.5 MG/ML SUSPENSION, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	3-Preferred Brands	
<i>levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)</i>	2-Generic	
<i>levetiracetam er</i>	2-Generic	
<i>levetiracetam in nacl</i>	4-Non-Preferred Drug	
<i>roweepra</i>	2-Generic	
<i>roweepra xr</i>	2-Generic	
SPRITAM	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)</i>	2-Generic	
<i>topiramate er</i>	4-Non-Preferred Drug	
<i>valproate sodium (100 mg/ml, 250 mg/5ml, 500 mg/5ml)</i>	2-Generic	
<i>valproic acid (250 mg cap, 250 mg/5ml solution)</i>	2-Generic	
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)	5-Specialty	
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	4-Non-Preferred Drug	
XCOPRI (250 MG DAILY DOSE)	5-Specialty	
XCOPRI (350 MG DAILY DOSE)	5-Specialty	

CALCIUM CHANNEL MODIFYING AGENTS

CELONTIN	3-Preferred Brands	
<i>ethosuximide (250 mg/5ml solution, 250 mg cap)</i>	2-Generic	

GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS

<i>clobazam 2.5 mg/ml suspension</i>	4-Non-Preferred Drug	QL (480 PER 30 DAYS)
<i>clobazam (10 mg tab, 20 mg tab)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)</i>	4-Non-Preferred Drug	
<i>gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)</i>	2-Generic	
NAYZILAM	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>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)</i>	2-Generic	
<i>primidone (50 mg tab, 250 mg tab)</i>	1-Preferred Generics	
SYMPAZAN	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>tiagabine hcl</i>	4-Non-Preferred Drug	
VALTOCO 10 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 15 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 20 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 5 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
<i>vigabatrin (500 mg tab, 500 mg packet)</i>	5-Specialty	
<i>vigadrone</i>	5-Specialty	
SODIUM CHANNEL AGENTS		
APTIOM	5-Specialty	
<i>carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)</i>	2-Generic	
<i>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)</i>	2-Generic	
DILANTIN 30 MG CAP	3-Preferred Brands	
<i>epitol</i>	2-Generic	
<i>fosphenytoin sodium</i>	4-Non-Preferred Drug	
<i>oxcarbazepine (150 mg tab, 300 mg/5ml suspension, 300 mg tab, 600 mg tab)</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)</i>	1-Preferred Generics	
<i>phenytoin infatabs</i>	1-Preferred Generics	
<i>phenytoin sodium 50 mg/ml solution</i>	1-Preferred Generics	
<i>phenytoin sodium extended</i>	1-Preferred Generics	
<i>rufinamide (40 mg/ml suspension, 200 mg tab, 400 mg tab)</i>	5-Specialty	
VIMPAT (10 MG/ML SOLUTION, 50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	3-Preferred Brands	
VIMPAT 200 MG/20ML SOLUTION	4-Non-Preferred Drug	
<i>zonisamide (25 mg cap, 50 mg cap, 100 mg cap)</i>	1-Preferred Generics	

ANTIDEMENTIA AGENTS

ANTIDEMENTIA AGENTS, OTHER

<i>ergoloid mesylates</i>	2-Generic	PA
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)	4-Non-Preferred Drug	

CHOLINESTERASE INHIBITORS

<i>donepezil hcl 23 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>donepezil hcl (5 mg tab, 5 mg tab disp, 10 mg tab, 10 mg tab disp)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>galantamine hydrobromide (4 mg tab, 4 mg/ml solution, 8 mg tab, 12 mg tab)</i>	2-Generic	
<i>galantamine hydrobromide er</i>	2-Generic	
<i>rivastigmine</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>rivastigmine tartrate</i>	2-Generic	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
<i>memantine hcl (2 mg/ml solution, 10 mg/5ml solution, 28 x 5 mg & 21 x 10 mg tab)</i>	2-Generic	
<i>memantine hcl (5 mg tab, 10 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>memantine hcl er</i>	2-Generic	QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
<i>bupropion hcl</i>	2-Generic	QL (120 PER 30 DAYS)
<i>bupropion hcl er (sr)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>bupropion hcl er (xl) 150 mg tab er 24h</i>	2-Generic	QL (90 PER 30 DAYS)
<i>bupropion hcl er (xl) 300 mg tab er 24h</i>	2-Generic	QL (30 PER 30 DAYS)
<i>bupropion hcl er (xl) 450 mg tab er 24h</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>chlordiazepoxide-amitriptyline</i>	4-Non-Preferred Drug	
<i>mirtazapine (15 mg tab, 15 mg tab disp)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>mirtazapine (30 mg tab disp, 30 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>mirtazapine (7.5 mg tab, 45 mg tab disp, 45 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>olanzapine-fluoxetine hcl</i>	4-Non-Preferred Drug	
<i>perphenazine-amitriptyline</i>	4-Non-Preferred Drug	
MONOAMINE OXIDASE INHIBITORS		
EMSAM	5-Specialty	
MARPLAN	3-Preferred Brands	
<i>phenelzine sulfate 15 mg tab</i>	1-Preferred Generics	
<i>tranylcypromine sulfate</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
<i>citalopram hydrobromide 10 mg/5ml solution</i>	2-Generic	QL (600 PER 30 DAYS)
<i>citalopram hydrobromide (20 mg tab, 40 mg tab)</i>	1-Preferred Generics	QL (45 PER 30 DAYS)
<i>citalopram hydrobromide 10 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
DESVENLAFAXINE ER	4-Non-Preferred Drug	
<i>desvenlafaxine succinate er</i>	2-Generic	
<i>escitalopram oxalate 5 mg/5ml solution</i>	2-Generic	QL (600 PER 30 DAYS)
<i>escitalopram oxalate 10 mg tab</i>	1-Preferred Generics	QL (45 PER 30 DAYS)
<i>escitalopram oxalate 20 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>escitalopram oxalate 5 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
FETZIMA	4-Non-Preferred Drug	
FETZIMA TITRATION	4-Non-Preferred Drug	
<i>fluoxetine hcl 10 mg cap</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>fluoxetine hcl 20 mg cap</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>fluoxetine hcl 40 mg cap</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>fluoxetine hcl 90 mg cap dr</i>	1-Preferred Generics	QL (4 PER 28 DAYS)
<i>fluoxetine hcl 20 mg/5ml solution</i>	1-Preferred Generics	
<i>fluoxetine hcl 10 mg tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>fluoxetine hcl 20 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluoxetine hcl 60 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>fluvoxamine maleate</i>	2-Generic	QL (90 PER 30 DAYS)
<i>fluvoxamine maleate er</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nefazodone hcl (50 mg tab, 100 mg tab, 250 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nefazodone hcl 150 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>nefazodone hcl 200 mg tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>paroxetine hcl (10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	1-Preferred Generics	
<i>paroxetine hcl er</i>	4-Non-Preferred Drug	
<i>paroxetine mesylate</i>	4-Non-Preferred Drug	
PAXIL 10 MG/5ML SUSPENSION	4-Non-Preferred Drug	
<i>sertraline hcl 20 mg/ml conc</i>	2-Generic	QL (300 PER 30 DAYS)
<i>sertraline hcl (25 mg tab, 50 mg tab)</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>sertraline hcl 100 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>trazodone hcl (50 mg tab, 100 mg tab, 150 mg tab, 300 mg tab)</i>	1-Preferred Generics	
TRINTELLIX	4-Non-Preferred Drug	
<i>venlafaxine hcl</i>	2-Generic	
<i>venlafaxine hcl er (er 150 mg tab er, er 150 mg cap er)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>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)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>venlafaxine hcl er 225 mg tab er 24h</i>	2-Generic	QL (30 PER 30 DAYS)
VIIBRYD	4-Non-Preferred Drug	
VIIBRYD STARTER PACK	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRICYCLICS		
<i>amitriptyline hcl</i>	2-Generic	
<i>amoxapine</i>	1-Preferred Generics	
<i>clomipramine hcl</i>	4-Non-Preferred Drug	
<i>desipramine hcl</i>	1-Preferred Generics	
<i>doxepin hcl (10 mg/ml conc, 10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)</i>	2-Generic	
<i>imipramine hcl (10 mg tab, 25 mg tab, 50 mg tab)</i>	2-Generic	
<i>imipramine pamoate</i>	2-Generic	
<i>nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)</i>	1-Preferred Generics	
<i>protriptyline hcl</i>	2-Generic	
<i>trimipramine maleate (25 mg cap, 50 mg cap, 100 mg cap)</i>	1-Preferred Generics	
ANTIEMETICS		
ANTIEMETICS, OTHER		
<i>compro</i>	2-Generic	
<i>meclizine hcl (12.5 mg tab, 25 mg tab)</i>	2-Generic	
<i>metoclopramide hcl (5 mg/5ml solution, 5 mg tab, 10 mg/10ml solution, 10 mg tab)</i>	1-Preferred Generics	
<i>perphenazine (2 mg tab, 4 mg tab, 8 mg tab, 16 mg tab)</i>	2-Generic	
<i>phenadoz 25 mg suppos</i>	2-Generic	
<i>prochlorperazine</i>	2-Generic	
<i>prochlorperazine edisylate (10 mg/2ml, 50 mg/10ml)</i>	4-Non-Preferred Drug	
<i>prochlorperazine maleate (5 mg tab, 10 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>promethazine hcl (12.5 mg, 25 mg)</i>	2-Generic	
<i>promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)</i>	1-Preferred Generics	PA
<i>promethegan</i>	2-Generic	
<i>scopolamine</i>	4-Non-Preferred Drug	QL (10 PER 30 DAYS)

EMETOGENIC THERAPY ADJUNCTS

<i>aprepitant (40 mg cap, 80 & 125 mg misc, 80 & 125 mg cap, 80 mg cap, 125 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>dronabinol</i>	4-Non-Preferred Drug	PA
EMEND 125 MG/5ML RECON SUSP	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>granisetron hcl 1 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
<i>ondansetron 4 mg tab disp</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
<i>ondansetron 8 mg tab disp</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
<i>ondansetron hcl 4 mg/5ml solution</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl 40 mg/20ml solution</i>	2-Generic	
<i>ondansetron hcl 24 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (30 PER 30 DAYS)
<i>ondansetron hcl 4 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
<i>ondansetron hcl 8 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
<i>ondansetron hcl inj 4 mg/2ml</i>	2-Generic	
SANCUSO	5-Specialty	ST, QL (4 PER 28 DAYS)

ANTIFUNGALS

ABELCET	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AMBISOME	5-Specialty	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>amphotericin b</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>caspofungin acetate</i>	4-Non-Preferred Drug	
<i>ciclopirox olamine (0.77 % suspension, 0.77 % cream)</i>	2-Generic	
<i>clotrimazole 1 % cream</i>	2-Generic	QL (90 PER 30 DAYS)
<i>clotrimazole 1 % solution</i>	2-Generic	QL (30 PER 30 DAYS)
<i>clotrimazole 10 mg troche</i>	2-Generic	
<i>econazole nitrate</i>	4-Non-Preferred Drug	QL (85 PER 30 DAYS)
<i>fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	2-Generic	
<i>fluconazole in sodium chloride (200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%)</i>	2-Generic	
<i>flucytosine</i>	5-Specialty	
<i>griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)</i>	2-Generic	
<i>griseofulvin ultramicronize</i>	2-Generic	
GYNAZOLE-1	3-Preferred Brands	
<i>itraconazole (10 mg/ml solution, 100 mg cap)</i>	4-Non-Preferred Drug	
<i>ketconazole 2 % cream</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ketconazole 2 % shampoo</i>	2-Generic	QL (120 PER 30 DAYS)
<i>ketconazole 200 mg tab</i>	2-Generic	
<i>micafungin sodium</i>	5-Specialty	
<i>naftifine hcl (1 %, 2 %)</i>	2-Generic	
NOXAFIL 40 MG/ML SUSPENSION	5-Specialty	
<i>nyamyc</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/gm ointment, 100000 unit/gm cream, 100000 unit/gm powder)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/ml suspension, 500000 unit tab)</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nystop</i>	2-Generic	QL (60 PER 30 DAYS)
<i>posaconazole</i>	5-Specialty	
<i>terbinafine hcl 250 mg tab</i>	2-Generic	
<i>terconazole (0.4 %, 0.8 %)</i>	2-Generic	
<i>terconazole 80 mg suppos</i>	1-Preferred Generics	
<i>voriconazole 200 mg recon soln</i>	5-Specialty	PA
<i>voriconazole (40 mg/ml recon susp, 50 mg tab, 200 mg tab)</i>	4-Non-Preferred Drug	

ANTIGOUT AGENTS

<i>allopurinol</i>	1-Preferred Generics	
<i>colchicine 0.6 mg tab</i>	2-Generic	
<i>colchicine-probenecid</i>	2-Generic	
<i>febuxostat</i>	2-Generic	ST
MITIGARE	3-Preferred Brands	
<i>probenecid</i>	2-Generic	

ANTIMIGRAINE AGENTS

ANTIMIGRAINE AGENTS, OTHER

AIMOVIG	4-Non-Preferred Drug	PA, QL (1 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN A-INJ	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN PRSYR	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	4-Non-Preferred Drug	PA, QL (2 PER 28 DAYS)
EMGALITY (300 MG DOSE)	4-Non-Preferred Drug	PA, QL (3 PER 28 DAYS)
UBRELVY	5-Specialty	ST, QL (16 PER 30 DAYS)

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on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ERGOT ALKALOIDS		
<i>dihydroergotamine mesylate 4 mg/ml solution</i>	5-Specialty	PA
<i>ergotamine-caffeine</i>	2-Generic	
SEROTONIN (5-HT) RECEPTOR AGONIST		
<i>almotriptan malate</i>	2-Generic	QL (9 PER 30 DAYS)
<i>frovatriptan succinate</i>	4-Non-Preferred Drug	QL (12 PER 30 DAYS)
<i>naratriptan hcl</i>	2-Generic	QL (9 PER 30 DAYS)
<i>rizatriptan benzoate (5 mg tab, 5 mg tab disp, 10 mg tab disp, 10 mg tab)</i>	2-Generic	QL (12 PER 30 DAYS)
<i>sumatriptan (5 mg/act, 20 mg/act)</i>	4-Non-Preferred Drug	QL (12 PER 28 DAYS)
<i>sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)</i>	4-Non-Preferred Drug	
<i>sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)</i>	2-Generic	QL (9 PER 30 DAYS)
<i>sumatriptan succinate refill</i>	4-Non-Preferred Drug	
<i>zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)</i>	2-Generic	QL (9 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
<i>pyridostigmine bromide (30 mg tab, 60 mg tab, 60 mg/5ml solution)</i>	2-Generic	
<i>pyridostigmine bromide er</i>	4-Non-Preferred Drug	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
<i>dapsone (25 mg tab, 100 mg tab)</i>	2-Generic	
<i>rifabutin</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTITUBERCULARS		
<i>ethambutol hcl</i>	2-Generic	
<i>isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)</i>	1-Preferred Generics	
PASER	4-Non-Preferred Drug	
PRETOMANID	3-Preferred Brands	
PRIFTIN	3-Preferred Brands	
<i>pyrazinamide 500 mg tab</i>	2-Generic	
<i>rifampin (150 mg cap, 300 mg cap, 600 mg recon soln)</i>	2-Generic	
SIRTURO	5-Specialty	
TRECTOR	4-Non-Preferred Drug	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
<i>busulfan</i>	5-Specialty	
<i>cyclophosphamide (25 mg cap, 25 mg tab, 50 mg cap, 50 mg tab)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution)</i>	4-Non-Preferred Drug	
LEUKERAN	3-Preferred Brands	
MATULANE	5-Specialty	
<i>melphalan</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>melphalan hcl</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TREANDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VALCHLOR	5-Specialty	QL (60 PER 30 DAYS)
YONDELIS	5-Specialty	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIANDROGENS		
<i>abiraterone acetate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
<i>bicalutamide</i>	2-Generic	QL (30 PER 30 DAYS)
ERLEADA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>flutamide</i>	2-Generic	
<i>nilutamide</i>	5-Specialty	
NUBEQA	5-Specialty	PA - FOR NEW STARTS ONLY
XTANDI (40 MG TAB, 40 MG CAP, 80 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
YONSA	5-Specialty	PA - FOR NEW STARTS ONLY
ZYTIGA 500 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY
ANTIANGIOGENIC AGENTS		
POMALYST	5-Specialty	PA - FOR NEW STARTS ONLY
REVLIMID	5-Specialty	PA - FOR NEW STARTS ONLY
THALOMID	5-Specialty	PA - FOR NEW STARTS ONLY
ANTIESTROGENS/MODIFIERS		
EMCYT	3-Preferred Brands	
<i>fulvestrant</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
SOLTAMOX	5-Specialty	
<i>tamoxifen citrate (10 mg tab, 20 mg tab)</i>	2-Generic	
<i>toremifene citrate</i>	5-Specialty	
ANTIMETABOLITES		
<i>adrucil</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
ALIMTA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>cladribine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>clofarabine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine (pf)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DROXIA	3-Preferred Brands	
<i>fluorouracil (1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
FOLOTYN 40 MG/2ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>gemcitabine hcl 1 gm recon soln</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>hydroxyurea 500 mg cap</i>	2-Generic	
INQOVI	5-Specialty	PA - FOR NEW STARTS ONLY
<i>mercaptopurine 50 mg tab</i>	2-Generic	
NIPENT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PURIXAN	3-Preferred Brands	
TABLOID	3-Preferred Brands	

ANTINEOPLASTICS, OTHER

ABRAXANE	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>adriamycin 2 mg/ml solution</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ARRANON	5-Specialty	
<i>arsenic trioxide 10 mg/10ml solution</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
AYVAKIT	5-Specialty	PA - FOR NEW STARTS ONLY
<i>azacitidine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>bleomycin sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
BORTEZOMIB	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BRUKINSA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>carboplatin</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cisplatin</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>dacarbazine 200 mg recon soln</i>	4-Non-Preferred Drug	
<i>dactinomycin</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>daunorubicin hcl 20 mg/4ml solution</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>decitabine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>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)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>doxorubicin hcl 2 mg/ml solution</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>doxorubicin hcl liposomal</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>epirubicin hcl</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ERWINAZE	5-Specialty	
<i>fludarabine phosphate 50 mg recon soln</i>	4-Non-Preferred Drug	
FOTIVDA	5-Specialty	PA - FOR NEW STARTS ONLY
HALAVEN	5-Specialty	
<i>idarubicin hcl</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IDHIFA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>irinotecan hcl</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ISTODAX (OVERFILL)	5-Specialty	
KISQALI FEMARA (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA(200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LONSURF	5-Specialty	PA - FOR NEW STARTS ONLY
LUMAKRAS	5-Specialty	PA - FOR NEW STARTS ONLY
<i>mitomycin (5 mg soln, 20 mg soln, 40 mg soln)</i>	4-Non-Preferred Drug	
<i>mitoxantrone hcl</i>	4-Non-Preferred Drug	
<i>mutamycin</i>	4-Non-Preferred Drug	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NINLARO	5-Specialty	PA - FOR NEW STARTS ONLY
ONUREG	5-Specialty	PA - FOR NEW STARTS ONLY
<i>oxaliplatin (50 mg/10ml solution, 50 mg recon soln, 100 mg/20ml solution, 100 mg recon soln)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>paclitaxel</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>paraplatin</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
QINLOCK	5-Specialty	PA - FOR NEW STARTS ONLY
RETEVMO	5-Specialty	PA - FOR NEW STARTS ONLY
ROMIDEPSIN 10 MG RECON SOLN	5-Specialty	
SYNRIBO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TABRECTA	5-Specialty	PA - FOR NEW STARTS ONLY
TAZVERIK	5-Specialty	PA - FOR NEW STARTS ONLY
VELCADE	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>vinblastine sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vincasar pfs</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vincristine sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vinorelbine tartrate 50 mg/5ml solution</i>	4-Non-Preferred Drug	
VYXEOS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
XPOVIO (100 MG ONCE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG ONCE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (60 MG ONCE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (60 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG ONCE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
ZALTRAP 100 MG/4ML SOLUTION	5-Specialty	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZANOSAR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ZOLINZA	5-Specialty	PA - FOR NEW STARTS ONLY
AROMATASE INHIBITORS, 3RD GENERATION		
<i>anastrozole</i>	2-Generic	QL (30 PER 30 DAYS)
<i>exemestane</i>	2-Generic	
<i>letrozole 2.5 mg tab</i>	2-Generic	
ENZYME INHIBITORS		
<i>etoposide (1 gm/50ml, 100 mg/5ml, 500 mg/25ml)</i>	2-Generic	
<i>toposar</i>	2-Generic	
<i>topotecan hcl 4 mg recon soln</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MOLECULAR TARGET INHIBITORS		
AFINITOR 10 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY
AFINITOR DISPERZ	5-Specialty	PA - FOR NEW STARTS ONLY
ALECENSA	5-Specialty	PA - FOR NEW STARTS ONLY
ALIQOPA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ALUNBRIG (30 MG TAB, 90 MG TAB, 90 & 180 MG TAB THPK, 180 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
BALVERSA	5-Specialty	PA - FOR NEW STARTS ONLY
BOSULIF	5-Specialty	PA - FOR NEW STARTS ONLY
BRAFTOVI 75 MG CAP	5-Specialty	PA - FOR NEW STARTS ONLY
CABOMETYX	5-Specialty	PA - FOR NEW STARTS ONLY
CALQUENCE	5-Specialty	PA - FOR NEW STARTS ONLY
CAPRELSA	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (100 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (140 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (60 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COPIKTRA	5-Specialty	PA - FOR NEW STARTS ONLY
COTELLIC	5-Specialty	PA - FOR NEW STARTS ONLY

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CYRAMZA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DAURISMO	5-Specialty	PA - FOR NEW STARTS ONLY
ERIVEDGE	5-Specialty	PA - FOR NEW STARTS ONLY
<i>erlotinib hcl</i>	5-Specialty	PA - FOR NEW STARTS ONLY
<i>everolimus (2.5 mg tab, 5 mg tab, 7.5 mg tab)</i>	5-Specialty	PA - FOR NEW STARTS ONLY
FARYDAK	5-Specialty	PA - FOR NEW STARTS ONLY
GAVRETO	5-Specialty	PA - FOR NEW STARTS ONLY
GILOTRIF	5-Specialty	PA - FOR NEW STARTS ONLY
IBRANCE (75 MG TAB, 75 MG CAP, 100 MG CAP, 100 MG TAB, 125 MG TAB, 125 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
ICLUSIG	5-Specialty	PA - FOR NEW STARTS ONLY
<i>imatinib mesylate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
IMBRUVICA (70 MG CAP, 140 MG TAB, 140 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
INLYTA	5-Specialty	PA - FOR NEW STARTS ONLY
INREBIC	5-Specialty	PA - FOR NEW STARTS ONLY
IRESSA	5-Specialty	PA - FOR NEW STARTS ONLY
JAKAFI	5-Specialty	PA - FOR NEW STARTS ONLY
JEVTANA	5-Specialty	
KISQALI (200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KOSELUGO	5-Specialty	PA - FOR NEW STARTS ONLY
KYPROLIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>lapatinib ditosylate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (10 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (12 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (14 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (18 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LENVIMA (20 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (24 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (4 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (8 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LORBRENA	5-Specialty	PA - FOR NEW STARTS ONLY
LYNPARZA	5-Specialty	PA - FOR NEW STARTS ONLY
MEKINIST	5-Specialty	PA - FOR NEW STARTS ONLY
MEKTOVI	5-Specialty	PA - FOR NEW STARTS ONLY
NERLYNX	5-Specialty	PA - FOR NEW STARTS ONLY
NEXAVAR	5-Specialty	PA - FOR NEW STARTS ONLY
ODOMZO	5-Specialty	PA - FOR NEW STARTS ONLY
PEMAZYRE	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (200 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (250 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (300 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
ROZLYTREK	5-Specialty	PA - FOR NEW STARTS ONLY
RUBRACA	5-Specialty	PA - FOR NEW STARTS ONLY
RYDAPT	5-Specialty	PA - FOR NEW STARTS ONLY
SPRYCEL	5-Specialty	PA - FOR NEW STARTS ONLY
STIVARGA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>sunitinib malate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
SUTENT	5-Specialty	PA - FOR NEW STARTS ONLY
TAFINLAR	5-Specialty	PA - FOR NEW STARTS ONLY
TAGRISSO	5-Specialty	PA - FOR NEW STARTS ONLY
TALZENNA	5-Specialty	PA - FOR NEW STARTS ONLY
TASIGNA	5-Specialty	PA - FOR NEW STARTS ONLY
TEPMETKO	5-Specialty	PA - FOR NEW STARTS ONLY
TIBSOVO	5-Specialty	PA - FOR NEW STARTS ONLY
TUKYSA	5-Specialty	PA - FOR NEW STARTS ONLY
TURALIO	5-Specialty	PA - FOR NEW STARTS ONLY

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
UKONIQ	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA (10 MG TAB, 50 MG TAB)	3-Preferred Brands	PA - FOR NEW STARTS ONLY
VENCLEXTA 100 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK	5-Specialty	PA - FOR NEW STARTS ONLY
VERZENIO	5-Specialty	PA - FOR NEW STARTS ONLY
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
VIZIMPRO	5-Specialty	PA - FOR NEW STARTS ONLY
VOTRIENT	5-Specialty	PA - FOR NEW STARTS ONLY
XALKORI	5-Specialty	PA - FOR NEW STARTS ONLY
XOSPATA	5-Specialty	PA - FOR NEW STARTS ONLY
ZEJULA	5-Specialty	PA - FOR NEW STARTS ONLY
ZELBORAF	5-Specialty	PA - FOR NEW STARTS ONLY
ZYDELIG	5-Specialty	PA - FOR NEW STARTS ONLY
ZYKADIA 150 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY

MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE

AVASTIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BAVENCIO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DARZALEX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
EMPLICITI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ERBITUX 100 MG/50ML SOLUTION	5-Specialty	
HERCEPTIN HYLECTA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
HERZUMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IMFINZI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KADCYLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KANJINTI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KEYTRUDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MVASI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MYLOTARG	5-Specialty	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OGIVRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ONTRUZANT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OPDIVO (40 MG/4ML, 100 MG/10ML, 240 MG/24ML)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PERJETA	5-Specialty	
RITUXAN HYCELA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RUXIENCE	5-Specialty	PA - TO CONFIRM PART D COVERAGE
SYLVANT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TECENTRIQ	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRAZIMERA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRUXIMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VECTIBIX 100 MG/5ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
YERVOY 50 MG/10ML SOLUTION	5-Specialty	
ZIRABEV	5-Specialty	PA - TO CONFIRM PART D COVERAGE

RETINOIDS

<i>bexarotene</i>	5-Specialty	PA - FOR NEW STARTS ONLY
TARGRETIN 1 % GEL	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>tretinoin 10 mg cap</i>	5-Specialty	

TREATMENT ADJUNCTS

<i>leucovorin calcium (50 mg soln, 100 mg soln, 200 mg soln, 350 mg soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)</i>	2-Generic	
<i>levoleucovorin calcium 50 mg recon soln</i>	5-Specialty	
<i>levoleucovorin calcium pf</i>	5-Specialty	
<i>mesna</i>	4-Non-Preferred Drug	
MESNEX 400 MG TAB	5-Specialty	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPARASITICS		
ANTHELMINTHICS		
<i>albendazole</i>	5-Specialty	
<i>ivermectin 3 mg tab</i>	2-Generic	
<i>praziquantel 600 mg tab</i>	2-Generic	
ANTIPROTOZOALS		
<i>atovaquone</i>	4-Non-Preferred Drug	
<i>atovaquone-proguanil hcl</i>	2-Generic	
BENZNIDAZOLE	4-Non-Preferred Drug	
<i>chloroquine phosphate</i>	2-Generic	
COARTEM	3-Preferred Brands	
<i>hydroxychloroquine sulfate 200 mg tab</i>	2-Generic	
<i>mefloquine hcl</i>	2-Generic	
<i>nitazoxanide 500 mg tab</i>	4-Non-Preferred Drug	
<i>pentamidine isethionate</i>	2-Generic	
<i>pentamidine isethionate 300 mg inject soln</i>	2-Generic	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>primaquine phosphate</i>	2-Generic	
<i>pyrimethamine 25 mg tab</i>	5-Specialty	
<i>quinine sulfate 324 mg cap</i>	4-Non-Preferred Drug	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
<i>benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)</i>	1-Preferred Generics	
ANTIPARKINSON AGENTS, OTHER		
<i>amantadine hcl (50 mg/5ml solution, 50 mg/5ml syrup, 100 mg tab, 100 mg cap)</i>	2-Generic	
<i>carbidopa-levodopa-entacapone</i>	2-Generic	
<i>entacapone</i>	4-Non-Preferred Drug	
<i>tolcapone</i>	5-Specialty	
DOPAMINE AGONISTS		
APOKYN	5-Specialty	
<i>bromocriptine mesylate (2.5 mg tab, 5 mg cap)</i>	2-Generic	
NEUPRO	4-Non-Preferred Drug	
<i>pramipexole dihydrochloride</i>	1-Preferred Generics	
<i>pramipexole dihydrochloride er</i>	2-Generic	
<i>ropinirole hcl</i>	1-Preferred Generics	
<i>ropinirole hcl er</i>	2-Generic	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	4-Non-Preferred Drug	
<i>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)</i>	2-Generic	
<i>carbidopa-levodopa er</i>	2-Generic	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
<i>rasagiline mesylate</i>	4-Non-Preferred Drug	
<i>selegiline hcl (5 mg cap, 5 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
<i>chlorpromazine hcl (25 mg/ml, 50 mg/2ml)</i>	4-Non-Preferred Drug	
<i>chlorpromazine hcl (10 mg tab, 25 mg tab, 30 mg/ml conc, 50 mg tab, 100 mg tab, 100 mg/ml conc, 200 mg tab)</i>	2-Generic	
<i>fluphenazine decanoate 25 mg/ml solution</i>	4-Non-Preferred Drug	
<i>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)</i>	2-Generic	
<i>haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	2-Generic	
<i>haloperidol decanoate (50 mg/ml, 100 mg/ml)</i>	2-Generic	
<i>haloperidol lactate (2 mg/ml conc, 5 mg/ml solution)</i>	2-Generic	
<i>loxapine succinate</i>	2-Generic	
<i>molindone hcl</i>	2-Generic	
<i>pimozide</i>	2-Generic	
<i>thioridazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	2-Generic	
<i>thiothixene</i>	2-Generic	
<i>trifluoperazine hcl</i>	2-Generic	
2ND GENERATION/ATYPICAL		
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG SRER, 400 MG PRSYR)	5-Specialty	QL (1 PER 28 DAYS)
ABILIFY MYCITE (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 30 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ABILIFY MYCITE 2 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ABILIFY MYCITE MAINTENANCE KIT (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 30 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ABILIFY MYCITE MAINTENANCE KIT 2 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
ABILIFY MYCITE STARTER KIT (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 30 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ABILIFY MYCITE STARTER KIT 2 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	2-Generic	
<i>aripiprazole (10 mg tab disp, 15 mg tab disp)</i>	4-Non-Preferred Drug	
ARISTADA 1064 MG/3.9ML PRSYR	5-Specialty	QL (3.9 PER 56 DAYS)
ARISTADA 441 MG/1.6ML PRSYR	5-Specialty	QL (1.6 PER 28 DAYS)
ARISTADA 662 MG/2.4ML PRSYR	5-Specialty	QL (2.4 PER 28 DAYS)
ARISTADA 882 MG/3.2ML PRSYR	5-Specialty	QL (3.2 PER 28 DAYS)
ARISTADA INITIO	5-Specialty	
<i>asenapine maleate</i>	4-Non-Preferred Drug	
CAPLYTA	5-Specialty	QL (30 PER 30 DAYS)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB)	4-Non-Preferred Drug	
FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5-Specialty	
FANAPT TITRATION PACK	4-Non-Preferred Drug	
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	5-Specialty	QL (0.75 PER 28 DAYS)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	5-Specialty	QL (1 PER 28 DAYS)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	5-Specialty	QL (1.5 PER 28 DAYS)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	3-Preferred Brands	QL (0.25 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	3-Preferred Brands	QL (0.5 PER 28 DAYS)
INVEGA TRINZA 273 MG/0.875ML SUSP PRSYR	5-Specialty	QL (0.88 PER 84 DAYS)
INVEGA TRINZA 410 MG/1.315ML SUSP PRSYR	5-Specialty	QL (1.32 PER 84 DAYS)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	5-Specialty	QL (1.75 PER 84 DAYS)
INVEGA TRINZA 819 MG/2.625ML SUSP PRSYR	5-Specialty	QL (2.62 PER 84 DAYS)
LATUDA	5-Specialty	
NUPLAZID (10 MG TAB, 34 MG CAP)	5-Specialty	QL (30 PER 30 DAYS)
<i>olanzapine (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab, 10 mg recon soln, 15 mg tab, 20 mg tab)</i>	1-Preferred Generics	
<i>olanzapine (5 mg tab disp, 10 mg tab disp, 15 mg tab disp, 20 mg tab disp)</i>	2-Generic	
<i>paliperidone er 1.5 mg tab er 24h</i>	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
<i>paliperidone er 3 mg tab er 24h</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>paliperidone er 6 mg tab er 24h</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>paliperidone er 9 mg tab er 24h</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
PERSERIS	5-Specialty	QL (1 PER 28 DAYS)
<i>quetiapine fumarate</i>	2-Generic	
<i>quetiapine fumarate er</i>	2-Generic	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
RISPERDAL CONSTA (12.5 MG, 25 MG)	4-Non-Preferred Drug	
RISPERDAL CONSTA (37.5 MG, 50 MG)	5-Specialty	
<i>risperidone 1 mg/ml solution</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>risperidone (0.25 mg tab, 0.5 mg tab, 1 mg tab, 2 mg tab, 3 mg tab, 4 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>risperidone (0.25 mg tab disp, 2 mg tab disp, 4 mg tab disp)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>risperidone 0.5 mg tab disp</i>	2-Generic	QL (120 PER 30 DAYS)
<i>risperidone 1 mg tab disp</i>	2-Generic	QL (30 PER 30 DAYS)
<i>risperidone 3 mg tab disp</i>	2-Generic	QL (90 PER 30 DAYS)
<i>risperidone m-tab (2 mg tab disp, 4 mg tab disp)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>risperidone m-tab 0.5 mg tab disp</i>	2-Generic	QL (120 PER 30 DAYS)
<i>risperidone m-tab 1 mg tab disp</i>	2-Generic	QL (30 PER 30 DAYS)
<i>risperidone m-tab 3 mg tab disp</i>	2-Generic	QL (90 PER 30 DAYS)
SECUADO	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	5-Specialty	QL (30 PER 30 DAYS)
VRAYLAR 1.5 & 3 MG CAP THPK	4-Non-Preferred Drug	
<i>ziprasidone hcl</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ziprasidone mesylate</i>	2-Generic	
ZYPREXA RELPREVV	4-Non-Preferred Drug	

TREATMENT-RESISTANT

<i>clozapine (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)</i>	2-Generic	
<i>clozapine (12.5 mg tab disp, 25 mg tab disp, 100 mg tab disp, 150 mg tab disp, 200 mg tab disp)</i>	4-Non-Preferred Drug	
VERSACLOZ	4-Non-Preferred Drug	

ANTISPASTICITY AGENTS

<i>baclofen (5 mg tab, 10 mg tab, 20 mg tab)</i>	2-Generic	
<i>dantrolene sodium (25 mg cap, 50 mg cap, 100 mg cap)</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tizanidine hcl (2 mg tab, 4 mg tab)</i>	2-Generic	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS (240 MG TAB, 480 MG TAB)	5-Specialty	QL (28 PER 28 DAYS)
<i>valganciclovir hcl 50 mg/ml recon soln</i>	5-Specialty	
<i>valganciclovir hcl 450 mg tab</i>	2-Generic	
ANTI-HEPATITIS B (HBV) AGENTS		
<i>adefovir dipivoxil</i>	5-Specialty	
BARACLUDE 0.05 MG/ML SOLUTION	4-Non-Preferred Drug	QL (600 PER 30 DAYS)
<i>entecavir</i>	4-Non-Preferred Drug	
EPIVIR HBV 5 MG/ML SOLUTION	3-Preferred Brands	
<i>lamivudine 100 mg tab</i>	1-Preferred Generics	
VEMLIDY	5-Specialty	
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA 200-50 MG TAB	5-Specialty	PA, QL (56 PER 28 DAYS)
EPCLUSA 400-100 MG TAB	5-Specialty	PA, QL (28 PER 28 DAYS)
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	5-Specialty	PA, QL (28 PER 28 DAYS)
HARVONI (45-200 MG PACKET, 45-200 MG TAB)	5-Specialty	PA, QL (56 PER 28 DAYS)
MAVYRET	5-Specialty	PA, QL (84 PER 28 DAYS)
<i>ribavirin (200 mg cap, 200 mg tab)</i>	2-Generic	
SOFOSBUVIR-VELPATASVIR	5-Specialty	PA, QL (28 PER 28 DAYS)
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY	5-Specialty	QL (30 PER 30 DAYS)
DOVATO	5-Specialty	QL (30 PER 30 DAYS)
GENVOYA	5-Specialty	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB, 100 MG PACKET)	3-Preferred Brands	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	5-Specialty	QL (60 PER 30 DAYS)
ISENTRESS HD	5-Specialty	QL (60 PER 30 DAYS)
JULUCA	5-Specialty	QL (30 PER 30 DAYS)
STRIBILD	5-Specialty	QL (30 PER 30 DAYS)
TIVICAY (25 MG TAB, 50 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
TIVICAY 10 MG TAB	3-Preferred Brands	QL (60 PER 30 DAYS)
TIVICAY PD	5-Specialty	QL (180 PER 30 DAYS)

ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)

COMPLERA	5-Specialty	QL (30 PER 30 DAYS)
DELSTRIGO	5-Specialty	QL (30 PER 30 DAYS)
EDURANT	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>efavirenz 200 mg cap</i>	2-Generic	QL (90 PER 30 DAYS)
<i>efavirenz 50 mg cap</i>	2-Generic	QL (240 PER 30 DAYS)
<i>efavirenz 600 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>efavirenz-emtricitab-tenofovir</i>	5-Specialty	QL (30 PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir</i>	5-Specialty	QL (30 PER 30 DAYS)
<i>etravirine</i>	2-Generic	
INTELENCE (100 MG TAB, 200 MG TAB)	3-Preferred Brands	QL (60 PER 30 DAYS)
INTELENCE 25 MG TAB	3-Preferred Brands	QL (120 PER 30 DAYS)
<i>nevirapine 50 mg/5ml suspension</i>	1-Preferred Generics	
<i>nevirapine 200 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>nevirapine er 100 mg tab er 24h</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>nevirapine er 400 mg tab er 24h</i>	1-Preferred Generics	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ODEFSEY	5-Specialty	QL (30 PER 30 DAYS)
PIFELTRO	5-Specialty	QL (60 PER 30 DAYS)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
<i>abacavir sulfate 20 mg/ml solution</i>	1-Preferred Generics	
<i>abacavir sulfate 300 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>abacavir sulfate-lamivudine</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>abacavir-lamivudine-zidovudine</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
CIMDUO	3-Preferred Brands	QL (30 PER 30 DAYS)
DESCOVY	5-Specialty	QL (30 PER 30 DAYS)
<i>emtricitabine</i>	2-Generic	QL (30 PER 30 DAYS)
<i>emtricitabine-tenofovir df</i>	5-Specialty	QL (30 PER 30 DAYS)
EMTRIVA 10 MG/ML SOLUTION	3-Preferred Brands	
<i>lamivudine 10 mg/ml solution</i>	1-Preferred Generics	
<i>lamivudine 150 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>lamivudine 300 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>lamivudine-zidovudine</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
TEMIXYS	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>tenofovir disoproxil fumarate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
TRIUMEQ	5-Specialty	QL (30 PER 30 DAYS)
VIREAD 40 MG/GM POWDER	3-Preferred Brands	
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>zidovudine 100 mg cap</i>	1-Preferred Generics	QL (180 PER 30 DAYS)
<i>zidovudine 50 mg/5ml syrup</i>	1-Preferred Generics	
<i>zidovudine 300 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)

ANTI-HIV AGENTS, OTHER

CABENUVA	5-Specialty	
FUZEON	5-Specialty	QL (60 PER 30 DAYS)
RUKOBIA	5-Specialty	QL (60 PER 30 DAYS)
SELZENTRY (20 MG/ML SOLUTION, 25 MG TAB, 75 MG TAB, 150 MG TAB, 300 MG TAB)	3-Preferred Brands	
TROGARZO	5-Specialty	
TYBOST	3-Preferred Brands	QL (30 PER 30 DAYS)

ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)

APTIVUS 250 MG CAP	3-Preferred Brands	QL (120 PER 30 DAYS)
<i>atazanavir sulfate (150 mg cap, 200 mg cap)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>atazanavir sulfate 300 mg cap</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
EVOTAZ	5-Specialty	QL (30 PER 30 DAYS)
<i>fosamprenavir calcium</i>	2-Generic	
INVIRASE 500 MG TAB	3-Preferred Brands	
KALETRA (100-25 MG TAB, 200-50 MG TAB)	3-Preferred Brands	
LEXIVA 50 MG/ML SUSPENSION	3-Preferred Brands	
<i>lopinavir-ritonavir 400-100 mg/5ml solution</i>	1-Preferred Generics	
<i>lopinavir-ritonavir (100-25 mg tab, 200-50 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NORVIR 100 MG PACKET	3-Preferred Brands	QL (360 PER 30 DAYS)
NORVIR 80 MG/ML SOLUTION	3-Preferred Brands	
PREZCOBIX	5-Specialty	
PREZISTA (100 MG/ML SUSPENSION, 600 MG TAB, 800 MG TAB)	5-Specialty	
PREZISTA (75 MG TAB, 150 MG TAB)	3-Preferred Brands	
REYATAZ 50 MG PACKET	3-Preferred Brands	
<i>ritonavir</i>	2-Generic	QL (360 PER 30 DAYS)
SYM TUZA	5-Specialty	QL (30 PER 30 DAYS)
VIRACEPT 250 MG TAB	3-Preferred Brands	QL (270 PER 30 DAYS)
VIRACEPT 625 MG TAB	3-Preferred Brands	QL (120 PER 30 DAYS)

ANTI-INFLUENZA AGENTS

<i>oseltamivir phosphate (6 mg/ml recon susp, 30 mg cap, 45 mg cap, 75 mg cap)</i>	2-Generic	
RELENZA DISKHALER	3-Preferred Brands	
<i>rimantadine hcl</i>	2-Generic	

ANTIHERPETIC AGENTS

<i>acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab)</i>	2-Generic	
<i>acyclovir sodium 50 mg/ml solution</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>famciclovir</i>	2-Generic	QL (90 PER 30 DAYS)
<i>trifluridine 1 % solution</i>	2-Generic	
<i>valacyclovir hcl (1 gm tab, 500 mg tab)</i>	2-Generic	QL (120 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
<i>bupirone hcl</i>	2-Generic	
<i>hydroxyzine pamoate (25 mg cap, 50 mg cap, 100 mg cap)</i>	2-Generic	
BENZODIAZEPINES		
<i>alprazolam (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 0.5 mg tab disp)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>alprazolam (1 mg tab disp, 1 mg tab, 2 mg tab disp, 2 mg tab)</i>	2-Generic	QL (150 PER 30 DAYS)
ALPRAZOLAM INTENSOL	2-Generic	QL (300 PER 30 DAYS)
<i>chlordiazepoxide hcl 10 mg cap</i>	4-Non-Preferred Drug	QL (300 PER 30 DAYS)
<i>chlordiazepoxide hcl 25 mg cap</i>	4-Non-Preferred Drug	QL (360 PER 30 DAYS)
<i>chlordiazepoxide hcl 5 mg cap</i>	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
<i>clonazepam (2 mg tab, 2 mg tab disp)</i>	2-Generic	QL (300 PER 30 DAYS)
<i>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)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>clorazepate dipotassium 15 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)
<i>diazepam 5 mg/ml conc</i>	2-Generic	QL (240 PER 30 DAYS)
<i>diazepam 5 mg/5ml solution</i>	2-Generic	QL (1200 PER 30 DAYS)
<i>diazepam (2 mg tab, 5 mg tab, 10 mg tab)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>diazepam intensol</i>	2-Generic	QL (240 PER 30 DAYS)
<i>lorazepam (2 mg tab, 2 mg/ml conc)</i>	2-Generic	QL (150 PER 30 DAYS)
<i>lorazepam 0.5 mg tab</i>	2-Generic	QL (600 PER 30 DAYS)
<i>lorazepam 1 mg tab</i>	2-Generic	QL (300 PER 30 DAYS)
<i>lorazepam intensol</i>	2-Generic	QL (150 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>oxazepam</i>	2-Generic	QL (120 PER 30 DAYS)

BIPOLAR AGENTS

MOOD STABILIZERS

<i>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)</i>	1-Preferred Generics	
<i>lamotrigine er</i>	4-Non-Preferred Drug	
<i>lamotrigine starter kit-blue</i>	1-Preferred Generics	
<i>lamotrigine starter kit-green</i>	1-Preferred Generics	
<i>lamotrigine starter kit-orange</i>	1-Preferred Generics	
LITHIUM	2-Generic	
<i>lithium carbonate (150 mg cap, 300 mg tab, 300 mg cap, 600 mg cap)</i>	1-Preferred Generics	
<i>lithium carbonate er</i>	1-Preferred Generics	
<i>subvenite</i>	1-Preferred Generics	
<i>subvenite starter kit-blue</i>	1-Preferred Generics	
<i>subvenite starter kit-green</i>	1-Preferred Generics	
<i>subvenite starter kit-orange</i>	1-Preferred Generics	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>alogliptin benzoate</i>	2-Generic	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>alogliptin-metformin hcl</i>	2-Generic	QL (60 PER 30 DAYS)
<i>alogliptin-pioglitazone</i>	2-Generic	QL (30 PER 30 DAYS)
BYDUREON 2 MG PEN	3-Preferred Brands	QL (4 PER 28 DAYS)
BYDUREON BCISE	3-Preferred Brands	QL (3.4 PER 28 DAYS)
BYETTA 10 MCG PEN	3-Preferred Brands	QL (2.4 PER 30 DAYS)
BYETTA 5 MCG PEN	3-Preferred Brands	QL (1.2 PER 30 DAYS)
CYCLOSET	3-Preferred Brands	
FARXIGA	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>glimepiride (1 mg tab, 2 mg tab)</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glimepiride 4 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>glipizide</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glipizide er 10 mg tab er 24h</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>glipizide er 2.5 mg tab er 24h</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glipizide er 5 mg tab er 24h</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>glipizide xl 10 mg tab er 24h</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>glipizide xl 2.5 mg tab er 24h</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glipizide xl 5 mg tab er 24h</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>glipizide-metformin hcl</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glyburide (1.25 mg tab, 2.5 mg tab, 5 mg tab)</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>glyburide micronized</i>	1-Preferred Generics	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>glyburide-metformin</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
GLYXAMBI	3-Preferred Brands	QL (30 PER 30 DAYS)
JANUMET	3-Preferred Brands	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER, 50-500 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
JANUVIA	3-Preferred Brands	QL (30 PER 30 DAYS)
JARDIANCE	3-Preferred Brands	QL (30 PER 30 DAYS)
JENTADUETO	3-Preferred Brands	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	3-Preferred Brands	QL (60 PER 30 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>metformin hcl 1000 mg tab</i>	1-Preferred Generics	QL (75 PER 30 DAYS)
<i>metformin hcl 500 mg tab</i>	1-Preferred Generics	QL (150 PER 30 DAYS)
<i>metformin hcl 850 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>metformin hcl er 500 mg tab er 24h</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>metformin hcl er 750 mg tab er 24h</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>miglitol</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>nateglinide 120 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>nateglinide 60 mg tab</i>	1-Preferred Generics	QL (180 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE)	3-Preferred Brands	QL (1.5 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OZEMPIC (1 MG/DOSE)	3-Preferred Brands	QL (3 PER 28 DAYS)
<i>pioglitazone hcl</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-glimepiride</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>pioglitazone hcl-metformin hcl</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>repaglinide (0.5 mg tab, 1 mg tab)</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>repaglinide 2 mg tab</i>	1-Preferred Generics	QL (240 PER 30 DAYS)
RYBELSUS	3-Preferred Brands	QL (30 PER 30 DAYS)
SOLIQUA	3-Preferred Brands	QL (18 PER 30 DAYS)
SYMLINPEN 120	5-Specialty	QL (10.8 PER 30 DAYS)
SYMLINPEN 60	5-Specialty	QL (6 PER 30 DAYS)
SYNJARDY (5-1000 MG TAB, 12.5-500 MG TAB, 12.5-1000 MG TAB)	3-Preferred Brands	QL (60 PER 30 DAYS)
SYNJARDY 5-500 MG TAB	3-Preferred Brands	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER, 10-1000 MG TAB ER, 12.5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
TRADJENTA	3-Preferred Brands	QL (30 PER 30 DAYS)
TRIJARDY XR (10-5-1000 MG TAB ER, 25-5-1000 MG TAB ER)	3-Preferred Brands	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1000 MG TAB ER, 12.5-2.5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN, 1.5 MG/0.5ML SOLN)	3-Preferred Brands	QL (2 PER 28 DAYS)
TRULICITY (3 MG/0.5ML SOLN, 4.5 MG/0.5ML SOLN)	3-Preferred Brands	QL (2 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VICTOZA	3-Preferred Brands	QL (9 PER 30 DAYS)
XIGDUO XR (10-500 MG TAB ER, 10-1000 MG TAB ER)	3-Preferred Brands	QL (30 PER 30 DAYS)
XIGDUO XR (2.5-1000 MG TAB ER, 5-500 MG TAB ER, 5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
GLYCEMIC AGENTS		
<i>diazoxide</i>	4-Non-Preferred Drug	
GLUCAGEN HYPOKIT	3-Preferred Brands	
GLUCAGON EMERGENCY (1 MG KIT, 1 MG/ML RECON SOLN)	3-Preferred Brands	
<i>glucagon emergency 1 mg kit (generic)</i>	3-Preferred Brands	
GVOKE HYPOPEN 1-PACK	3-Preferred Brands	
GVOKE HYPOPEN 2-PACK	3-Preferred Brands	
GVOKE PFS	3-Preferred Brands	
INSULINS		
HUMALOG (100 UNIT/ML SOLUTION, 100 UNIT/ML SOLN CART)	3-Preferred Brands	
HUMALOG JUNIOR KWIKPEN	3-Preferred Brands	
HUMALOG KWIKPEN	3-Preferred Brands	
HUMALOG MIX 50/50	3-Preferred Brands	
HUMALOG MIX 50/50 KWIKPEN	3-Preferred Brands	
HUMALOG MIX 75/25	3-Preferred Brands	
HUMALOG MIX 75/25 KWIKPEN	3-Preferred Brands	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMULIN 70/30	3-Preferred Brands	
HUMULIN 70/30 KWIKPEN	3-Preferred Brands	
HUMULIN N	3-Preferred Brands	
HUMULIN N KWIKPEN	3-Preferred Brands	
HUMULIN R	3-Preferred Brands	
HUMULIN R U-500 (CONCENTRATED)	3-Preferred Brands	
HUMULIN R U-500 KWIKPEN	3-Preferred Brands	
INSULIN LISPRO	3-Preferred Brands	
INSULIN LISPRO (1 UNIT DIAL)	3-Preferred Brands	
INSULIN LISPRO JUNIOR KWIKPEN	3-Preferred Brands	
INSULIN LISPRO PROT & LISPRO	3-Preferred Brands	
LANTUS	3-Preferred Brands	QL (40 PER 30 DAYS)
LANTUS SOLOSTAR	3-Preferred Brands	QL (45 PER 30 DAYS)
LEVEMIR	3-Preferred Brands	QL (40 PER 30 DAYS)
LEVEMIR FLEXTOUCH	3-Preferred Brands	QL (45 PER 30 DAYS)
LYUMJEV	3-Preferred Brands	
LYUMJEV KWIKPEN	3-Preferred Brands	
TOUJEO MAX SOLOSTAR	3-Preferred Brands	QL (18 PER 30 DAYS)
TOUJEO SOLOSTAR	3-Preferred Brands	QL (13.5 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRESIBA	3-Preferred Brands	QL (40 PER 30 DAYS)
TRESIBA FLEXTOUCH 100 UNIT/ML SOLN PEN	3-Preferred Brands	QL (45 PER 30 DAYS)
TRESIBA FLEXTOUCH 200 UNIT/ML SOLN PEN	3-Preferred Brands	QL (27 PER 30 DAYS)

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

ELIQUIS	3-Preferred Brands	
ELIQUIS DVT/PE STARTER PACK	3-Preferred Brands	
<i>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)</i>	2-Generic	
<i>fondaparinux sodium</i>	4-Non-Preferred Drug	
<i>heparin sodium (porcine) ((porcine) 1000 unit/ml, (porcine) 5000 unit/ml, (porcine) 10000 unit/ml, (porcine) 20000 unit/ml)</i>	1-Preferred Generics	
<i>jantoven</i>	1-Preferred Generics	
<i>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)</i>	1-Preferred Generics	
XARELTO	3-Preferred Brands	
XARELTO STARTER PACK	3-Preferred Brands	
ZONTIVITY	4-Non-Preferred Drug	

BLOOD PRODUCTS AND MODIFIERS, OTHER

<i>anagrelide hcl</i>	2-Generic	
LEUKINE	5-Specialty	
NYVEPRIA	5-Specialty	PA

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROCRIT	3-Preferred Brands	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)	5-Specialty	PA
RETACRIT	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
ZARXIO	5-Specialty	PA
ZIEXTENZO	5-Specialty	PA

HEMOSTASIS AGENTS

<i>tranexamic acid 650 mg tab</i>	2-Generic	
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PLATELET MODIFYING AGENTS

<i>aspirin-dipyridamole er</i>	2-Generic	QL (90 PER 30 DAYS)
BRILINTA	3-Preferred Brands	
<i>cilostazol</i>	2-Generic	
<i>clopidogrel bisulfate 300 mg tab</i>	2-Generic	
<i>clopidogrel bisulfate 75 mg tab</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>dipyridamole (25 mg tab, 50 mg tab, 75 mg tab)</i>	1-Preferred Generics	PA
<i>prasugrel hcl</i>	2-Generic	

CARDIOVASCULAR AGENTS

ALPHA-ADRENERGIC AGONISTS

<i>clonidine</i>	2-Generic	QL (4 PER 28 DAYS)
<i>clonidine hcl</i>	1-Preferred Generics	
<i>droxidopa</i>	5-Specialty	
<i>guanfacine hcl</i>	1-Preferred Generics	PA
METHYLDOPA	1-Preferred Generics	PA
<i>midodrine hcl</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ALPHA-ADRENERGIC BLOCKING AGENTS		
<i>doxazosin mesylate</i>	2-Generic	
<i>phenoxybenzamine hcl 10 mg cap</i>	5-Specialty	
<i>prazosin hcl (1 mg cap, 2 mg cap, 5 mg cap)</i>	2-Generic	
<i>terazosin hcl</i>	1-Preferred Generics	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil</i>	1-Preferred Generics	
<i>irbesartan</i>	1-Preferred Generics	
<i>losartan potassium (25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Preferred Generics	
<i>olmesartan medoxomil (5 mg tab, 20 mg tab, 40 mg tab)</i>	1-Preferred Generics	
<i>telmisartan</i>	1-Preferred Generics	
<i>valsartan</i>	1-Preferred Generics	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
<i>benazepril hcl</i>	1-Preferred Generics	
<i>captopril</i>	1-Preferred Generics	
<i>enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Preferred Generics	
<i>fosinopril sodium</i>	1-Preferred Generics	
<i>lisinopril (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	1-Preferred Generics	
<i>moexipril hcl</i>	1-Preferred Generics	
<i>perindopril erbumine</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>quinapril hcl</i>	1-Preferred Generics	
<i>ramipril</i>	1-Preferred Generics	
<i>trandolapril</i>	1-Preferred Generics	
ANTIARRHYTHMICS		
<i>amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)</i>	1-Preferred Generics	
<i>disopyramide phosphate</i>	1-Preferred Generics	PA
<i>dofetilide</i>	2-Generic	
<i>flecainide acetate</i>	2-Generic	
<i>mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)</i>	1-Preferred Generics	
MULTAQ	3-Preferred Brands	
<i>pacerone</i>	1-Preferred Generics	
<i>propafenone hcl</i>	2-Generic	
<i>propafenone hcl er</i>	4-Non-Preferred Drug	
<i>quinidine gluconate er</i>	1-Preferred Generics	
<i>quinidine sulfate (200 mg tab, 300 mg tab)</i>	1-Preferred Generics	
<i>sorine</i>	1-Preferred Generics	
<i>sotalol hcl</i>	1-Preferred Generics	
<i>sotalol hcl (af)</i>	1-Preferred Generics	
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol hcl</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>atenolol</i>	1-Preferred Generics	
<i>betaxolol hcl (10 mg tab, 20 mg tab)</i>	1-Preferred Generics	
<i>bisoprolol fumarate (5 mg tab, 10 mg tab)</i>	1-Preferred Generics	
BYSTOLIC	4-Non-Preferred Drug	
<i>carvedilol</i>	1-Preferred Generics	
<i>carvedilol phosphate er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)</i>	1-Preferred Generics	
<i>metoprolol succinate er (er 25 mg tab er, er 50 mg tab er, er 100 mg tab er)</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>metoprolol succinate er 200 mg tab er 24h</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)</i>	1-Preferred Generics	
<i>nadolol (20 mg tab, 40 mg tab, 80 mg tab)</i>	2-Generic	
<i>pindolol</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>propranolol hcl er</i>	2-Generic	
<i>timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Preferred Generics	
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
<i>amlodipine besylate</i>	1-Preferred Generics	
<i>felodipine er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>isradipine</i>	2-Generic	
<i>nicardipine hcl (20 mg cap, 30 mg cap)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nifedipine (10 mg cap, 20 mg cap)</i>	2-Generic	PA
<i>nifedipine er</i>	2-Generic	
<i>nifedipine er osmotic release</i>	2-Generic	
<i>nimodipine 30 mg cap</i>	2-Generic	

CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES

<i>cartia xt</i>	2-Generic	
<i>dilt-xr</i>	2-Generic	
<i>diltiazem cd</i>	2-Generic	
<i>diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>diltiazem hcl er beads</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>matzim la</i>	2-Generic	
<i>taztia xt</i>	2-Generic	
<i>tiadylt er</i>	2-Generic	
<i>verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)</i>	2-Generic	
<i>verapamil hcl er (er 100 mg cap er 24h, er 120 mg tab er, er 120 mg cap er 24h, er 180 mg cap er 24h, er 180 mg tab er, er 200 mg cap er 24h, er 240 mg tab er, er 240 mg cap er 24h, er 300 mg cap er 24h, er 360 mg cap er 24h)</i>	2-Generic	

CARDIOVASCULAR AGENTS, OTHER

<i>acetazolamide (125 mg tab, 250 mg tab)</i>	2-Generic	
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>aliskiren fumarate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>amiloride-hydrochlorothiazide</i>	2-Generic	
<i>amlodipine besy-benazepril hcl</i>	1-Preferred Generics	
<i>amlodipine besylate-valsartan</i>	1-Preferred Generics	
<i>amlodipine-atorvastatin</i>	1-Preferred Generics	
<i>amlodipine-olmesartan</i>	1-Preferred Generics	
<i>amlodipine-valsartan-hctz</i>	1-Preferred Generics	
<i>atenolol-chlorthalidone</i>	1-Preferred Generics	
<i>benazepril-hydrochlorothiazide (5-6.25 mg tab)</i>	1-Preferred Generics	
<i>bisoprolol-hydrochlorothiazide</i>	1-Preferred Generics	
<i>candesartan cilexetil-hctz</i>	1-Preferred Generics	
CORLANOR 5 MG/5ML SOLUTION	4-Non-Preferred Drug	QL (450 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>digitek</i>	2-Generic	
<i>digox</i>	2-Generic	
<i>digoxin (0.05 mg/ml solution, 125 mcg tab, 250 mcg tab)</i>	2-Generic	
<i>enalapril-hydrochlorothiazide</i>	1-Preferred Generics	
ENTRESTO	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>fosinopril sodium-hctz</i>	1-Preferred Generics	
<i>irbesartan-hydrochlorothiazide</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lisinopril-hydrochlorothiazide</i>	1-Preferred Generics	
<i>losartan potassium-hctz</i>	1-Preferred Generics	
<i>metoprolol-hydrochlorothiazide</i>	1-Preferred Generics	
<i>metyrosine</i>	5-Specialty	
<i>olmesartan medoxomil-hctz</i>	1-Preferred Generics	
<i>olmesartan-amlodipine-hctz</i>	1-Preferred Generics	
<i>pentoxifylline er</i>	2-Generic	
<i>quinapril-hydrochlorothiazide</i>	1-Preferred Generics	
<i>ranolazine er</i>	2-Generic	
<i>spironolactone-hctz</i>	2-Generic	
TEKTURNA HCT	4-Non-Preferred Drug	
<i>telmisartan-amlodipine</i>	1-Preferred Generics	
<i>telmisartan-hctz</i>	1-Preferred Generics	
<i>trandolapril-verapamil hcl er (er, er 2-240 mg tab er)</i>	1-Preferred Generics	
<i>triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)</i>	1-Preferred Generics	
<i>valsartan-hydrochlorothiazide</i>	1-Preferred Generics	
VECAMYL	5-Specialty	
DIURETICS, LOOP		
<i>bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Preferred Generics	
<i>furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1-Preferred Generics	
<i>toremide</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURETICS, POTASSIUM-SPARING		
<i>amiloride hcl</i>	2-Generic	
<i>eplerenone</i>	4-Non-Preferred Drug	
<i>spironolactone (25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Preferred Generics	
DIURETICS, THIAZIDE		
<i>chlorthalidone</i>	1-Preferred Generics	
DIURIL	3-Preferred Brands	
<i>hydrochlorothiazide (12.5 mg tab, 12.5 mg cap, 25 mg tab, 50 mg tab)</i>	1-Preferred Generics	
<i>indapamide</i>	1-Preferred Generics	
<i>metolazone</i>	2-Generic	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
<i>fenofibrate (40 mg tab, 48 mg tab, 50 mg cap, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 150 mg cap, 160 mg tab, 200 mg cap)</i>	2-Generic	
<i>fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)</i>	2-Generic	
<i>fenofibric acid (45 mg cap dr, 135 mg cap dr)</i>	2-Generic	
<i>gemfibrozil</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium (10 mg tab, 40 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>atorvastatin calcium 20 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>atorvastatin calcium 80 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
LIVALO	3-Preferred Brands	ST, QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lovastatin (10 mg tab, 20 mg tab)</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>lovastatin 40 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>pravastatin sodium</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>rosuvastatin calcium 40 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>simvastatin (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
<i>cholestyramine (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
<i>cholestyramine light (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
<i>colesevelam hcl 3.75 gm packet</i>	4-Non-Preferred Drug	
<i>colesevelam hcl 625 mg tab</i>	2-Generic	
<i>colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)</i>	2-Generic	
<i>ezetimibe</i>	2-Generic	QL (30 PER 30 DAYS)
<i>ezetimibe-simvastatin</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
JUXTAPID (5 MG CAP, 10 MG CAP, 20 MG CAP, 30 MG CAP)	5-Specialty	PA
<i>niacin er (antihyperlipidemic)</i>	4-Non-Preferred Drug	
<i>omega-3-acid ethyl esters</i>	2-Generic	
<i>prevalite (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
REPATHA	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
REPATHA PUSHRONEX SYSTEM	3-Preferred Brands	PA, QL (3.5 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REPATHA SURECLICK	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
VASCEPA	3-Preferred Brands	
VASODILATORS, DIRECT-ACTING ARTERIAL		
<i>hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	2-Generic	
<i>minoxidil (2.5 mg tab, 10 mg tab)</i>	1-Preferred Generics	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
<i>isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)</i>	2-Generic	
<i>isosorbide dinitrate 40 mg tab</i>	4-Non-Preferred Drug	
<i>isosorbide mononitrate</i>	1-Preferred Generics	
<i>isosorbide mononitrate er</i>	2-Generic	
<i>minitran</i>	2-Generic	
NITRO-BID	3-Preferred Brands	
NITRO-DUR (0.3 MG/HR, 0.8 MG/HR)	3-Preferred Brands	
<i>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, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)</i>	2-Generic	
<i>nitroglycerin 0.4 mg/spray solution</i>	4-Non-Preferred Drug	
RECTIV	4-Non-Preferred Drug	
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
<i>amphetamine-dextroamphet er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)</i>	2-Generic	QL (90 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>amphetamine-dextroamphetamine 30 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>dextroamphetamine sulfate (5 mg tab, 10 mg tab)</i>	2-Generic	
<i>dextroamphetamine sulfate er</i>	4-Non-Preferred Drug	

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES

<i>atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>atomoxetine hcl 18 mg cap</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>clonidine hcl er</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>guanfacine hcl er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>methylphenidate hcl (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	1-Preferred Generics	
<i>methylphenidate hcl 10 mg/5ml solution</i>	2-Generic	QL (900 PER 30 DAYS)
<i>methylphenidate hcl 5 mg/5ml solution</i>	2-Generic	QL (1800 PER 30 DAYS)
<i>methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>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)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>methylphenidate hcl er (er 36 mg tab er 24h, er 36 mg tab er)</i>	2-Generic	QL (60 PER 30 DAYS)

CENTRAL NERVOUS SYSTEM, OTHER

AUSTEDO	5-Specialty	PA
<i>bac</i>	2-Generic	PA, QL (180 PER 30 DAYS)
<i>butalbital-apap-caffeine (50-325-40 mg cap, 50-325-40 mg tab)</i>	2-Generic	PA, QL (180 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>esgic 50-325-40 mg cap</i>	2-Generic	PA, QL (180 PER 30 DAYS)
INGREZZA (40 MG CAP, 80 MG CAP)	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 60 MG CAP	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 40 & 80 MG CAP THPK	5-Specialty	PA, QL (28 PER 28 DAYS)
NUEDEXTA	3-Preferred Brands	PA, QL (60 PER 30 DAYS)
<i>riluzole</i>	2-Generic	
<i>tetrabenazine</i>	5-Specialty	PA
<i>zebutal</i>	2-Generic	PA, QL (180 PER 30 DAYS)

FIBROMYALGIA AGENTS

DRIZALMA SPRINKLE	4-Non-Preferred Drug	
<i>duloxetine hcl</i>	2-Generic	
<i>pregabalin (225 mg cap, 300 mg cap)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>pregabalin 20 mg/ml solution</i>	2-Generic	QL (900 PER 30 DAYS)
<i>pregabalin er (er 82.5 mg tab er, er 165 mg tab er)</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>pregabalin er 330 mg tab er 24h</i>	2-Generic	PA, QL (60 PER 30 DAYS)
SAVELLA	4-Non-Preferred Drug	
SAVELLA TITRATION PACK	4-Non-Preferred Drug	

MULTIPLE SCLEROSIS AGENTS

AUBAGIO	5-Specialty	QL (30 PER 30 DAYS)
AVONEX PEN	5-Specialty	
AVONEX PREFILLED	5-Specialty	
BETASERON	5-Specialty	
COPAXONE 20 MG/ML SOLN PRSYR	5-Specialty	QL (30 PER 30 DAYS)
COPAXONE 40 MG/ML SOLN PRSYR	5-Specialty	QL (12 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dalfampridine er</i>	5-Specialty	QL (60 PER 30 DAYS)
GILENYA 0.5 MG CAP	5-Specialty	QL (30 PER 30 DAYS)
MAVENCLAD (10 TABS)	5-Specialty	PA
MAVENCLAD (4 TABS)	5-Specialty	PA
MAVENCLAD (5 TABS)	5-Specialty	PA
MAVENCLAD (6 TABS)	5-Specialty	PA
MAVENCLAD (7 TABS)	5-Specialty	PA
MAVENCLAD (8 TABS)	5-Specialty	PA
MAVENCLAD (9 TABS)	5-Specialty	PA
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	5-Specialty	
PLEGRIDY STARTER PACK (63 94 MCG/0.5ML SOLN PRSYR, 63 94 MCG/0.5ML SOLN PEN)	5-Specialty	
TECFIDERA (120 & 240 MG MISC, 120 MG CAP DR, 240 MG CAP DR)	5-Specialty	
VUMERITY	5-Specialty	
VUMERITY (STARTER)	5-Specialty	

DENTAL AND ORAL AGENTS

<i>cevimeline hcl</i>	2-Generic	
<i>chlorhexidine gluconate 0.12 % solution</i>	1-Preferred Generics	
<i>oralone</i>	2-Generic	
<i>paroex</i>	1-Preferred Generics	
<i>periogard</i>	1-Preferred Generics	
<i>pilocarpine hcl (5 mg tab, 7.5 mg tab)</i>	2-Generic	
<i>triamcinolone acetonide 0.1 % paste</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
<i>accutane</i>	4-Non-Preferred Drug	
<i>acitretin</i>	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY
<i>amnesteam</i>	4-Non-Preferred Drug	
<i>avita (0.025 % cream, 0.025 % gel)</i>	2-Generic	PA
<i>benzoyl peroxide-erythromycin</i>	4-Non-Preferred Drug	
<i>claravis</i>	4-Non-Preferred Drug	
<i>clindamycin phos-benzoyl perox (1-5 % gel, 1.2-5 % gel)</i>	2-Generic	
<i>isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)</i>	4-Non-Preferred Drug	
<i>myorisan</i>	4-Non-Preferred Drug	
<i>tazarotene 0.1 % cream</i>	2-Generic	QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
TAZORAC (0.05 % GEL, 0.1 % GEL)	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>tretinoin (0.01 % gel, 0.025 % gel, 0.025 % cream, 0.05 % gel, 0.05 % cream, 0.1 % cream)</i>	2-Generic	PA
<i>zenatane</i>	4-Non-Preferred Drug	
DERMATITIS AND PRURITUS AGENTS		
<i>ala-cort</i>	1-Preferred Generics	
<i>alclometasone dipropionate (0.05 % cream, 0.05 % ointment)</i>	2-Generic	
<i>ammonium lactate (12 % lotion, 12 % cream)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>betamethasone dipropionate (0.05 % lotion, 0.05 % ointment, 0.05 % cream)</i>	2-Generic	
<i>betamethasone dipropionate aug (0.05 % cream, 0.05 % ointment, 0.05 % gel)</i>	2-Generic	
<i>betamethasone valerate (0.1 % cream, 0.1 % ointment, 0.1 % lotion)</i>	2-Generic	
<i>clobetasol prop emollient base</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clobetasol propionate 0.05 % foam</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>clobetasol propionate 0.05 % liquid</i>	4-Non-Preferred Drug	QL (125 PER 30 DAYS)
<i>clobetasol propionate (0.05 % lotion, 0.05 % shampoo)</i>	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
<i>clobetasol propionate (0.05 % ointment, 0.05 % gel, 0.05 % cream)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clobetasol propionate 0.05 % solution</i>	2-Generic	QL (100 PER 30 DAYS)
<i>clobetasol propionate e</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clobetasol propionate emulsion</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>clodan</i>	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
<i>desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	2-Generic	
<i>desoximetasone (0.05 % ointment, 0.05 % cream, 0.05 % gel, 0.25 % cream, 0.25 % ointment)</i>	2-Generic	
<i>fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % ointment, 0.025 % cream)</i>	2-Generic	
<i>fluocinolone acetonide body</i>	2-Generic	
<i>fluocinolone acetonide scalp</i>	2-Generic	
<i>fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluocinonide 0.05 % solution</i>	2-Generic	QL (60 PER 30 DAYS)
<i>fluocinonide emulsified base</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluticasone propionate (0.005 % ointment, 0.05 % cream, 0.05 % lotion)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>halobetasol propionate (0.05 % ointment, 0.05 % cream)</i>	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
<i>hydrocortisone (1 % cream, 1 % ointment, 2.5 % ointment, 2.5 % cream)</i>	1-Preferred Generics	
<i>hydrocortisone 2.5 % lotion</i>	2-Generic	
<i>hydrocortisone (perianal)</i>	2-Generic	
<i>hydrocortisone butyrate (0.1 % ointment, 0.1 % solution)</i>	2-Generic	
<i>hydrocortisone valerate (0.2 % ointment, 0.2 % cream)</i>	2-Generic	
<i>mometasone furoate (0.1 % solution, 0.1 % ointment, 0.1 % cream)</i>	2-Generic	
<i>procto-med hc</i>	2-Generic	
<i>procto-pak</i>	2-Generic	
<i>proctosol hc</i>	2-Generic	
<i>proctozone-hc</i>	2-Generic	
<i>selenium sulfide 2.5 % lotion</i>	2-Generic	
<i>tacrolimus (0.03 %, 0.1 %)</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>tovet</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>triamcinolone acetonide (0.025 % ointment, 0.025 % cream, 0.025 % lotion, 0.1 % lotion, 0.1 % cream, 0.1 % ointment, 0.5 % cream, 0.5 % ointment)</i>	2-Generic	
<i>triderm</i>	2-Generic	
DERMATOLOGICAL AGENTS, OTHER		
<i>calcipotriene (0.005 % cream, 0.005 % ointment)</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>calcipotriene 0.005 % solution</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>calcitrene</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>clotrimazole-betamethasone 1-0.05 % cream</i>	2-Generic	QL (45 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clotrimazole-betamethasone 1-0.05 % lotion</i>	2-Generic	QL (60 PER 30 DAYS)
<i>fluorouracil 0.5 % cream</i>	5-Specialty	QL (30 PER 30 DAYS)
<i>fluorouracil 5 % cream</i>	2-Generic	QL (80 PER 30 DAYS)
<i>fluorouracil (2 %, 5 %)</i>	2-Generic	QL (20 PER 30 DAYS)
<i>imiquimod 5 % cream</i>	2-Generic	
<i>nystatin-triamcinolone (100000-0.1 unit/gm-% ointment, 100000-0.1 unit/gm-% cream)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>podofilox 0.5 % solution</i>	2-Generic	
REGRANEX	5-Specialty	PA, QL (30 PER 30 DAYS)
SANTYL	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
<i>silver sulfadiazine 1 % cream</i>	2-Generic	
<i>ssd</i>	2-Generic	
PEDICULICIDES/SCABICIDES		
<i>lindane</i>	2-Generic	
<i>malathion</i>	4-Non-Preferred Drug	
<i>permethrin 5 % cream</i>	2-Generic	
TOPICAL ANTI-INFECTIVES		
<i>acyclovir 5 % ointment</i>	2-Generic	QL (30 PER 30 DAYS)
<i>ciclodan</i>	2-Generic	
<i>ciclopirox (0.77 % gel, 1 % shampoo, 8 % solution)</i>	2-Generic	
<i>clindamycin phosphate 1 % gel</i>	2-Generic	QL (75 PER 30 DAYS)
<i>clindamycin phosphate (1 % lotion, 1 % solution)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ery</i>	2-Generic	
<i>erythromycin (2 % solution, 2 % pad, 2 % gel)</i>	2-Generic	
<i>mupirocin 2 % ointment</i>	2-Generic	QL (66 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
AMINOSYN-PF	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CARBAGLU	5-Specialty	
CLINIMIX E/DEXTROSE (2.75/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>clinisol sf</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINOLIPID	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>dextrose (5 %, 10 %, 50 %, 70 %, 250 mg/ml)</i>	2-Generic	
<i>dextrose-nacl (2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.9 %, 5-0.45 %, 10-0.45 %, 10-0.2 %)</i>	2-Generic	
<i>dextrose-sodium chloride (2.5-0.45 %, 5-0.45 %, 5-0.9 %)</i>	2-Generic	
FREAMINE HBC	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FREAMINE III	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
INTRALIPID	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>kcl in dextrose-nacl (10-5-0.45 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-%-%)</i>	2-Generic	
KCL-LACTATED RINGERS-D5W	2-Generic	
<i>klor-con (8 tab er, 20 packet)</i>	2-Generic	
<i>klor-con 10</i>	2-Generic	
<i>klor-con m10</i>	2-Generic	
<i>klor-con m15</i>	2-Generic	
<i>klor-con m20</i>	2-Generic	
<i>klor-con sprinkle</i>	2-Generic	
<i>levocarnitine (1 gm/10ml solution, 330 mg tab)</i>	2-Generic	
<i>levocarnitine sf</i>	2-Generic	
<i>magnesium sulfate 50 % solution</i>	1-Preferred Generics	
NUTRILIPID	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
PLASMA-LYTE 148	4-Non-Preferred Drug	
PLASMA-LYTE A	4-Non-Preferred Drug	
<i>plenamine</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>potassium chloride (2 meq/ml solution, 10 % 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)</i>	2-Generic	
<i>potassium chloride crys er</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>potassium chloride in dextrose 20-5 meq/l-% solution</i>	2-Generic	
<i>potassium chloride in nacl 20-0.9 meq/l-% solution</i>	2-Generic	
<i>potassium citrate er</i>	2-Generic	
PREMASOL 10 % SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
PROSOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>sodium chloride (0.45 %, 0.9 %, 3 %, 5 %)</i>	2-Generic	
<i>sodium chloride (pf)</i>	2-Generic	
<i>sodium fluoride (0.55 (0.25 f) mg chew tab, 1.1 (0.5 f) mg/ml solution, 1.1 (0.5 f) mg chew tab, 2.2 (1 f) mg chew tab)</i>	1-Preferred Generics	
TPN ELECTROLYTES	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE 10 % SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

ELECTROLYTE/MINERAL/METAL MODIFIERS

CHEMET	3-Preferred Brands	
<i>clovique</i>	5-Specialty	QL (240 PER 30 DAYS)
<i>deferasirox (90 mg packet, 90 mg tab, 125 mg tab sol, 180 mg tab, 180 mg packet, 250 mg tab sol, 360 mg packet, 360 mg tab, 500 mg tab sol)</i>	5-Specialty	PA
<i>deferasirox granules</i>	5-Specialty	PA
<i>deferiprone</i>	5-Specialty	
FERRIPROX (100 MG/ML SOLUTION, 1000 MG TAB)	5-Specialty	
FERRIPROX TWICE-A-DAY	5-Specialty	
<i>trientine hcl</i>	5-Specialty	QL (240 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PHOSPHATE BINDERS		
<i>calcium acetate 667 mg tab</i>	2-Generic	
<i>calcium acetate (phos binder) (binder) 667 mg tab, binder) 667 mg cap)</i>	2-Generic	
FOSRENOL (750 MG, 1000 MG)	4-Non-Preferred Drug	
<i>sevelamer carbonate 800 mg tab</i>	2-Generic	
POTASSIUM BINDERS		
<i>kionex 15 gm/60ml suspension</i>	2-Generic	
LOKELMA	3-Preferred Brands	
<i>sodium polystyrene sulfonate (15gm/60mlsuspension, powder)</i>	2-Generic	
<i>sps</i>	2-Generic	
VELTASSA	3-Preferred Brands	
VITAMINS		
PRENATAL VITAMIN ORAL TABLET	3-Preferred Brands	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
<i>constulose</i>	2-Generic	
<i>enulose</i>	2-Generic	
<i>generlac</i>	2-Generic	
<i>lactulose (10 gm/15ml, 20 gm/30ml)</i>	2-Generic	
<i>lactulose encephalopathy</i>	2-Generic	
LINZESS	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>lubiprostone</i>	2-Generic	QL (60 PER 30 DAYS)
MOVANTIK	3-Preferred Brands	QL (30 PER 30 DAYS)
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB)	5-Specialty	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-DIARRHEAL AGENTS		
<i>alosetron hcl</i>	5-Specialty	
<i>diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)</i>	2-Generic	
<i>loperamide hcl 2 mg cap</i>	2-Generic	
VIBERZI	5-Specialty	QL (60 PER 30 DAYS)
XERMELO	5-Specialty	PA
ANTISPASMODICS, GASTROINTESTINAL		
<i>dicyclomine hcl (10 mg cap, 10 mg/5ml solution)</i>	1-Preferred Generics	
<i>dicyclomine hcl 20 mg tab</i>	2-Generic	
<i>glycopyrrolate (1 mg tab, 2 mg tab)</i>	2-Generic	
<i>methscopolamine bromide (2.5 mg tab, 5 mg tab)</i>	2-Generic	
GASTROINTESTINAL AGENTS, OTHER		
<i>amoxicill-clarithro-lansopraz</i>	4-Non-Preferred Drug	
GATTEX	5-Specialty	PA
<i>gavilyte-c</i>	1-Preferred Generics	
<i>gavilyte-g</i>	1-Preferred Generics	
<i>gavilyte-n with flavor pack</i>	1-Preferred Generics	
MYALEPT	5-Specialty	PA
OCALIVA	5-Specialty	PA
<i>peg 3350-kcl-na bicarb-nacl</i>	1-Preferred Generics	
<i>peg 3350/electrolytes</i>	1-Preferred Generics	
<i>peg-3350/electrolytes</i>	1-Preferred Generics	
<i>peg-3350/electrolytes/ascorbat</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>peg-kcl-nacl-nasulf-na asc-c</i>	2-Generic	
SUPREP BOWEL PREP KIT	4-Non-Preferred Drug	
<i>trilyte</i>	1-Preferred Generics	
<i>ursodiol (250 mg tab, 300 mg cap, 500 mg tab)</i>	2-Generic	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
<i>cimetidine</i>	2-Generic	
<i>cimetidine hcl</i>	2-Generic	
<i>famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)</i>	2-Generic	
PROTECTANTS		
<i>misoprostol (100 mcg tab, 200 mcg tab)</i>	2-Generic	
<i>sucralfate 1 gm/10ml suspension</i>	4-Non-Preferred Drug	
<i>sucralfate 1 gm tab</i>	2-Generic	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>lansoprazole (15 mg cap dr, 30 mg cap dr)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>pantoprazole sodium (20 mg tab dr, 40 mg tab dr)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>rabeprazole sodium 20 mg tab dr</i>	2-Generic	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ARALAST NP	5-Specialty	
CREON	3-Preferred Brands	
<i>cromolyn sodium 100 mg/5ml conc</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CYSTADANE	5-Specialty	
CYSTAGON	3-Preferred Brands	
CYSTARAN	5-Specialty	PA
ENDARI	5-Specialty	PA, QL (180 PER 30 DAYS)
GLASSIA	5-Specialty	
KEVEYIS	5-Specialty	
<i>miglustat</i>	5-Specialty	
<i>nitisinone</i>	5-Specialty	
NITYR	5-Specialty	
PANCREAZE	3-Preferred Brands	
PROLASTIN-C (1000 MG/20ML SOLUTION, 1000 MG RECON SOLN)	5-Specialty	
RAVICTI	5-Specialty	PA, QL (525 PER 30 DAYS)
<i>sapropterin dihydrochloride (100 mg packet, 100 mg tab, 500 mg packet)</i>	5-Specialty	
<i>sodium phenylbutyrate 500 mg tab</i>	5-Specialty	
ZEMAIRA	5-Specialty	

GENITOURINARY AGENTS

ANTISPASMODICS, URINARY

<i>darifenacin hydrobromide er</i>	2-Generic	
<i>flavoxate hcl</i>	2-Generic	
MYRBETRIQ (25 MG TAB ER, 50 MG TAB ER)	3-Preferred Brands	
<i>oxybutynin chloride 5 mg/5ml syrup</i>	2-Generic	
<i>oxybutynin chloride 5 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>oxybutynin chloride er</i>	2-Generic	
OXYTROL	4-Non-Preferred Drug	
<i>solifenacin succinate</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tolterodine tartrate</i>	2-Generic	
<i>tolterodine tartrate er</i>	4-Non-Preferred Drug	
TOVIAZ	4-Non-Preferred Drug	
<i>trospium chloride</i>	2-Generic	
<i>trospium chloride er</i>	2-Generic	

BENIGN PROSTATIC HYPERTROPHY AGENTS

<i>alfuzosin hcl er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>dutasteride</i>	2-Generic	QL (30 PER 30 DAYS)
<i>dutasteride-tamsulosin hcl</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>finasteride 5 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>silodosin</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>tamsulosin hcl</i>	2-Generic	QL (60 PER 30 DAYS)

GENITOURINARY AGENTS, OTHER

<i>bethanechol chloride</i>	2-Generic	
ELMIRON	3-Preferred Brands	
<i>penicillamine 250 mg tab</i>	5-Specialty	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

ACTHAR	5-Specialty	PA
<i>betamethasone dipropionate aug 0.05 % lotion</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>dexamethasone sod phosphate pf 10 mg/ml solution</i>	4-Non-Preferred Drug	
<i>dexamethasone sodium phosphate (4 mg/ml, 10 mg/ml, 20 mg/5ml, 100 mg/10ml, 120 mg/30ml)</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EMFLAZA (6 MG TAB, 18 MG TAB, 22.75 MG/ML SUSPENSION, 30 MG TAB, 36 MG TAB)	5-Specialty	PA
<i>fludrocortisone acetate</i>	2-Generic	
KORLYM	5-Specialty	
<i>methylprednisolone (4 mg tab thpk, 4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)</i>	2-Generic	
<i>methylprednisolone acetate (40 mg/ml, 80 mg/ml)</i>	2-Generic	
<i>methylprednisolone sodium succ</i>	4-Non-Preferred Drug	
<i>prednisolone (15 mg/5ml syrup, 15 mg/5ml solution)</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>prednisone (1 mg tab, 2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 50 mg tab)</i>	1-Preferred Generics	
<i>prednisone (5 mg/5ml solution, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 10 mg (48) tab thpk, 10 mg (21) tab thpk)</i>	2-Generic	
PREDNISONE INTENSOL	4-Non-Preferred Drug	
SOLU-MEDROL 2 GM RECON SOLN	4-Non-Preferred Drug	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

<i>desmopressin ace spray refrig</i>	4-Non-Preferred Drug
<i>desmopressin acetate 4 mcg/ml solution</i>	4-Non-Preferred Drug
<i>desmopressin acetate (0.1 mg tab, 0.2 mg tab)</i>	2-Generic
<i>desmopressin acetate pf</i>	4-Non-Preferred Drug

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>desmopressin acetate spray</i>	4-Non-Preferred Drug	
INCRELEX	5-Specialty	
NORDITROPIN FLEXPRO	5-Specialty	PA

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

ANABOLIC STEROIDS

<i>oxandrolone 10 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>oxandrolone 2.5 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)

ANDROGENS

<i>danazol</i>	4-Non-Preferred Drug	
<i>methyltestosterone 10 mg cap</i>	5-Specialty	
<i>testosterone (25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)</i>	2-Generic	PA, QL (300 PER 30 DAYS)
<i>testosterone 12.5 mg/act (1%) gel</i>	4-Non-Preferred Drug	PA, QL (300 PER 30 DAYS)
<i>testosterone cypionate (100 mg/ml, 200 mg/ml)</i>	2-Generic	PA - FOR NEW STARTS ONLY
<i>testosterone enanthate</i>	2-Generic	PA - FOR NEW STARTS ONLY
<i>testosterone td gel pump 20.25 mg/act (1.62%)</i>	2-Generic	PA, QL (150 PER 30 DAYS)

ESTROGENS

<i>afirmelle</i>	2-Generic	
<i>altavera</i>	2-Generic	
<i>alyacen 1/35</i>	2-Generic	
<i>alyacen 7/7/7</i>	2-Generic	
<i>amabelz</i>	2-Generic	
<i>apri</i>	2-Generic	
<i>aubra</i>	2-Generic	
<i>aubra eq</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>aurovela 1.5/30</i>	2-Generic	
<i>aurovela 1/20</i>	2-Generic	
<i>aurovela fe 1.5/30</i>	2-Generic	
<i>aurovela fe 1/20</i>	2-Generic	
<i>aviane</i>	2-Generic	
<i>ayuna</i>	2-Generic	
<i>azurette</i>	2-Generic	
<i>bekyree</i>	2-Generic	
<i>blisovi fe 1.5/30</i>	2-Generic	
<i>blisovi fe 1/20</i>	2-Generic	
<i>camrese lo</i>	2-Generic	
<i>caziant</i>	2-Generic	
<i>chateal</i>	2-Generic	
<i>chateal eq</i>	2-Generic	
<i>cryselle-28</i>	2-Generic	
<i>cyclafem 1/35</i>	2-Generic	
<i>cyclafem 7/7/7</i>	2-Generic	
<i>cyred</i>	2-Generic	
<i>cyred eq</i>	2-Generic	
<i>dasetta 1/35</i>	2-Generic	
<i>dasetta 7/7/7</i>	2-Generic	
<i>delyla</i>	2-Generic	
<i>desogestrel-ethinyl estradiol</i>	2-Generic	
<i>dotti</i>	2-Generic	
<i>drospirenone-ethinyl estradiol</i>	2-Generic	
<i>elinest</i>	2-Generic	
<i>eluryng</i>	2-Generic	QL (1 PER 28 DAYS)
<i>emoquette</i>	2-Generic	
<i>enskyce</i>	2-Generic	
<i>estarylla</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>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)</i>	2-Generic	
<i>estradiol valerate (20 mg/ml, 40 mg/ml)</i>	2-Generic	
<i>estradiol-norethindrone acet</i>	2-Generic	
<i>ethynodiol diac-eth estradiol</i>	2-Generic	
<i>etonogestrel-ethinyl estradiol</i>	2-Generic	QL (1 PER 28 DAYS)
<i>falmina</i>	2-Generic	
<i>femynor</i>	2-Generic	
<i>hailey 1.5/30</i>	2-Generic	
<i>hailey fe 1.5/30</i>	2-Generic	
<i>hailey fe 1/20</i>	2-Generic	
<i>iclevia</i>	2-Generic	
<i>introvale</i>	2-Generic	
<i>isibloom</i>	2-Generic	
<i>jasmiel</i>	2-Generic	
<i>jolessa</i>	2-Generic	
<i>juleber</i>	2-Generic	
<i>junel 1.5/30</i>	2-Generic	
<i>junel 1/20</i>	2-Generic	
<i>junel fe 1.5/30</i>	2-Generic	
<i>junel fe 1/20</i>	2-Generic	
<i>kalliga</i>	2-Generic	
<i>kariva</i>	2-Generic	
<i>kelnor 1/35</i>	2-Generic	
<i>kelnor 1/50</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>kimidess</i>	2-Generic	
<i>kurvelo</i>	2-Generic	
<i>larin 1.5/30</i>	2-Generic	
<i>larin 1/20</i>	2-Generic	
<i>larin fe 1.5/30</i>	2-Generic	
<i>larin fe 1/20</i>	2-Generic	
<i>larissia</i>	2-Generic	
<i>lessina</i>	2-Generic	
<i>levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)</i>	2-Generic	
<i>levonorgestrel-ethinyl estrad (0.1-20 tab, 0.15-30 tab)</i>	2-Generic	
<i>levora 0.15/30 (28)</i>	2-Generic	
<i>lillow</i>	2-Generic	
<i>lo-zumandimine</i>	2-Generic	
<i>loestrin 1.5/30 (21)</i>	2-Generic	
<i>loestrin 1/20 (21)</i>	2-Generic	
<i>loestrin fe 1.5/30</i>	2-Generic	
<i>loestrin fe 1/20</i>	2-Generic	
<i>lojaimiess</i>	2-Generic	
<i>lopreeza 1-0.5 mg tab</i>	2-Generic	
<i>loryna</i>	2-Generic	
<i>low-ogestrel</i>	2-Generic	
<i>lutera</i>	2-Generic	
<i>lyllana</i>	2-Generic	
<i>marlissa</i>	2-Generic	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB)	3-Preferred Brands	
<i>microgestin 1.5/30</i>	2-Generic	
<i>microgestin 1/20</i>	2-Generic	
<i>microgestin fe 1.5/30</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>microgestin fe 1/20</i>	2-Generic	
<i>mili</i>	2-Generic	
<i>mimvey</i>	2-Generic	
<i>mono-linyah</i>	2-Generic	
<i>necon 0.5/35 (28)</i>	2-Generic	
<i>nikki</i>	2-Generic	
<i>norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)</i>	2-Generic	
<i>norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab</i>	2-Generic	
<i>norethindrone acet-ethinyl est (1-20 tab, 1.5-30 tab)</i>	2-Generic	
<i>norgestim-eth estrad triphasic</i>	2-Generic	
<i>norgestimate-eth estradiol</i>	2-Generic	
<i>nortrel 0.5/35 (28)</i>	2-Generic	
<i>nortrel 1/35 (21)</i>	2-Generic	
<i>nortrel 1/35 (28)</i>	2-Generic	
<i>nortrel 7/7/7</i>	2-Generic	
<i>nylia 7/7/7</i>	2-Generic	
<i>nymyo</i>	2-Generic	
<i>ocella</i>	2-Generic	
<i>orsythia</i>	2-Generic	
<i>pimtrea</i>	2-Generic	
<i>pirmella 1/35</i>	2-Generic	
<i>pirmella 7/7/7</i>	2-Generic	
<i>portia-28</i>	2-Generic	
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)	3-Preferred Brands	
PREMPHASE	3-Preferred Brands	
PREMPRO	3-Preferred Brands	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>previfem</i>	2-Generic	
<i>quasense</i>	2-Generic	
<i>reclipsen</i>	2-Generic	
<i>setlakin</i>	2-Generic	
<i>simliya</i>	2-Generic	
<i>sprintec 28</i>	2-Generic	
<i>sronyx</i>	2-Generic	
<i>syeda</i>	2-Generic	
<i>tarina fe 1/20</i>	2-Generic	
<i>tarina fe 1/20 eq</i>	2-Generic	
<i>tilia fe</i>	2-Generic	
<i>tri femynor</i>	2-Generic	
<i>tri-estarylla</i>	2-Generic	
<i>tri-legest fe</i>	2-Generic	
<i>tri-linyah</i>	2-Generic	
<i>tri-lo-estarylla</i>	2-Generic	
<i>tri-lo-marzia</i>	2-Generic	
<i>tri-lo-mili</i>	2-Generic	
<i>tri-lo-sprintec</i>	2-Generic	
<i>tri-mili</i>	2-Generic	
<i>tri-nymyo</i>	2-Generic	
<i>tri-previfem</i>	2-Generic	
<i>tri-sprintec</i>	2-Generic	
<i>tri-vylibra</i>	2-Generic	
<i>tri-vylibra lo</i>	2-Generic	
<i>velivet</i>	2-Generic	
<i>vestura</i>	2-Generic	
<i>vienva</i>	2-Generic	
<i>viorele</i>	2-Generic	
<i>volnea</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>vylibra</i>	2-Generic	
<i>wera</i>	2-Generic	
<i>wymzya fe</i>	2-Generic	
<i>xulane</i>	2-Generic	
<i>yuvafem</i>	2-Generic	
<i>zafemy</i>	2-Generic	
<i>zarah</i>	2-Generic	
<i>zovia 1/35 (28)</i>	2-Generic	
<i>zovia 1/35e (28)</i>	2-Generic	
<i>zumandimine</i>	2-Generic	
PROGESTINS		
<i>camila</i>	2-Generic	
<i>deblitane</i>	2-Generic	
DEPO-SUBQ PROVERA 104	4-Non-Preferred Drug	
<i>errin</i>	2-Generic	
<i>heather</i>	2-Generic	
<i>incassia</i>	2-Generic	
<i>jencycla</i>	2-Generic	
<i>jolivette</i>	2-Generic	
<i>lyleq</i>	2-Generic	
<i>lyza</i>	2-Generic	
<i>medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml suspension, 150 mg/ml susp prsyr)</i>	2-Generic	
<i>megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension)</i>	2-Generic	
<i>nora-be</i>	2-Generic	
<i>norethindrone 0.35 mg tab</i>	2-Generic	
<i>norethindrone acetate 5 mg tab</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>norlyda</i>	2-Generic	
<i>norlyroc</i>	2-Generic	
<i>progesterone (100 mg cap, 200 mg cap)</i>	2-Generic	
<i>sharobel</i>	2-Generic	
<i>tulana</i>	2-Generic	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
DUAVEE	3-Preferred Brands	
<i>raloxifene hcl</i>	2-Generic	QL (30 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
<i>euthyrox</i>	1-Preferred Generics	
<i>levo-t</i>	1-Preferred Generics	
<i>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)</i>	1-Preferred Generics	
<i>levoxyl</i>	1-Preferred Generics	
<i>liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)</i>	2-Generic	
SYNTHROID	3-Preferred Brands	
<i>unithroid</i>	1-Preferred Generics	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	5-Specialty	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
<i>cabergoline</i>	2-Generic	
ELIGARD	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FIRMAGON	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>leuprolide acetate 1 mg/0.2ml kit</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (4-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (6-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>octreotide acetate (50 mcg/ml solution, 50 mcg/ml soln prsy, 100 mcg/ml soln prsy, 100 mcg/ml solution, 200 mcg/ml solution, 500 mcg/ml solution, 500 mcg/ml soln prsy, 1000 mcg/ml solution)</i>	4-Non-Preferred Drug	
ORGOVYX	5-Specialty	PA - FOR NEW STARTS ONLY
SIGNIFOR	5-Specialty	
SOMATULINE DEPOT	5-Specialty	
SOMAVERT	5-Specialty	
SYNAREL	5-Specialty	
TRELSTAR MIXJECT	5-Specialty	PA - TO CONFIRM PART D COVERAGE

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

<i>methimazole (5 mg tab, 10 mg tab)</i>	1-Preferred Generics	
<i>propylthiouracil 50 mg tab</i>	2-Generic	

IMMUNOLOGICAL AGENTS

ANGIOEDEMA AGENTS

CINRYZE	5-Specialty	PA
<i>icatibant acetate</i>	5-Specialty	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sajazir</i>	5-Specialty	
IMMUNOGLOBULINS		
ATGAM	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BIVIGAM 5 GM/50ML SOLUTION	5-Specialty	PA
FLEBOGAMMA DIF	5-Specialty	PA
GAMMAGARD	5-Specialty	PA
GAMMAGARD S/D LESS IGA	5-Specialty	PA
GAMMAKED	5-Specialty	PA
GAMMAPLEX	5-Specialty	PA
GAMUNEX-C	5-Specialty	PA
OCTAGAM	5-Specialty	PA
PANZYGA	5-Specialty	PA
PRIVIGEN	5-Specialty	PA
THYMOGLOBULIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VARIZIG	3-Preferred Brands	
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	5-Specialty	
BENLYSTA (200 MG/ML SOLN PRSYR, 200 MG/ML SOLN A-INJ)	5-Specialty	
DUPIXENT (200 MG/1.14ML SOLN PEN, 200 MG/1.14ML SOLN PRSYR, 300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	5-Specialty	PA
RIDAURA	5-Specialty	
SIMULECT 20 MG RECON SOLN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
SKYRIZI (150 MG/ML SOLN A-INJ, 150 MG/ML SOLN PRSYR)	5-Specialty	PA
SKYRIZI (150 MG DOSE)	5-Specialty	PA
STELARA (45 MG/0.5ML SOLUTION, 45 MG/0.5ML SOLN PRSYR, 90 MG/ML SOLN PRSYR, 130 MG/26ML SOLUTION)	5-Specialty	PA

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	5-Specialty	PA
XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB)	5-Specialty	PA
XELJANZ XR	5-Specialty	PA
XOLAIR (75 MG/0.5ML SOLN PRSYR, 150 MG/ML SOLN PRSYR, 150 MG RECON SOLN)	5-Specialty	PA
IMMUNOSTIMULANTS		
ACTIMMUNE	5-Specialty	PA
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	5-Specialty	
PEGASYS (180 MCG/0.5ML SOLN PRSYR, 180 MCG/ML SOLUTION)	5-Specialty	
PEGASYS PROCLICK	5-Specialty	
IMMUNOSUPPRESSANTS		
ASTAGRAF XL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AVSOLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
AZASAN	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>azathioprine</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
AZATHIOPRINE SODIUM	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)</i>	2-Generic	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)	5-Specialty	PA
ENBREL MINI	5-Specialty	PA

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENBREL SURECLICK	5-Specialty	PA
ENVARUSUS XR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>everolimus (0.5 mg tab, 0.75 mg tab)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>everolimus 0.25 mg tab</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>gengraf (25 mg cap, 100 mg/ml solution, 100 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
HUMIRA (10 MG/0.1ML PEF SY KT, 20 MG/0.2ML PEF SY KT, 40 MG/0.4ML PEF SY KT, 40 MG/0.8ML PEF SY KT, 80 MG/0.8ML PEN KIT)	5-Specialty	PA
HUMIRA PEDIATRIC CROHNS START (80 MG/0.8ML & 40MG/0.4ML, 80 MG/0.8ML)	5-Specialty	PA
HUMIRA PEN	5-Specialty	PA
HUMIRA PEN-CD/UC/HS STARTER	5-Specialty	PA
HUMIRA PEN-PEDIATRIC UC START	5-Specialty	PA
HUMIRA PEN-PS/UV/ADOL HS START	5-Specialty	PA
HUMIRA PEN-PSOR/UEIT STARTER	5-Specialty	PA
INFLECTRA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>leflunomide 10 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>leflunomide 20 mg tab</i>	2-Generic	QL (150 PER 30 DAYS)
<i>methotrexate 2.5 mg tab</i>	2-Generic	
<i>methotrexate sodium 1 gm recon soln</i>	4-Non-Preferred Drug	
<i>methotrexate sodium (2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution)</i>	2-Generic	
<i>methotrexate sodium (pf)</i>	2-Generic	
<i>mycophenolate mofetil (200 mg/ml recon susp, 250 mg cap, 500 mg recon soln, 500 mg tab)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate mofetil hcl</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate sodium</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NULOJIX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OTREXUP	4-Non-Preferred Drug	
PROGRAF (0.2 MG, 1 MG)	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
RASUVO	4-Non-Preferred Drug	
RENFLEXIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
REZUROCK	5-Specialty	
RINVOQ	5-Specialty	PA
SANDIMMUNE 100 MG/ML SOLUTION	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>sirolimus (0.5 mg tab, 1 mg tab, 1 mg/ml solution, 2 mg tab)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>temsirolimus</i>	5-Specialty	
TREXALL	4-Non-Preferred Drug	
XATMEP	4-Non-Preferred Drug	
ZORTRESS 1 MG TAB	5-Specialty	PA - TO CONFIRM PART D COVERAGE

VACCINES

ACTHIB	3-Preferred Brands	
ADACEL	3-Preferred Brands	
BCG VACCINE	3-Preferred Brands	
BEXSERO	3-Preferred Brands	
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	3-Preferred Brands	
DAPTACEL	3-Preferred Brands	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIPHTHERIA-TETANUS TOXOIDS DT	3-Preferred Brands	
ENGERIX-B	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9 (9SUSPPRSYR, 9SUSPENSION)	3-Preferred Brands	
HAVRIX	3-Preferred Brands	
HIBERIX	3-Preferred Brands	
IMOVAX RABIES	3-Preferred Brands	
INFANRIX	3-Preferred Brands	
IPOL	3-Preferred Brands	
IXIARO	3-Preferred Brands	
KINRIX (0.5MLSUSPPRSYR, SUSPENSION)	3-Preferred Brands	
M-M-R II	3-Preferred Brands	
MENACTRA	3-Preferred Brands	
MENQUADFI	3-Preferred Brands	
MENVEO	3-Preferred Brands	
PEDIARIX	3-Preferred Brands	
PEDVAX HIB	3-Preferred Brands	
PROQUAD	3-Preferred Brands	
QUADRACEL	3-Preferred Brands	
RABAVERT	3-Preferred Brands	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RECOMBIVAX HB	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
ROTARIX	3-Preferred Brands	
ROTATEQ	3-Preferred Brands	
SHINGRIX	3-Preferred Brands	
TDVAX	3-Preferred Brands	
TENIVAC	3-Preferred Brands	
TRUMENBA	3-Preferred Brands	
TWINRIX	3-Preferred Brands	
TYPHIM VI	3-Preferred Brands	
VAQTA	3-Preferred Brands	
VARIVAX	3-Preferred Brands	
YF-VAX	3-Preferred Brands	

INFLAMMATORY BOWEL DISEASE AGENTS

AMINOSALICYLATES

<i>balsalazide disodium</i>	2-Generic
<i>mesalamine (4 gm enema, 1000 mg suppos)</i>	4-Non-Preferred Drug
<i>mesalamine (1.2 gm tab dr, 400 mg cap dr, 800 mg tab dr)</i>	2-Generic
<i>mesalamine er</i>	2-Generic
<i>mesalamine-cleanser</i>	4-Non-Preferred Drug
<i>sulfasalazine (500 mg tab dr, 500 mg tab)</i>	2-Generic

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GLUCOCORTICOIDS		
<i>budesonide 3 mg cp dr part</i>	2-Generic	
<i>budesonide er</i>	4-Non-Preferred Drug	
<i>hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)</i>	2-Generic	
METABOLIC BONE DISEASE AGENTS		
<i>alendronate sodium 70 mg/75ml solution</i>	1-Preferred Generics	
<i>alendronate sodium (35 mg tab, 70 mg tab)</i>	1-Preferred Generics	QL (4 PER 28 DAYS)
<i>alendronate sodium 10 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>calcitonin (salmon) 200 unit/act solution</i>	2-Generic	
<i>calcitriol (0.25 mcg cap, 0.5 mcg cap, 1 mcg/ml solution)</i>	2-Generic	
<i>cinacalcet hcl (60 mg tab, 90 mg tab)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>cinacalcet hcl 30 mg tab</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>doxercalciferol (0.5 mcg cap, 1 mcg cap, 2.5 mcg cap)</i>	2-Generic	
FORTEO	5-Specialty	PA
<i>ibandronate sodium 150 mg tab</i>	2-Generic	QL (1 PER 30 DAYS)
NATPARA	5-Specialty	PA
PROLIA	4-Non-Preferred Drug	
RAYALDEE	5-Specialty	
<i>risedronate sodium (5 mg tab, 30 mg tab, 35 mg tab dr, 35 mg tab, 150 mg tab)</i>	4-Non-Preferred Drug	
XGEVA	5-Specialty	PA
<i>zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL PADS	2-Generic	
GAUZE PADS & DRESSINGS - PADS 2 X 2	2-Generic	
INSULIN PEN NEEDLE (Novo/BD/Ultimed/Owen/Trividia)	2-Generic	
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
NEEDLES, INSULIN DISP., SAFETY	2-Generic	
<i>sterile water for irrigation</i>	4-Non-Preferred Drug	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
<i>ak-poly-bac</i>	1-Preferred Generics	
ATROPINE SULFATE 1 % SOLUTION	2-Generic	
<i>bacitra-neomycin-polymyxin-hc</i>	2-Generic	
<i>bacitracin-polymyxin b</i>	1-Preferred Generics	
BLEPHAMIDE	3-Preferred Brands	
BLEPHAMIDE S.O.P.	3-Preferred Brands	
COMBIGAN	3-Preferred Brands	
<i>cyclopentolate hcl</i>	2-Generic	
<i>dorzolamide hcl-timolol mal</i>	2-Generic	
<i>dorzolamide hcl-timolol mal pf</i>	2-Generic	
ISOPTO ATROPINE	2-Generic	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>neo-polycin</i>	2-Generic	
<i>neo-polycin hc</i>	2-Generic	
<i>neomycin-bacitracin zn-polymyx</i>	2-Generic	
<i>neomycin-polymyxin-dexameth (3.5-10000-0.1suspension, 3.5-10000-0.1ointment)</i>	2-Generic	
<i>neomycin-polymyxin-gramicidin</i>	2-Generic	
<i>neomycin-polymyxin-hc 3.5-10000-1 suspension</i>	2-Generic	
OXERVATE	5-Specialty	PA
<i>polycin</i>	1-Preferred Generics	
<i>proparacaine hcl 0.5 % solution</i>	2-Generic	
RESTASIS	3-Preferred Brands	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	3-Preferred Brands	QL (5.5 PER 28 DAYS)
<i>sulfacetamide-prednisolone</i>	1-Preferred Generics	
TOBRADEX 0.3-0.1 % OINTMENT	3-Preferred Brands	
<i>tobramycin-dexamethasone</i>	4-Non-Preferred Drug	
ZYLET	4-Non-Preferred Drug	

OPHTHALMIC ANTI-ALLERGY AGENTS

ALOCRIAL	3-Preferred Brands	
ALOMIDE	3-Preferred Brands	
<i>azelastine hcl 0.05 % solution</i>	2-Generic	
<i>bepotastine besilate</i>	4-Non-Preferred Drug	
<i>cromolyn sodium 4 % solution</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>epinastine hcl</i>	2-Generic	
<i>olopatadine hcl (0.1 %, 0.2 %)</i>	2-Generic	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE	3-Preferred Brands	
<i>bacitracin 500 unit/gm ointment</i>	2-Generic	
<i>erythromycin 5 mg/gm ointment</i>	2-Generic	
<i>gatifloxacin</i>	2-Generic	
<i>gentak</i>	2-Generic	
<i>gentamicin sulfate 0.3 % solution</i>	2-Generic	
<i>levofloxacin 0.5 % solution</i>	2-Generic	
<i>moxifloxacin hcl 0.5 % solution</i>	2-Generic	
<i>moxifloxacin hcl (2x day)</i>	4-Non-Preferred Drug	
NATACYN	3-Preferred Brands	
<i>ofloxacin 0.3 % solution</i>	2-Generic	
<i>polymyxin b-trimethoprim</i>	1-Preferred Generics	
<i>sulfacetamide sodium 10 % ointment</i>	1-Preferred Generics	
<i>sulfacetamide sodium 10 % solution</i>	2-Generic	
<i>tobramycin 0.3 % solution</i>	1-Preferred Generics	
ZIRGAN	3-Preferred Brands	
OPHTHALMIC ANTI-INFLAMMATORIES		
<i>bromfenac sodium (once-daily)</i>	4-Non-Preferred Drug	
<i>dexamethasone sodium phosphate 0.1 % solution</i>	2-Generic	
<i>diclofenac sodium 0.1 % solution</i>	2-Generic	
DUREZOL	3-Preferred Brands	

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Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FLAREX	3-Preferred Brands	
<i>fluorometholone</i>	2-Generic	
<i>flurbiprofen sodium</i>	2-Generic	
FML	3-Preferred Brands	
ILEVRO	3-Preferred Brands	
<i>ketorolac tromethamine (0.4 %, 0.5 %)</i>	2-Generic	
LOTEMAX 0.5 % OINTMENT	4-Non-Preferred Drug	
<i>loteprednol etabonate (0.5 % gel, 0.5 % suspension)</i>	4-Non-Preferred Drug	
<i>prednisolone acetate 1 % suspension</i>	2-Generic	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	2-Generic	
PROLENSA	4-Non-Preferred Drug	

OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS

<i>betaxolol hcl 0.5 % solution</i>	2-Generic	
<i>carteolol hcl</i>	2-Generic	
<i>levobunolol hcl</i>	2-Generic	
<i>timolol maleate (0.25 % gel f soln, 0.5 % gel f soln, 0.5 % (daily) solution)</i>	2-Generic	
<i>timolol maleate (0.25 %, 0.5 %)</i>	1-Preferred Generics	

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

<i>acetazolamide er</i>	2-Generic	
ALPHAGAN P 0.1 % SOLUTION	3-Preferred Brands	
<i>apraclonidine hcl</i>	2-Generic	
AZOPT	3-Preferred Brands	
<i>brimonidine tartrate (0.15 %, 0.2 %)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dorzolamide hcl</i>	2-Generic	
<i>methazolamide (25 mg tab, 50 mg tab)</i>	4-Non-Preferred Drug	
<i>pilocarpine hcl (1 %, 2 %, 4 %)</i>	2-Generic	
RHOPRESSA	3-Preferred Brands	
SIMBRINZA	3-Preferred Brands	

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

<i>bimatoprost 0.03% ophth solution</i>	2-Generic	
<i>latanoprost 0.005 % solution</i>	1-Preferred Generics	
LUMIGAN	3-Preferred Brands	
<i>travoprost (bak free)</i>	2-Generic	

OTIC AGENTS

CIPRODEX	3-Preferred Brands	
<i>ciprofloxacin hcl 0.2 % solution</i>	2-Generic	
<i>flac</i>	2-Generic	
<i>fluocinolone acetonide 0.01 % oil</i>	2-Generic	
<i>hydrocortisone-acetic acid</i>	2-Generic	
<i>neomycin-polymyxin-hc (1 %, 3.5-10000-1)</i>	2-Generic	

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ARNUITY ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>budesonide (0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
FLOVENT DISKUS	3-Preferred Brands	QL (80 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FLOVENT HFA (110 MCG/ACT, 220 MCG/ACT)	3-Preferred Brands	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	3-Preferred Brands	QL (22 PER 30 DAYS)
<i>flunisolide</i>	2-Generic	
<i>fluticasone propionate 50 mcg/act suspension</i>	2-Generic	QL (16 PER 30 DAYS)
<i>mometasone furoate 50 mcg/act suspension</i>	4-Non-Preferred Drug	
PULMICORT FLEXHALER	3-Preferred Brands	QL (2 PER 30 DAYS)

ANTIHISTAMINES

<i>azelastine hcl (0.1 %, 0.15 %, 137 mcg/spray)</i>	2-Generic	
<i>cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)</i>	2-Generic	
<i>desloratadine 5 mg tab</i>	2-Generic	
<i>diphenhydramine hcl 50 mg/ml solution</i>	2-Generic	
<i>hydroxyzine hcl (10 mg/5ml syrup, 10 mg tab, 25 mg tab, 50 mg tab)</i>	1-Preferred Generics	
<i>levocetirizine dihydrochloride 2.5 mg/5ml solution</i>	4-Non-Preferred Drug	
<i>levocetirizine dihydrochloride 5 mg tab</i>	2-Generic	
<i>olopatadine hcl 0.6 % solution</i>	2-Generic	
<i>promethazine hcl (6.25 mg/5ml solution, 6.25 mg/5ml syrup)</i>	1-Preferred Generics	PA

ANTILEUKOTRIENES

<i>montelukast sodium (4 mg chew tab, 4 mg packet, 5 mg chew tab, 10 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>zafirlukast 10 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>zafirlukast 20 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)

BRONCHODILATORS, ANTICHOLINERGIC

ATROVENT HFA	3-Preferred Brands	
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INCRUSE ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>ipratropium bromide (0.03 %, 0.06 %)</i>	2-Generic	
<i>ipratropium bromide 0.02 % solution</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
SPIRIVA HANDIHALER	3-Preferred Brands	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
YUPELRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE

BRONCHODILATORS, SYMPATHOMIMETIC

<i>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)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)</i>	2-Generic	
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)</i>	2-Generic	QL (17 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)</i>	2-Generic	QL (13.4 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)</i>	2-Generic	QL (36 PER 30 DAYS)
<i>arformoterol tartrate</i>	5-Specialty	
<i>epinephrine (0.15 mg/0.15ml soln, 0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)</i>	2-Generic	
EPIPEN 2-PAK	3-Preferred Brands	
EPIPEN JR 2-PAK	3-Preferred Brands	
<i>formoterol fumarate</i>	5-Specialty	
<i>levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/3ml soln, 1.25 mg/0.5ml soln)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>levalbuterol tartrate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
SEREVENT DISKUS	3-Preferred Brands	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
STRIVERDI RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
<i>terbutaline sulfate (2.5 mg tab, 5 mg tab)</i>	2-Generic	
CYSTIC FIBROSIS AGENTS		
CAYSTON	5-Specialty	
KALYDECO (25 MG PACKET, 50 MG PACKET, 75 MG PACKET, 150 MG TAB)	5-Specialty	PA
ORKAMBI (100-125 MG TAB, 100-125 MG PACKET, 150-188 MG PACKET, 200-125 MG TAB)	5-Specialty	PA
PULMOZYME	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TOBI PODHALER	5-Specialty	
<i>tobramycin 300 mg/5ml nebu soln</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MAST CELL STABILIZERS		
<i>cromolyn sodium 20 mg/2ml nebu soln</i>	1-Preferred Generics	PA - TO CONFIRM PART D COVERAGE, QL (240 PER 30 DAYS)
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
DALIRESP	4-Non-Preferred Drug	
THEO-24	4-Non-Preferred Drug	
<i>theophylline</i>	2-Generic	
<i>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)</i>	2-Generic	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	5-Specialty	PA
<i>alyq</i>	5-Specialty	PA, QL (60 PER 30 DAYS)
<i>ambrisentan</i>	5-Specialty	PA
<i>bosentan</i>	5-Specialty	PA
OPSUMIT	5-Specialty	PA
<i>sildenafil citrate 20 mg tab</i>	2-Generic	PA

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tadalafil (pah)</i>	5-Specialty	PA, QL (60 PER 30 DAYS)
TRACLEER 32 MG TAB SOL	5-Specialty	PA
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)	5-Specialty	PA
PULMONARY FIBROSIS AGENTS		
ESBRIET (267 MG CAP, 267 MG TAB, 801 MG TAB)	5-Specialty	PA
OFEV	5-Specialty	PA
RESPIRATORY TRACT AGENTS, OTHER		
<i>acetylcysteine (10 %, 20 %)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
ADVAIR DISKUS	2-Generic	QL (60 PER 30 DAYS)
ADVAIR HFA	3-Preferred Brands	QL (12 PER 30 DAYS)
ANORO ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)
BREO ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)
COMBIVENT RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
FASENRA	5-Specialty	PA
FASENRA PEN	5-Specialty	PA
<i>ipratropium-albuterol</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
NUCALA (100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR)	5-Specialty	PA
ORALAIR	4-Non-Preferred Drug	
ORALAIR ADULT SAMPLE KIT	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ORALAIR ADULT STARTER PACK	4-Non-Preferred Drug	
SYMBICORT	3-Preferred Brands	QL (10.2 PER 30 DAYS)
TRELEGY ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)

SKELETAL MUSCLE RELAXANTS

BOTOX	4-Non-Preferred Drug	PA
<i>carisoprodol 350 mg tab</i>	2-Generic	PA, QL (120 PER 30 DAYS)
<i>cyclobenzaprine hcl 10 mg tab</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>cyclobenzaprine hcl 5 mg tab</i>	2-Generic	PA, QL (180 PER 30 DAYS)
<i>metaxalone</i>	4-Non-Preferred Drug	PA
<i>methocarbamol (500 mg tab, 750 mg tab)</i>	2-Generic	PA
<i>vanadom</i>	2-Generic	PA, QL (120 PER 30 DAYS)
XEOMIN	4-Non-Preferred Drug	PA

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

<i>doxepin hcl (3 mg tab, 6 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>estazolam</i>	2-Generic	QL (30 PER 30 DAYS)
<i>eszopiclone</i>	2-Generic	PA, QL (30 PER 30 DAYS)
HETLIOZ	5-Specialty	PA
HETLIOZ LQ	5-Specialty	PA
<i>ramelteon</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>temazepam (15 mg cap, 30 mg cap)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>triazolam 0.125 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>triazolam 0.25 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>zaleplon</i>	2-Generic	PA, QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2022 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>zolpidem tartrate 10 mg tab</i>	2-Generic	PA, QL (30 PER 30 DAYS)
<i>zolpidem tartrate 5 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>zolpidem tartrate er</i>	2-Generic	PA, QL (30 PER 30 DAYS)
WAKEFULNESS PROMOTING AGENTS		
<i>armodafinil</i>	2-Generic	PA, QL (30 PER 30 DAYS)
XYREM	5-Specialty	PA

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

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cataflam.....	2	CIMDUO.....	43
CAYSTON.....	103	cimetidine.....	76
caziant.....	81	cimetidine hcl.....	76
cefaclor.....	8	cinacalcet hcl.....	95
CEFACLOR ER.....	8	CINRYZE.....	88
cefadroxil.....	9	CIPRODEX.....	100
CEFAZOLIN SODIUM.....	9	ciprofloxacin hcl.....	12,100
cefdinir.....	9	ciprofloxacin in d5w.....	12
cefepime hcl.....	9	cisplatin.....	27
cefixime.....	9	citalopram hydrobromide.....	18
cefotetan disodium.....	9	cladribine.....	26
cefoxitin sodium.....	9	claravis.....	67

clarithromycin	11	colesevelam hcl	62
clarithromycin er	11	colestipol hcl	62
clindacin etz	7	colistimethate sodium (cba)	7
clindacin-p	7	COMBIGAN	96
clindamycin hcl	7	COMBIVENT RESPIMAT	104
clindamycin palmitate hcl	7	COMETRIQ (100 MG DAILY DOSE)	30
clindamycin phos-benzoyl perox	67	COMETRIQ (140 MG DAILY DOSE)	30
clindamycin phosphate	7,70	COMETRIQ (60 MG DAILY DOSE)	30
clindamycin phosphate in d5w	7	COMPLERA	42
CLINIMIX E/DEXTROSE (2.75/5)	71	compro	20
CLINIMIX E/DEXTROSE (4.25/10)	71	constulose	74
CLINIMIX E/DEXTROSE (4.25/5)	71	COPAXONE	65
CLINIMIX E/DEXTROSE (5/15)	71	COPIKTRA	30
CLINIMIX E/DEXTROSE (5/20)	71	CORLANOR	59
CLINIMIX/DEXTROSE (4.25/10)	71	COTELLIC	30
CLINIMIX/DEXTROSE (4.25/5)	71	CREON	76
CLINIMIX/DEXTROSE (5/15)	71	cromolyn sodium	76,97,103
CLINIMIX/DEXTROSE (5/20)	71	cryselle-28	81
clinisol sf	71	cyclafem 1/35	81
CLINOLIPID	71	cyclafem 7/7/7	81
clobazam	14	cyclobenzaprine hcl	105
clobetasol prop emollient base	68	cyclopentolate hcl	96
clobetasol propionate	68	CYCLOPHOSPHAMIDE	25
clobetasol propionate e	68	CYCLOSET	48
clobetasol propionate emulsion	68	cyclosporine	90
clodan	68	cyclosporine modified	90
clofarabine	26	cyproheptadine hcl	101
clomipramine hcl	20	CYRAMZA	31
clonazepam	46	cyred	81
clonidine	54	cyred eq	81
clonidine hcl	54	CYSTADANE	77
clonidine hcl er	64	CYSTAGON	77
clopidogrel bisulfate	54	CYSTARAN	77
clorazepate dipotassium	46	cytarabine	26
clotrimazole	22	cytarabine (pf)	26
clotrimazole-betamethasone	69,70		
clovique	73	D	
clozapine	40	dacarbazine	27
COARTEM	35	dactinomycin	27
colchicine	23	dalfampridine er	66
colchicine-probenecid	23	DALIRESP	103

danazol.....	80	dextrose-sodium chloride.....	71
dantrolene sodium.....	40	DIACOMIT.....	13
dapsone.....	24	diazepam.....	14,46
DAPTACEL.....	92	diazepam intensol.....	46
daptomycin.....	7	diazoxide.....	51
darifenacin hydrobromide er.....	77	diclofenac potassium.....	2
DARZALEX.....	33	diclofenac sodium.....	2,98
dasetta 1/35.....	81	diclofenac sodium er.....	2
dasetta 7/7/7.....	81	diclofenac-misoprostol.....	2
daunorubicin hcl 20 mg/4ml solution.....	28	dicloxacillin sodium.....	10
DAUNORUBICIN HCL 50 MG/10ML SOLUTION.....	28	dicyclomine hcl.....	75
DAURISMO.....	31	DIFICID.....	11
deblitane.....	86	diflunisal.....	2
decitabine.....	28	digitek.....	59
deferasirox.....	73	digox.....	59
deferasirox granules.....	73	digoxin.....	59
deferiprone.....	73	dihydroergotamine mesylate.....	24
DELSTRIGO.....	42	DILANTIN.....	15
delyla.....	81	dilt-xr.....	58
demeclocycline hcl.....	12	diltiazem cd.....	58
DEPO-SUBQ PROVERA 104.....	86	diltiazem hcl.....	58
DESCOVY.....	43	diltiazem hcl er.....	58
desipramine hcl.....	20	diltiazem hcl er beads.....	58
desloratadine.....	101	diltiazem hcl er coated beads.....	58
desmopressin ace spray refrig.....	79	diphenhydramine hcl.....	101
desmopressin acetate.....	79	diphenoxylate-atropine.....	75
desmopressin acetate pf.....	79	DIPHThERIA-TETANUS TOXOIDS DT.....	93
desmopressin acetate spray.....	80	dipyridamole.....	54
desogestrel-ethinyl estradiol.....	81	disopyramide phosphate.....	56
desonide.....	68	disulfiram.....	5
desoximetasone.....	68	DIURIL.....	61
DESVENLAFAXINE ER.....	18	divalproex sodium.....	13
desvenlafaxine succinate er.....	18	divalproex sodium er.....	13
dexamethasone.....	78	docetaxel.....	28
dexamethasone sod phosphate pf.....	78	dofetilide.....	56
dexamethasone sodium phosphate.....	78,98	donepezil hcl.....	16
dextroamphetamine sulfate.....	64	dorzolamide hcl.....	100
dextroamphetamine sulfate er.....	64	dorzolamide hcl-timolol mal.....	96
dextrose.....	71	dorzolamide hcl-timolol mal pf.....	96
dextrose-nacl.....	71	dotti.....	81
		DOVATO.....	41

doxazosin mesylate	55	EMSAM	17
doxepin hcl	20,105	emtricitabine	43
doxercalciferol	95	emtricitabine-tenofovir df	43
doxorubicin hcl	28	EMTRIVA	43
doxorubicin hcl liposomal	28	enalapril maleate	55
doxy 100	12	enalapril-hydrochlorothiazide	59
doxycycline hyclate	12	ENBREL	90
doxycycline monohydrate	12	ENBREL MINI	90
DRIZALMA SPRINKLE	65	ENBREL SURECLICK	91
dronabinol	21	ENDARI	77
drospirenone-ethinyl estradiol	81	endocet	4
DROXIA	27	ENGERIX-B	93
droxidopa	54	enoxaparin sodium	53
DUAVEE	87	enskyce	81
duloxetine hcl	65	entacapone	36
DUPIXENT	89	entecavir	41
DUREZOL	98	ENTRESTO	59
dutasteride	78	enulose	74
dutasteride-tamsulosin hcl	78	ENVARUSUS XR	91
E		EPCLUSA	41
E.E.S. 400	11	EPIDIOLEX	13
ec-naproxen	2	epinastine hcl	98
econazole nitrate	22	epinephrine	102
EDURANT	42	EPIPEN 2-PAK	102
efavirenz	42	EPIPEN JR 2-PAK	102
efavirenz-emtricitab-tenofovir	42	epirubicin hcl	28
efavirenz-lamivudine-tenofovir	42	epitol	15
ELIGARD	87	EPIVIR HBV	41
elinest	81	eplerenone	61
ELIQUIS	53	ERBITUX	33
ELIQUIS DVT/PE STARTER PACK	53	ergoloid mesylates	16
ELMIRON	78	ergotamine-caffeine	24
eluryng	81	ERIVEDGE	31
EMCYT	26	ERLEADA	26
EMEND	21	erlotinib hcl	31
EMFLAZA	79	errin	86
EMGALITY	23	ertapenem sodium	11
EMGALITY (300 MG DOSE)	23	ERWINAZE	28
emoquette	81	ery	70
EMPLICITI	33	ery-tab	11
		ERYTHROCIN LACTOBIONATE	11

erythromycin	11,70,98	fenofibrate	61
erythromycin base	11	fenofibrate micronized	61
erythromycin ethylsuccinate	11	fenofibric acid	61
ESBRIET	104	fentanyl	3
escitalopram oxalate	18	fentanyl citrate	4
esgic	65	FERRIPROX	73
esomeprazole magnesium	76	FERRIPROX TWICE-A-DAY	73
estarylla	81	FETZIMA	18
estazolam	105	FETZIMA TITRATION	18
estradiol	82	finasteride	78
estradiol valerate	82	FINTEPLA	13
estradiol-norethindrone acet	82	FIRMAGON	88
eszopiclone	105	FIRMAGON (240 MG DOSE)	88
ethambutol hcl	25	flac	100
ethosuximide	14	FLAREX	99
ethynodiol diac-eth estradiol	82	flavoxate hcl	77
etodolac	2	FLEBOGAMMA DIF	89
etonogestrel-ethinyl estradiol	82	flecainide acetate	56
etoposide	30	FLOVENT DISKUS	100
etravirine	42	FLOVENT HFA	101
euthyrox	87	fluconazole	22
everolimus	31,91	fluconazole in sodium chloride	22
EVOTAZ	44	flucytosine	22
exemestane	30	fludarabine phosphate	28
ezetimibe	62	fludrocortisone acetate	79
ezetimibe-simvastatin	62	flunisolide	101
F		fluocinolone acetonide	68,100
falmina	82	fluocinolone acetonide body	68
famciclovir	45	fluocinolone acetonide scalp	68
famotidine	76	fluocinonide	68
FANAPT	38	fluocinonide emulsified base	68
FANAPT TITRATION PACK	38	fluorometholone	99
FARXIGA	48	fluorouracil	27,70
FARYDAK	31	fluoxetine hcl	18
FASENRA	104	fluphenazine decanoate	37
FASENRA PEN	104	fluphenazine hcl	37
febuxostat	23	flurbiprofen	2
felbamate	13	flurbiprofen sodium	99
felodipine er	57	flutamide	26
femynor	82	fluticasone propionate	68,101
		fluvoxamine maleate	19

fluvoxamine maleate er.....	19	generlac.....	74
FML.....	99	gengraf.....	91
FOLOTYN.....	27	gentak.....	98
fondaparinux sodium.....	53	gentamicin in saline.....	6
formoterol fumarate.....	102	gentamicin sulfate.....	7,98
FORTEO.....	95	GENVOYA.....	41
fosamprenavir calcium.....	44	GILENYA.....	66
fosfomycin tromethamine.....	7	GILOTRIF.....	31
fosinopril sodium.....	55	GLASSIA.....	77
fosinopril sodium-hctz.....	59	glimepiride.....	48
fosphenytoin sodium.....	15	glipizide.....	48
FOSRENOL.....	74	glipizide er.....	48
FOTIVDA.....	28	glipizide xl.....	48
FREAMINE HBC.....	71	glipizide-metformin hcl.....	48
FREAMINE III.....	72	GLUCAGEN HYPOKIT.....	51
frovatriptan succinate.....	24	GLUCAGON EMERGENCY.....	51
fulvestrant.....	26	glucagon emergency 1 mg kit (generic).....	51
furosemide.....	60	glyburide.....	48
FUZEON.....	44	glyburide micronized.....	48
FYCOMPA.....	13	glyburide-metformin.....	49
		glycopyrrolate.....	75
G		glydo.....	5
gabapentin.....	14	GLYXAMBI.....	49
galantamine hydrobromide.....	16	granisetron hcl.....	21
galantamine hydrobromide er.....	16	griseofulvin microsize.....	22
GAMMAGARD.....	89	griseofulvin ultramicrosize.....	22
GAMMAGARD S/D LESS IGA.....	89	guanfacine hcl.....	54
GAMMAKED.....	89	guanfacine hcl er.....	64
GAMMAPLEX.....	89	GVOKE HYPOPEN 1-PACK.....	51
GAMUNEX-C.....	89	GVOKE HYPOPEN 2-PACK.....	51
GARDASIL 9.....	93	GVOKE PFS.....	51
gatifloxacin.....	98	GYNAZOLE-1.....	22
GATTEX.....	75		
GAUZE PADS & DRESSINGS - PADS 2 X		H	
2.....	96	hailey 1.5/30.....	82
gavilyte-c.....	75	hailey fe 1.5/30.....	82
gavilyte-g.....	75	hailey fe 1/20.....	82
gavilyte-n with flavor pack.....	75	HALAVEN.....	28
GAVRETO.....	31	halobetasol propionate.....	69
gemcitabine hcl.....	27	haloperidol.....	37
gemfibrozil.....	61	haloperidol decanoate.....	37

INSULIN PEN NEEDLE (Novo/BD/Ultimed/Owen/Trividia).....	96	JANUMET XR.....	49
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/Ultimed/Allison/Trividia/MHC).....	96	JANUVIA.....	49
INSULIN SYRINGE (DISP) U-100 1 ML (BD/Ultimed/Allison/Trividia/MHC).....	96	JARDIANCE.....	49
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/Ultimed/Allison/Trividia/MHC).....	96	jasmiel.....	82
INTELENCE.....	42	jencycla.....	86
INTRALIPID.....	72	JENTADUETO.....	49
INTRON A.....	90	JENTADUETO XR.....	49
introvale.....	82	JEVTANA.....	31
INVEGA SUSTENNA.....	38,39	jolessa.....	82
INVEGA TRINZA.....	39	jolivette.....	86
INVIRASE.....	44	juleber.....	82
IPOL.....	93	JULUCA.....	42
ipratropium bromide.....	102	junel 1.5/30.....	82
ipratropium-albuterol.....	104	junel 1/20.....	82
irbesartan.....	55	junel fe 1.5/30.....	82
irbesartan-hydrochlorothiazide.....	59	junel fe 1/20.....	82
IRESSA.....	31	JUXTAPID.....	62
irinotecan hcl.....	28		
ISENTRESS.....	42	K	
ISENTRESS HD.....	42	KADCYLA.....	33
isibloom.....	82	KALETRA.....	44
isoniazid.....	25	kalliga.....	82
ISOPTO ATROPINE.....	96	KALYDECO.....	103
isosorbide dinitrate.....	63	KANJINTI.....	33
isosorbide mononitrate.....	63	kariva.....	82
isosorbide mononitrate er.....	63	kcl in dextrose-nacl.....	72
isotretinoin.....	67	KCL-LACTATED RINGERS-D5W.....	72
isradipine.....	57	kelnor 1/35.....	82
ISTODAX (OVERFILL).....	28	kelnor 1/50.....	82
itraconazole.....	22	ketoconazole.....	22
ivermectin.....	35	ketorolac tromethamine.....	99
IXIARO.....	93	KEVEYIS.....	77
		KEYTRUDA.....	33
J		kimidess.....	83
JAKAFI.....	31	KINRIX.....	93
jantoven.....	53	kionex.....	74
JANUMET.....	49	KISQALI (200 MG DOSE).....	31
		KISQALI (400 MG DOSE).....	31
		KISQALI (600 MG DOSE).....	31
		KISQALI FEMARA (400 MG DOSE).....	28
		KISQALI FEMARA (600 MG DOSE).....	28

KISQALI FEMARA(200 MG DOSE).....	28	LENVIMA (4 MG DAILY DOSE).....	32
klor-con.....	72	LENVIMA (8 MG DAILY DOSE).....	32
klor-con 10.....	72	lessina.....	83
klor-con m10.....	72	letrozole.....	30
klor-con m15.....	72	leucovorin calcium.....	34
klor-con m20.....	72	LEUKERAN.....	25
klor-con sprinkle.....	72	LEUKINE.....	53
KORLYM.....	79	leuprolide acetate.....	88
KOSELUGO.....	31	levalbuterol hcl.....	102
kurvelo.....	83	levalbuterol tartrate.....	102
KYPROLIS.....	31	LEVEMIR.....	52
		LEVEMIR FLEXTOUCH.....	52
L		levetiracetam.....	13
labetalol hcl.....	57	levetiracetam er.....	13
lactulose.....	74	levetiracetam in nacl.....	13
lactulose encephalopathy.....	74	levo-t.....	87
lamivudine.....	41,43	levobunolol hcl.....	99
lamivudine-zidovudine.....	43	levocarnitine.....	72
lamotrigine.....	47	levocarnitine sf.....	72
lamotrigine er.....	47	levocetirizine dihydrochloride.....	101
lamotrigine starter kit-blue.....	47	levofloxacin.....	12,98
lamotrigine starter kit-green.....	47	levofloxacin 25 mg/ml oral solution.....	12
lamotrigine starter kit-orange.....	47	levofloxacin in d5w.....	12
lansoprazole.....	76	levofloxacin iv soln 25 mg/ml.....	12
LANTUS.....	52	levoleucovorin calcium.....	34
LANTUS SOLOSTAR.....	52	levoleucovorin calcium pf.....	34
lapatinib ditosylate.....	31	levonorgest-eth estrad 91-day.....	83
larin 1.5/30.....	83	levonorgestrel-ethinyl estrad.....	83
larin 1/20.....	83	levora 0.15/30 (28).....	83
larin fe 1.5/30.....	83	levothyroxine sodium.....	87
larin fe 1/20.....	83	levoxyl.....	87
larissia.....	83	LEXIVA.....	44
latanoprost.....	100	lidocaine.....	5
LATUDA.....	39	lidocaine 5 % ointment.....	5
leflunomide.....	91	lidocaine hcl urethral/mucosal.....	5
LENVIMA (10 MG DAILY DOSE).....	31	lidocaine viscous hcl.....	5
LENVIMA (12 MG DAILY DOSE).....	31	lidocaine-prilocaine.....	5
LENVIMA (14 MG DAILY DOSE).....	31	lillow.....	83
LENVIMA (18 MG DAILY DOSE).....	31	lindane.....	70
LENVIMA (20 MG DAILY DOSE).....	32	linezolid.....	7,8
LENVIMA (24 MG DAILY DOSE).....	32	LINZESS.....	74

liothyronine sodium	87	lyllana	83
lisinopril	55	LYNPARZA	32
lisinopril-hydrochlorothiazide	60	LYSODREN	87
LITHIUM	47	LYUMJEV	52
lithium carbonate	47	LYUMJEV KWIKPEN	52
lithium carbonate er	47	lyza	86
LIVALO	61		
lo-zumandimine	83	M	
loestrin 1.5/30 (21)	83	M-M-R II	93
loestrin 1/20 (21)	83	magnesium sulfate	72
loestrin fe 1.5/30	83	malathion	70
loestrin fe 1/20	83	marlissa	83
lojaimiess	83	MARPLAN	17
LOKELMA	74	MATULANE	25
LONSURF	28	matzim la	58
loperamide hcl	75	MAVENCLAD (10 TABS)	66
lopinavir-ritonavir	44	MAVENCLAD (4 TABS)	66
lopreeza	83	MAVENCLAD (5 TABS)	66
lorazepam	46	MAVENCLAD (6 TABS)	66
lorazepam intensol	46	MAVENCLAD (7 TABS)	66
LORBRENA	32	MAVENCLAD (8 TABS)	66
loryna	83	MAVENCLAD (9 TABS)	66
losartan potassium	55	MAVYRET	41
losartan potassium-hctz	60	meclizine hcl	20
LOTEMAX	99	medroxyprogesterone acetate	86
loteprednol etabonate	99	mefloquine hcl	35
lovastatin	62	megestrol acetate	86
low-ogestrel	83	MEKINIST	32
loxapine succinate	37	MEKTOVI	32
lubiprostone	74	meloxicam	2
LUCEMYRA	6	melphalan	25
LUMAKRAS	28	melphalan hcl	25
LUMIGAN	100	memantine hcl	17
LUPRON DEPOT (1-MONTH)	88	memantine hcl er	17
LUPRON DEPOT (3-MONTH)	88	MENACTRA	93
LUPRON DEPOT (4-MONTH)	88	MENEST	83
LUPRON DEPOT (6-MONTH)	88	MENQUADFI	93
LUPRON DEPOT-PED (1-MONTH)	88	MENVEO	93
LUPRON DEPOT-PED (3-MONTH)	88	mercaptopurine	27
lutea	83	meropenem	11
lyleq	86	mesalamine	94

mesalamine er.....	94	miglustat.....	77
mesalamine-cleanser.....	94	mili.....	84
mesna.....	34	mimvey.....	84
MESNEX.....	34	minitran.....	63
metaxalone.....	105	minocycline hcl.....	13
metformin hcl.....	49	minoxidil.....	63
metformin hcl er.....	49	mirtazapine.....	17
methadone hcl.....	3	misoprostol.....	76
methazolamide.....	100	MITIGARE.....	23
methenamine hippurate.....	8	mitomycin.....	28
methimazole.....	88	mitoxantrone hcl.....	28
methocarbamol.....	105	moexipril hcl.....	55
methotrexate.....	91	molindone hcl.....	37
methotrexate sodium.....	91	mometasone furoate.....	69,101
methotrexate sodium (pf).....	91	mondoxyne nl.....	13
methscopolamine bromide.....	75	mono-lynyah.....	84
METHYLDOPA.....	54	montelukast sodium.....	101
methylphenidate hcl.....	64	morgidox.....	13
methylphenidate hcl er.....	64	morphine sulfate.....	4
methylprednisolone.....	79	morphine sulfate (concentrate).....	4
methylprednisolone acetate.....	79	morphine sulfate er.....	3
methylprednisolone sodium succ.....	79	MOVANTIK.....	74
methyltestosterone.....	80	moxifloxacin hcl.....	12,98
metoclopramide hcl.....	20	moxifloxacin hcl (2x day).....	98
metolazone.....	61	moxifloxacin hcl in nacl.....	12
metoprolol succinate er.....	57	MULTAQ.....	56
metoprolol tartrate.....	57	mupirocin.....	70
metoprolol-hydrochlorothiazide.....	60	mutamycin.....	28
metronidazole.....	8	MVASI.....	33
metronidazole in nacl.....	8	MYALEPT.....	75
metronidazole in nacl 0.74% iv soln 500 mg/100ml.....	8	mycophenolate mofetil.....	91
metyrosine.....	60	mycophenolate mofetil hcl.....	91
mexiletine hcl.....	56	mycophenolate sodium.....	91
micafungin sodium.....	22	MYLOTARG.....	33
microgestin 1.5/30.....	83	myorisan.....	67
microgestin 1/20.....	83	MYRBETRIQ.....	77
microgestin fe 1.5/30.....	83		
microgestin fe 1/20.....	84	N	
midodrine hcl.....	54	nabumetone.....	2
miglitol.....	49	nadolol.....	57
		nafcillin sodium.....	10

OCTAGAM.....	89	oxycodone hcl.....	4
octreotide acetate.....	88	oxycodone-acetaminophen.....	5
ODEFSEY.....	43	oxymorphone hcl.....	5
ODOMZO.....	32	OXYTROL.....	77
OFEV.....	104	OZEMPIC (0.25 OR 0.5 MG/DOSE).....	49
ofloxacin.....	12,98	OZEMPIC (1 MG/DOSE).....	50
OGIVRI.....	34		
olanzapine.....	39	P	
olanzapine-fluoxetine hcl.....	17	pacerone.....	56
olmesartan medoxomil.....	55	paclitaxel.....	29
olmesartan medoxomil-hctz.....	60	paliperidone er.....	39
olmesartan-amlodipine-hctz.....	60	PANCREAZE.....	77
olopatadine hcl.....	98,101	pantoprazole sodium.....	76
omega-3-acid ethyl esters.....	62	PANZYGA.....	89
omeprazole.....	76	paraplatin.....	29
ondansetron.....	21	paroex.....	66
ondansetron hcl.....	21	paromomycin sulfate.....	7
ondansetron hcl inj 4 mg/2ml.....	21	paroxetine hcl.....	19
ONTRUZANT.....	34	paroxetine hcl er.....	19
ONUREG.....	29	paroxetine mesylate.....	19
OPDIVO.....	34	PASER.....	25
OPSUMIT.....	103	PAXIL.....	19
ORALAIR.....	104	PEDIARIX.....	93
ORALAIR ADULT SAMPLE KIT.....	104	PEDVAX HIB.....	93
ORALAIR ADULT STARTER PACK.....	105	peg 3350-kcl-na bicarb-nacl.....	75
oralone.....	66	peg 3350/electrolytes.....	75
ORGOVYX.....	88	peg-3350/electrolytes.....	75
ORKAMBI.....	103	peg-3350/electrolytes/ascorbat.....	75
orsythia.....	84	peg-kcl-nacl-nasulf-na asc-c.....	76
oseltamivir phosphate.....	45	PEGASYS.....	90
OTREXUP.....	92	PEGASYS PROCLICK.....	90
oxacillin sodium.....	10	PEMAZYRE.....	32
OXACILLIN SODIUM IN DEXTROSE.....	10	penicillamine.....	78
oxaliplatin.....	29	PENICILLIN G POT IN DEXTROSE.....	10
oxandrolone.....	80	penicillin g potassium.....	10
oxaprozin.....	3	PENICILLIN G PROCAINE.....	10
oxazepam.....	47	penicillin g sodium.....	10
oxcarbazepine.....	15	penicillin v potassium.....	10
OXERVATE.....	97	pentamidine isethionate.....	35
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