

Kaiser Permanente Insurance Company (KPIC)

Point-of-Service (POS) Drug Formulary with Specialty Drug Tier

This Drug Formulary was updated: November 1, 2021

NOTE: This drug formulary is updated often and is subject to change. Upon revision, all previous versions of the drug formulary are no longer in effect.

This document contains information regarding the drugs that are covered when you participate in the California Nongrandfathered Point of Service (POS) for Large Groups Health Insurance Plan(s) with specialty drug tier issued by Kaiser Permanente Insurance Company (KPIC) and fill your prescription at a MedImpact network pharmacy. If you belong to our POS plan and you intend to fill your prescriptions at a Kaiser Permanente pharmacy, please visit **kp.org/formulary** for details on the drugs covered through your HMO Tier benefit.

Access to the most current version of the Formulary can be obtained by visiting **kp.org/kpic-ca-rx-pos-ngf**.

For help understanding your KPIC insurance plan benefits, including cost sharing for drugs under the prescription drug benefit and under the medical benefit, please call **1-800-788-0710 or 711 (TTY)** Monday through Friday, 7 a.m. to 7 p.m.

For help with this Formulary, including the processes for submitting an exception request and requesting prior authorization and step therapy exceptions, please call MedImpact 24 hours a day, 7 days a week, at **1-800-788-2949 or 711 (TTY)**.

For cost sharing information for the outpatient prescription drug benefits in your specific plan, please visit: **kp.org/kpic-ca-rx-pos-ngf**.

For help in your preferred language, please see the “Kaiser Permanente Insurance Company Notice of Language Assistance” in this document.

Table of Contents

Informational Section.....	2
Alternative Therapy - Vitamins And Minerals.....	9
Analgesic, Anti-Inflammatory Or Antipyretic.....	14
Analgesic, Anti-Inflammatory Or Antipyretic - Drugs For Pain And Fever.....	14
Anesthetics - Drugs For Pain And Fever.....	44
Anorectal Preparations - Rectal Preparations.....	45
Antidotes And Other Reversal Agents - Drugs For Overdose Or Poisoning.....	46
Anti-Infective Agents - Drugs For Infections.....	49
Antineoplastics.....	76
Antineoplastics - Drugs For Cancer.....	77
Antiseptics And Disinfectants - Antiseptics And Disinfectants.....	97
Biologicals - Biological Agents.....	99
Cardiovascular Therapy Agents - Drugs For The Heart.....	108
Central Nervous System Agents - Drugs For The Nervous System.....	136
Chemical Dependency, Agents To Treat - Drugs For Addiction.....	195
Chemicals-Pharmaceutical Adjuvants.....	197
Cognitive Disorder Therapy - Drugs For The Nervous System.....	200
Contraceptives - Drugs For Women.....	201
Dermatological.....	217
Dermatological - Drugs For The Skin.....	218
Diagnostic Agents.....	288
Drugs To Treat Erectile Dysfunction - Drugs For The Urinary System.....	289
Eating Disorder Therapy - Drugs For Eating Disorders.....	289
Electrolyte Balance-Nutritional Products - Drugs For Nutrition.....	289
Endocrine - Hormones.....	328
Enzymes - Vitamins And Minerals.....	363
Fdb Class Obsolete-Not Used.....	363
Gastrointestinal Therapy Agents - Drugs For The Stomach.....	364
Genitourinary Therapy - Drugs For The Urinary System.....	390
Gout And Hyperuricemia Therapy - Drugs For Pain And Fever.....	398
Hematological Agents - Drugs For The Blood.....	399
Hepatobiliary System Treatment Agents.....	415
Hepatobiliary System Treatment Agents - Drugs For The Liver.....	415
Immunosuppressive Agents - Drugs For Organ Transplants.....	415
Locomotor System - Drugs For Muscles, Ligaments, Tendons, And Bones.....	417
Medical Supplies And Durable Medical Equipment (Dme) - Medical Supplies And Durable Medical Equipment.....	420
Medical Supply, Fdb Superset.....	527
Metabolic Disease Enzyme Replacement Agents - Drugs For Metabolic Disease.....	602
Metabolic Modifiers - Drugs That Alter Metabolism.....	603
Mouth-Throat-Dental - Preparations - Drugs For The Mouth And Throat.....	605
Multiple Sclerosis Agents - Drugs For The Nervous System.....	610
Ophthalmic Agents - Drugs For The Eye.....	613
Otic (Ear) - Drugs For The Ear.....	631
Respiratory Therapy Agents - Drugs For The Lungs.....	632
Vaginal Products - Drugs For Women.....	654

FORMULARY INFORMATION

Notice: The Formulary is updated with changes on a monthly basis. Updates will be effective on the first day of the month. During the policy year, the following types of changes may be made:

- Removal of a drug or dosage form of a drug from the Formulary;
- A change in tier placement of a drug that results in an increase or decrease in cost sharing; and
- Adding or changing utilization management procedures applicable to a drug.

How to Use This Document

This document is a list of the approved prescription medications covered under your Nongrandfathered POS Health Insurance Plan including both generic and brand name drugs. This document applies only to prescribed outpatient prescription drugs obtained through a retail pharmacy within the MedImpact network pharmacy network. This document does not apply to medications administered in the doctor's office or in the hospital which are covered under your medical benefit. For information on drugs covered under your medical benefit, please see the General Benefits section of your *Certificate of Insurance*.

The Formulary may be accessed using either the categorical list of drugs or the alphabetical index. The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB), a widely-accepted independent drug classification system.

A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the brand or generic name of the drug in the alphabetical index. A drug is listed alphabetically by the brand and generic name in the therapeutic category and class to which it belongs. The generic name for a brand name drug is included after the brand name in parentheses and all lowercase italicized letters. If a generic equivalent for a brand name drug is both available and covered, the generic drug will be listed separately from the brand name drug in all lowercase italicized letters. If a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized. If a generic equivalent for a brand name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

EXAMPLE of how drugs are listed on the Formulary:

Brand name drug. The brand name antibiotic drug "Moxatag" would be listed as follows:

Under the Prescription Drug Name Column, therapeutic category "ANTI-INFECTIVE AGENTS", drug class "AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS", the prescription brand name drug is listed in all capital letters, "MOXATAG" followed by the generic equivalent of the drug shown in parenthesis, all lower case italicized "(amoxicillin)".

ANTI-INFECTIVE AGENTS – DRUGS FOR INFECTIONS	
AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS	
MOXATAG ORAL TABLET, ER MULTIPHASE 24 HR 775 MG (<i>amoxicillin</i>)	3

Generic drug. The generic antibiotic drug "amoxicillin" would be listed as follows:

Under the therapeutic category "ANTI-INFECTIVE AGENTS", drug class "AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS", the prescription generic drug is listed in lower case italics "*amoxicillin*".

ANTI-INFECTIVE AGENTS – DRUGS FOR INFECTIONS	
AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS	
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1

Tier Benefit Design

The Formulary applies to a tier benefit design, where the insured shares the cost of prescription drug therapy based on the drug's tier and copay or coinsurance. In most instances, generically available drugs will be covered in a separate lower tier (lower copay), and branded drugs listed on the Formulary will be covered under a higher tier (higher copay). Specialty drugs will be covered under the highest tier (coinsurance with prescription maximum). Federal Affordable Care Act (ACA) preventative medications will be eligible for coverage without cost sharing (zero copay or zero coinsurance).

Under your POS Plan, you will pay a different copay or coinsurance for preferred generic or preferred brand drugs and non-preferred generic and brand drugs. Preferred drugs cost you less than non-preferred drugs. Please refer to the Tier Definition table below to see how to identify which drugs are preferred or non-preferred drugs.

If you request a brand-name drug when a generic drug is prescribed, you may be responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug. Please see your *Certificate of Insurance* for details.

For all drugs within the Drug Formulary table, the tier level is denoted throughout the document using the following symbols (*refer to table below*).

Tier Definition:

Symbol	Guideline	Description
T0	Tier 0	Preventive-care benefits required under the Affordable Care Act (ACA) at no cost
T1	Tier 1	Preferred Generic Drugs
T2	Tier 2	Preferred Brand Name Drugs
T3	Tier 3	Non-Preferred Generic and Brand Name Drugs
T4	Tier 4	Specialty Drugs
DME	Other pharmacy items	Other pharmacy items and certain DME, such as test strips and lancets, available at the pharmacy and through your medical benefit.

Maintaining and Updating the Formulary

The MedImpact Healthcare Systems Pharmacy and Therapeutics (P&T) and Formulary Committees provide physicians and pharmacists with a method to evaluate the safety, efficacy and competitive prices for commercially available drug products. The MedImpact P&T and Formulary Committees meet quarterly and more often as warranted to ensure clinical relevancy of the Formulary.

The Formulary is updated by the MedImpact P&T and Formulary Committees using a structured approach to the drug selection process to ensure continuing patient access to rational drug therapies.

The MedImpact P&T and Formulary Committees use the following criteria in the evaluation of drug selection for the Formulary:

- Drug safety profile
- Drug efficacy
- Comparison of relevant therapeutic benefits to current formulary drugs of similar use, and to minimize therapeutic duplication where possible
- Lower costs relative to comparable therapy

What medications are covered?

Your prescription drug benefit will generally cover prescribed generic, brand, and specialty drugs listed on the Formulary if the drug is medically necessary, the prescription is filled by a MedImpact network pharmacy provider, and other coverage rules are followed. Over-the-counter (OTC) medications are not generally covered, however, certain preventive OTC medications are covered when prescribed by a physician, such as aspirin, iron supplementation and smoking cessation drugs. Durable medical equipment, prescribed by a physician to treat diabetes or to assist with inhalation devices, is also covered.

The Formulary lists the pharmacy benefits covered under your outpatient prescription drug benefit and obtained from a MedImpact network retail pharmacy. This Formulary does not apply to drugs and devices that are obtained through the medical benefit portion of your coverage, for example, medications provided or administered in the doctor's office or in the hospital or, unless specifically stated otherwise, devices covered under the Durable Medical Equipment benefit that are obtained at the doctor's office or through a Durable Medical Equipment vendor.

Diabetes medication and equipment. Your outpatient prescription drug coverage includes the following prescription items for the management and treatment of diabetes:

- Insulin
- Needles and syringes for injecting insulin
- Prescriptive medications for the treatment of diabetes
- Glucagon

Other pharmacy items. Some Durable Medical Equipment that is covered through your medical benefit is also available at the pharmacy: disposable blood glucose and ketone urine test strips; blood glucose monitors; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; visual aids excluding eyewear to assist in insulin dosing; and peak flow meters.

Contraceptives. Your outpatient prescription drug coverage includes all prescribed FDA-approved contraceptive drugs, including over the counter FDA-approved female contraceptive methods at no cost-share when prescribed by a licensed health care professional authorized to prescribe drugs. All such medications require a prescription from your doctor.

ACA Preventive drugs at no cost. All medications, even over-the-counter (OTC) drugs, included under the federal Patient Protection and Affordable Care ACT (ACA) as preventive medications are eligible for coverage with no cost-share if the insured has a prescription from his or her doctor. However, some medications are only covered at no cost for patients who meet the criteria listed in the Formulary.

Note: The presence of a prescription drug on the Formulary does not guarantee that you will be prescribed that prescription drug by your prescribing provider for a particular medical condition.

Note: The copayment or coinsurance for a covered outpatient prescription drug for an individual prescription shall not exceed \$250 for a 30-day supply after satisfaction of the deductible, if any.

Note: The cost share for covered prescribed orally administered anti-cancer drugs shall not exceed \$200 for a 30-day supply.

What drugs are not covered?

General Exclusions

- Over-the-counter (OTC) medications or their equivalents, except for those OTC medications included in this Formulary.
- Any drug products used for cosmetic purposes.
- Experimental drug products or any drug product used in an experimental manner. Refer to your *Certificate of Insurance* for additional information.
- Replacement of lost or stolen medication.
- Medications administered by a clinician unless otherwise specified in the Formulary listing.
- Foreign-sourced drugs or drugs not approved by the U.S. Food & Drug Administration, except in certain cases of drug shortage, when allowed under the individual's pharmacy benefit.
- Weight loss drugs
- Sexual dysfunction drugs

Non-formulary drugs

Non-formulary drugs are covered when medically necessary.

How do I request an exception for a drug that is not on the Formulary?

You can request an exception to obtain coverage of a drug that is not on the Formulary by calling MedImpact at **1-800-788-2949**. Upon receipt of your exception request, MedImpact will notify you within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist of the request approval or other outcome. (Urgent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when you are using a drug while undergoing a current course of treatment.) If a standard exception request is granted, coverage of the non-formulary drug will be granted for the duration of the prescription, including refills. If an exception based on urgent circumstances is granted, coverage of the non-formulary drug will be granted for the duration of the urgency.

Are there any restrictions on the drugs covered on the Formulary?

Yes, for certain agents within the Formulary, a recommended prescribing guideline may apply. These are denoted throughout the document using the following symbols (*refer to table below*).

Note: Pursuant to Health and Safety Code section 1367.22, as then constituted and later amended, coverage for a prescription drug shall not be limited or excluded if the drug was previously approved for coverage for you under your plan for a medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the medical condition.

Guideline Symbol Table:

Symbol	Guidelines	Description
AGE	Age Edit	Coverage depends on patient age.
PA	Prior Authorization	Requires a prior authorization based on specific clinical criteria. See <i>“What is a Prior Authorization?”</i> below for additional
QL	Quantity Limit	Coverage is limited to specific quantities per prescription and/or time period. Prior authorization is required for quantities exceeding the restriction.
ST	Step Therapy	Coverage depends on previous use of another drug. Prior authorization may be required. See <i>“What is Step Therapy?”</i> below for additional information.

What is a Prior Authorization?

A prior authorization (“PA”) is a technique that is used to encourage safe and competitively priced medication use. Many drugs have multiple indications, so PAs are placed on drugs to make sure the drug is appropriate and safe for the insured.

How does the program work?

Drugs marked with a PA mean that your prescriber must first show that you have a medically necessary need for that particular drug. This means that to receive coverage your prescriber will need to work with MedImpact to receive pre-approval of the drug. Prior authorized drugs have specific clinical criteria that you must meet in order to obtain coverage. Refer to Requirements / Limits column in the Formulary for drugs that require a PA.

Upon receipt of your prior authorization request, MedImpact will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist of the request approval or other outcome. If MedImpact fails to respond within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist from receipt of a request form from a licensed prescribing provider, the request shall be deemed to have been approved. If you are not satisfied with the outcome, you can request a waiver by calling MedImpact at **1-800-788-2949**.

What are Quantity Limits?

Coverage for certain drugs may be limited to specific quantities per prescription and/or time period. Prior authorization is required for quantities exceeding the quantity limit guideline.

What is Step Therapy?

Selected prescription drugs require step therapy. The step therapy program encourages safe and competitively priced medication use. Under this program, a “step” approach is required to receive coverage for certain high-cost medications. This means that to receive coverage you may need to first try a proven, lower cost medication before using a more costly treatment.

How does the program work? The step therapy program requires that you have a prescription history for a “first-line” medication before your benefit plan will cover a “second-line” medication. A first-line medication is recognized as safe and effective in treating a specific medical condition, as well as keeping costs down. A second-line medication is a less- preferred or sometimes more costly treatment option. Refer to Step Therapy Edits in the Index section at the end of the Formulary for a complete list of medications requiring step therapy and their criteria.

When possible, your doctor should prescribe a first-line medication appropriate for your condition. If your doctor determines that a first-line drug is not appropriate for you or is not effective for you, your prescription drug benefit will cover a second-line drug when certain conditions are met. Prior authorization may be required. Upon receipt of your request for a second-line drug, MedImpact will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist of the request approval or other outcome. If you are not satisfied with the outcome, you can request a waiver by calling MedImpact at **1-800-788-2949**.

Note: If you have transitioned from a prior health insurance coverage to a new KPIC health insurance policy, any prescription drug that is currently being prescribed and considered safe and effective to treat a medical condition may not be subject to step therapy if, under your prior coverage:

- 1) The drug was not previously subject to step therapy; or
- 2) Step therapy was already obtained.

This does not apply if MedImpact’s P&T Committee and/or your provider determines that such drug is no longer safe or effective to treat your medical condition. Prior authorization may be required for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed under your prior coverage, and the prescribing provider is not precluded from prescribing another drug covered by the new policy that is medically appropriate for your condition.

The Pharmacy Network

This drug Formulary only applies to prescribed drugs, medicines and supplies purchased from a MedImpact network retail pharmacy. To fill your covered prescriptions, please visit a MedImpact network pharmacy. When visiting a MedImpact network pharmacy, please give the pharmacist your KPIC ID card with the MedImpact logo. The network of MedImpact network pharmacies includes over 60,000 chain and independent pharmacies nationwide. To find a MedImpact network pharmacy near you, call **1-800-788-2949**.

What drugs are eligible to be mailed from the mail-order pharmacy?

There is no mail-order pharmacy coverage available with respect to this Formulary through MedImpact network pharmacies. Mail-order pharmacy coverage is provided under the HMO tier of the POS Plan through Kaiser Permanente mail-order pharmacy. Please see your *Evidence of Coverage* or visit **kp.org/formulary** for details of this benefit.

Benefit Coverage and Limitations

This printed Formulary does not provide information regarding the specific coverage and limitations you may be subject to. Specific benefit inclusions, exclusions, and out-of-pocket costs are not reflected in the Formulary.

The Formulary applies only to outpatient drugs provided to you and does not apply to medications used in an inpatient setting. For specific questions regarding your coverage, please call KPIC Customer Service at **1-800-788-0710**.

Definition of Terms

The following terms apply to your prescription drug coverage and the drug Formulary.

“Brand name drug” means a drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this Formulary in all CAPITAL letters.

“Coinsurance” means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

“Copayment” means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

“Deductible” means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

“Drug Tier” means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

“Exception request” means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

“Exigent circumstances” means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

“Formulary” or “prescription drug list” means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

“Generic drug” means a drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this Formulary in italicized lowercase letters.

“Medically Necessary” means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

“Non-formulary drug” means a prescription drug that is not listed on this Formulary.

“Out-of-pocket costs” means your expenses for health care benefits that aren’t reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

“Over-the-counter (OTC) drugs” are medicines sold directly to a consumer without requiring a prescription from a healthcare professional. For purposes of this Formulary, OTC drugs that are covered under your outpatient prescription drug benefit require a prescription from your doctor.

“Prescribing provider” means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

“Prescription” means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.

“Prescription drug” means a drug that by law requires a prescription.

“Prior Authorization” means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this Formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

“Step therapy” means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this Formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

“Specialty drug” means high-cost prescription medications that are used to treat complex and chronic conditions, such as multiple sclerosis, rheumatoid arthritis, and hepatitis C. Specialty drugs often require special handling, administration, or monitoring.

Kaiser Foundation Health Plan, Inc. (KFHP) underwrites the HMO tier of the Kaiser Permanente POS Plan and Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the participating and non-participating provider tiers of the Kaiser Permanente POS Plan.

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alternative Therapy - Vitamins And Minerals		
Alternative Therapy - Antiarthritics - Vitamins And Minerals		
AZALGIA ORAL CAPSULE 125 MG-37.5 MG- 500 MCG- 1.25MG (glucosamine/methylsulf/vit C/folic ac/manganese/diet 29)	Tier 3	
COSAMIN AVOCA (WITH BOSWELLIA) ORAL TABLET 500-500-33.3-70 MG (glucosamine HCl/methylsulfonylmethane/Boswellia/herbal 182)	Tier 3	
<i>glucosam-chondr-vit c-mn-boron oral tablet 750-600-30-1 mg</i>	Tier 3	
<i>glucosamine hcl-hyaluronic oral tablet 1,000-1.65 mg</i>	Tier 3	
<i>glucosamine sulfate oral capsule 500 mg</i>	Tier 3	
<i>glucosamine sulfate oral tablet 1,000 mg</i>	Tier 3	
<i>glucosamine-chondroitin oral capsule 500-400 mg</i>	Tier 3	
<i>glucosamine-d3-hyaluronic acid oral tablet 1,000 mg- 25 mcg-1.65 mg</i>	Tier 3	
<i>glucosamine-msm-chondr-d3-bosw oral tablet 25 mcg- 937.5 mg</i>	Tier 3	
<i>glucosamine-msm-hyaluron acid oral tablet 500-500-1.1 mg</i>	Tier 3	
<i>glucosam-msm-chond-hrb149-hyal oral tablet 500-500-66.7 mg</i>	Tier 3	
INVIGOFLEX AMPM ORAL TABLETS, SEQUENTIAL 750 MG-600 MG- 50 MG-125 MG (glucosamine dipot chl/chondroitin sul A Na/Boswell/turmeric)	Tier 3	
INVIGOFLEX CS ORAL TABLET 600-125 MG (chondroitin sulfate/turmeric)	Tier 3	
INVIGOFLEX D ORAL POWDER IN PACKET 1,500 MG (glucosamine sulfate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INVIGOFLEX GS ORAL TABLET 750-50 MG (glucosamine sulfate dipotassium chlor/Boswellia serrata ext)	Tier 3	
MOVE FREE JOINT HEALTH ORAL TABLET 750 MG-100 MG- 1.65 MG-108 MG (glucosamine/chondroitin/hyaluronic acid/calcium fructoborate)	Tier 3	
MOVE FREE PLUS MSM ORAL TABLET 500 MG-66.7 MG- 500 MG-1.1 MG (glucosamine/chondroitin/msm/hyaluronic ac/calc fructoborate)	Tier 3	
MOVE FREE PLUS MSM-VIT D3 ORAL TABLET 750 MG-100 MG- 25 MCG (glucosamine/chondroitin/msm/D3/hyaluronic acid/cal borate)	Tier 3	
SYNOVX DJD ORAL CAPSULE 150 MG-150 MG- 250 MG-19 MG (glucosamin/chondroitin/msm/vit C/manganese/hyaluronic/mussel)	Tier 3	
Alternative Therapy - Antidepressants - Vitamins And Minerals		
<i>st. john's wort oral capsule 300 mg</i>	Tier 3	
Alternative Therapy - Antioxidant - Vitamins And Minerals		
ADULT 50 PLUS EYE HEALTH ORAL CAPSULE 250-5-1 MG (vit C,E,zinc,copper 11/omega-3/dha/epa/fish/lutein/zeaxanth)	Tier 3	
ALAMAX CR ORAL TABLET EXTENDED RELEASE 600 MG- 450 MCG (alpha lipoic acid/biotin)	Tier 3	
ALAMAX PROTECT ORAL CAPSULE 125 MG-95 MCG-250 MG (alpha lipoic acid/biotin/berberine chloride)	Tier 3	
<i>alpha lipoic acid oral capsule 100 mg</i>	Tier 3	
<i>alpha lipoic acid oral tablet 600 mg</i>	Tier 3	
<i>alpha lipoic acid-biotin oral capsule 300 mg- 333 mcg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIOXIDANT FORMULA (SELENIUM) ORAL TABLET 8,333-167-133 UNIT-MG-UNIT (beta-carotene/ascorbic acid/vitE ac/selenium yeast)	Tier 3	
EYE HEALTH PLUS LUTEIN ORAL TABLET 1,000 UNIT-200 MG-60 UNIT-2 MG (beta-carotene(A) w-C and E/lutein/minerals)	Tier 3	
EYE MULTIVITAMIN ORAL TABLET 7,160 UNIT- 113 MG-100 UNIT (beta-carotene/ascorbic acid/vitE ac/zinc oxide/cupric oxide)	Tier 3	
EYE MULTIVITAMIN WITH LUTEIN ORAL TABLET 300 MCG-200 MG- 27 MG (vit A, C, E/zinc oxide/sodium selenate/cupric oxide/lutein)	Tier 3	
<i>glutathione (bulk) powder 100 %</i>	Tier 3	
I-SIGHT ORAL CAPSULE 15 MG-100 MG-75 MG-50 MG (lutein/a-cysteine/ALA/quercet/zinc/taurine/bilberry/lycopene)	Tier 3	
LIVER PROTECT ORAL CAPSULE 200-200-262.5 MG (acetylcysteine/alpha lipoic/milk thistle/selenomethionine)	Tier 3	
<i>lutein oral capsule 20 mg</i>	Tier 3	
<i>lutein-zeaxanthin oral capsule 25-5 mg</i>	Tier 3	
<i>lutein-zeaxanthin oral capsule 40-1,600 mg-mcg</i>	Tier 3	
<i>lutein-zeaxanthin-bilberry ext oral capsule 20-1-2.2 mg</i>	Tier 3	
NUMAQUA VITAMIN ORAL TABLET 333 MCG-3 MG-0.67 MG (multivitamin with minerals/folic acid/lutein/zeaxanthin)	Tier 3	
PRESERVISION AREDS-2 ORAL TABLET,CHEWABLE 250-90-40-1 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
VISION HEALTH ORAL CAPSULE 250-90-40-2-5 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VISTA ADVANCED AREDS2 ORAL CAPSULE 250-137.5-12.5 MG (vit C/vit E/zinc/copper/selen/lutein/zeaxanthin/glutathione)	Tier 3	
Alternative Therapy - Cough And Cold Agents - Vitamins And Minerals		
BABY COUGH ORAL SYRUP 4 GRAM-45 MG- 9 MG/3 ML (agave extract/thyme leaf extract/English ivy extract)	Tier 3	
BABY COUGH-MUCUS ORAL SYRUP 4 GRAM- 21 MG/3 ML (blue agave extract/English ivy extract)	Tier 3	
Alternative Therapy - Pineal Hormone Agents - Vitamins And Minerals		
<i>melatonin oral lozenge 5 mg</i>	Tier 3	
Alternative Therapy - Sedative/Hypnotics - Vitamins And Minerals		
<i>valerian root extract-hops oral capsule 500-120 mg</i>	Tier 3	
Alternative Therapy - Unclassified - Vitamins And Minerals		
<i>ashwagandha root extract oral capsule 300 mg</i>	Tier 3	
ATRANTIL ORAL CAPSULE 275 MG (tannic acid/horse chestnut seed xt/peppermint leaf xt)	Tier 3	
AZO CRANBERRY PLUS PROBIOTIC ORAL TABLET 250-30-50 MG-MG-MILLION (cranberry fruit concentrate/ascorbic acid/Bacillus coagulans)	Tier 3	
AZO CRANBERRY PLUS VIT C ORAL CAPSULE 250-60 MG (cranberry fruit extract/ascorbic acid)	Tier 3	
<i>balsam peru (bulk) liquid</i>	Tier 3	
CANDICIDAL ORAL CAPSULE 100 MG-150 MG- 50 MG-150 MG (turmeric/ginger/olive/oregano/sodium caprylate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CRANBERRY URINARY TRACT HEALTH ORAL TABLET 250-30-3.5 MG (cranberry fruit concentrate/ascorbic acid/Bacillus coagulans)	Tier 3	
<i>echinacea purp aerial part ext oral capsule 65 mg</i>	Tier 3	
ESTROVEN CMPLT MENOPAUSE RLF ORAL TABLET 4 MG (rhubarb root extract)	Tier 3	
<i>ginkgo biloba leaf extract oral capsule 120 mg</i>	Tier 3	
GINKGO BILOBA PLUS (BACOPA) ORAL CAPSULE 120-40 MG (ginkgo biloba leaf extract/bacopa leaf extract)	Tier 3	
GLUCOSA IMMUNE BOOSTER ORAL CAPSULE (herbal complex no.306)	Tier 3	
MEDCAPS MENOPAUSE ORAL CAPSULE (herbal complex no.321)	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet extended release 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet, ir and er, biphasic 5-10 mg</i>	Tier 3	
MENOFEM ORAL CAPSULE (herbal complex no.323)	Tier 3	
MOVE FREE ULTRA TURMERIC-TAMAR ORAL TABLET 250 MG (tamarindus indica seed/turmeric root extract)	Tier 3	
NEURIVA DE-STRESS ORAL CAPSULE 100-200-10 MG (coffee extract/theanine/superoxide dismutase)	Tier 3	
NEURIVA ORIGINAL ORAL CAPSULE 100-100 MG (coffee extract/phosphatidyl serine)	Tier 3	
NEURIVA ORIGINAL ORAL TABLET,CHEWABLE 50-50 MG (coffee extract/phosphatidyl serine)	Tier 3	
NOOTROPIC COFFEE-PS ORAL CAPSULE 100-100 MG (coffee extract/phosphatidyl serine)	Tier 3	
NRF2 ACTIVATOR ORAL CAPSULE 200-200-50-30 MG (turmeric xt/green tea xt/pterostilbene/broccoli seed xt)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUMOISYN MUCOUS MEMBRANE LIQUID (flaxseed)	Tier 3	
ONCOPLEX ES ORAL CAPSULE 100 MG (broccoli seed extract)	Tier 3	
ONCOPLEX ORAL CAPSULE 30 MG (broccoli seed extract)	Tier 3	
ORAXINOL ORAL CAPSULE 500 MG (herbal complex no.319)	Tier 3	
<i>peppermint oil oil</i>	Tier 3	
<i>red yeast rice oral capsule 600 mg</i>	Tier 3	
SALOXICIN ORAL CAPSULE 60-25-20 MG (willow bark ext/Boswellia serrata ext/herbal complex no. 322)	Tier 3	
<i>tamarind seed-turmeric extract oral tablet 250 mg</i>	Tier 3	
<i>turmeric root-ginger root ext oral tablet, chewable 150-25 mg</i>	Tier 3	
<i>turmeric-turmeric root extract oral capsule 450-50 mg</i>	Tier 3	
<i>valerian-flower-hops-lemon oral capsule 450-100 mg</i>	Tier 3	
Analgesic, Anti-Inflammatory Or Antipyretic		
Immunomodulator - Rho Kinase Inhibitor		
REZUROCK ORAL TABLET 200 MG (belumosudil mesylate)	Tier 4	PA
Analgesic, Anti-Inflammatory Or Antipyretic - Drugs For Pain And Fever		
Analgesic Opioid Agonists - Arthritis And Pain Drugs		
<i>codeine sulfate oral tablet 15 mg, 30 mg</i>	Tier 1	QL (12 EA per 1 day); Age (Min 12 Years)
<i>codeine sulfate oral tablet 60 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
DEMEROL (PF) INJECTION SYRINGE 100 MG/ML, 25 MG/ML, 50 MG/ML, 75 MG/ML (meperidine HCl/PF)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILAUDID (PF) INJECTION SYRINGE 0.5 MG/0.5 ML, 1 MG/ML, 2 MG/ML, 4 MG/ML (hydromorphone HCl/PF)	Tier 3	
DSUVIA SUBLINGUAL TABLET IN APPLICATOR 30 MCG (sufentanil citrate)	Tier 3	
<i>fentanyl citrate (pf) intravenous patient control analgesia soln 1,500 mcg/30 ml (50 mcg/ml)</i>	Tier 3	
<i>fentanyl citrate (pf)-0.9%nacl intravenous pt controlled analgesia syring 500 mcg/50 ml (10 mcg/ml)</i>	Tier 3	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	Tier 1	PA
<i>fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	Tier 1	PA
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Tier 1	PA; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 3 days)
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour</i>	Tier 1	PA; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 3 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (fentanyl citrate)	Tier 3	PA
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone bitartrate oral tablet,oral only,ext.rel.24 hr 100 mg, 120 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>hydromorphone (pf)-0.9 % nacl intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	Tier 3	
<i>hydromorphone oral liquid 1 mg/ml</i>	Tier 1	
<i>hydromorphone oral tablet 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg</i>	Tier 1	PA; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>hydromorphone oral tablet extended release 24 hr 32 mg</i>	Tier 1	PA; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>hydromorphone rectal suppository 3 mg</i>	Tier 1	
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 120 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (hydrocodone bitartrate)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY (fentanyl citrate)	Tier 3	PA
<i>levorphanol tartrate oral tablet 2 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levorphanol tartrate oral tablet 3 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>meperidine (pf) injection solution 100 mg/ml, 50 mg/ml</i>	Tier 1	
<i>meperidine (pf) injection solution 25 mg/ml</i>	Tier 1	
<i>meperidine injection cartridge 10 mg/ml</i>	Tier 1	
<i>meperidine oral solution 50 mg/5 ml</i>	Tier 3	QL (30 ML per 1 day)
<i>meperidine oral tablet 50 mg</i>	Tier 3	QL (6 EA per 1 day)
<i>methadone injection solution 10 mg/ml</i>	Tier 1	QL (4 ML per 1 day)
methadone HCl (Methadone Intensol Oral Concentrate 10 Mg/ML)	Tier 1	QL (4 ML per 1 day)
<i>methadone oral concentrate 10 mg/ml</i>	Tier 1	QL (4 ML per 1 day)
<i>methadone oral solution 10 mg/5 ml</i>	Tier 1	QL (20 ML per 1 day)
<i>methadone oral solution 5 mg/5 ml</i>	Tier 1	QL (40 ML per 1 day)
<i>methadone oral tablet 10 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>methadone oral tablet 5 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>methadone oral tablet, soluble 40 mg</i>	Tier 1	QL (1 EA per 1 day)
methadone HCl (Methadose Oral Tablet, Soluble 40 Mg)	Tier 1	QL (1 EA per 1 day)
<i>morphine (pf) intravenous syringe 1 mg/2 ml</i>	Tier 1	
<i>morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)</i>	Tier 1	PA
<i>morphine in 0.9 % sodium chlor intravenous pt controlled analgesia syring 275 mg/55 ml (5 mg/ml)</i>	Tier 3	
<i>morphine in 0.9 % sodium chlor intravenous solution 1 mg/ml</i>	Tier 3	
<i>morphine in 0.9 % sodium chlor intravenous solution 5 mg/ml</i>	Tier 3	
<i>morphine intramuscular pen injector 10 mg/0.7 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	Tier 3	
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>morphine oral tablet 15 mg, 30 mg</i>	Tier 2	
<i>morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day)
<i>morphine rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG (tapentadol HCl)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (tapentadol HCl)	Tier 2	QL (6 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXAYDO ORAL TABLET, ORAL ONLY 5 MG, 7.5 MG (oxycodone HCl)	Tier 3	
<i>oxycodone oral capsule 5 mg</i>	Tier 1	
<i>oxycodone oral concentrate 20 mg/ml</i>	Tier 1	PA
<i>oxycodone oral solution 5 mg/5 ml</i>	Tier 1	
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>oxycodone oral tablet,oral only,ext.rel.12 hr 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG (oxycodone HCl)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG (oxycodone HCl)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
<i>oxymorphone oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxymorphone oral tablet extended release 12 hr 30 mg, 40 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
QDOLO ORAL SOLUTION 5 MG/ML (tramadol HCl)	Tier 3	PA
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 1,200 MCG (600 MCG/SPRAY X 2), 1,600 MCG (800 MCG/SPRAY X 2), 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY (fentanyl)	Tier 3	PA
<i>tramadol oral capsule, er biphase 24 hr 17-83 300 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral capsule, er biphase 24 hr 25-75 100 mg, 200 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet 100 mg</i>	Tier 1	QL (4 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet 50 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet extended release 24 hr 100 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day); Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tramadol oral tablet extended release 24 hr 200 mg, 300 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet, er multiphase 24 hr 100 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet, er multiphase 24 hr 200 mg, 300 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 9 MG (oxycodone myristate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 27 MG (oxycodone myristate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG (oxycodone myristate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (8 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG (hydrocodone bitartrate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
Analgesic Opioid Codeine Combinations - Arthritis And Pain Drugs		
<i>acetaminophen-codeine oral solution 120 mg-12 mg /5 ml (5 ml)</i>	Tier 3	QL (150 ML per 1 day); Age (Min 12 Years)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	Tier 1	QL (150 ML per 1 day); Age (Min 12 Years)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	Tier 1	QL (12 EA per 1 day); Age (Min 12 Years)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
codeine phosphate/butalbital/aspirin/caffeine (Ascomp With Codeine Oral Capsule 30-50-325-40 Mg)	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
codeine phosphate/butalbital/aspirin/caffeine (Butalbital Compound W/Codeine Oral Capsule 30-50-325-40 Mg)	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
Analgesic Opioid Dihydrocodeine Combinations - Arthritis And Pain Drugs		
<i>acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg</i>	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acetaminophen-caff-dihydrocod oral tablet 325-30-16 mg</i>	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)
acetaminophen/caffeine/dihydrocodeine bitartrate (Dvorah Oral Tablet 325-30-16 Mg)	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)
Analgesic Opioid Dihydrocodeine, Non-Salicylate Analgesic, Xanthine - Arthritis And Pain Drugs		
<i>acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg</i>	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)
<i>acetaminophen-caff-dihydrocod oral tablet 325-30-16 mg</i>	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)
acetaminophen/caffeine/dihydrocodeine bitartrate (Dvorah Oral Tablet 325-30-16 Mg)	Tier 1	ST: Must meet the following requirement: Acetaminophen With Codeine tablets in 120 days; QL (10 EA per 1 day); Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Analgesic Opioid Hydrocodone And Non-Salicylate Combinations - Arthritis And Pain Drugs		
APADAZ ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG (benzhydrocodone HCl/acetaminophen)	Tier 3	ST: Must meet the following requirement: generic Norco (Hydrocodone/acetaminophen) tablet in 120 days; QL (12 EA per 1 day)
<i>benzhydrocodone-acetaminophen oral tablet 4.08-325 mg, 6.12-325 mg, 8.16-325 mg</i>	Tier 1	ST: Must meet the following requirement: generic Norco (Hydrocodone/acetaminophen) tablet in 120 days; QL (12 EA per 1 day)
<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
LORTAB ELIXIR ORAL SOLUTION 10-300 MG/15 ML (hydrocodone bitartrate/acetaminophen)	Tier 3	QL (200 ML per 1 day)
hydrocodone bitartrate/acetaminophen (Vicodin Hp Oral Tablet 10-300 Mg)	Tier 1	QL (13 EA per 1 day)
Analgesic Opioid Hydrocodone Combinations - Arthritis And Pain Drugs		
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Tier 1	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 1	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier 1	QL (13 EA per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LORTAB ELIXIR ORAL SOLUTION 10-300 MG/15 ML (hydrocodone bitartrate/acetaminophen)	Tier 3	QL (200 ML per 1 day)
hydrocodone bitartrate/acetaminophen (Vicodin Hp Oral Tablet 10-300 Mg)	Tier 1	QL (13 EA per 1 day)
hydrocodone/ibuprofen (Xylon 10 Oral Tablet 10-200 Mg)	Tier 1	
Analgesic Opioid Oxycodone And Non-Salicylate Combinations - Arthritis And Pain Drugs		
oxycodone HCl/acetaminophen (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg</i>	Tier 1	QL (13 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i>	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 10-300 Mg)	Tier 1	QL (13 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 5-300 Mg, 7.5-300 Mg)	Tier 3	QL (13 EA per 1 day)
Analgesic Opioid Oxycodone Combinations - Arthritis And Pain Drugs		
oxycodone HCl/acetaminophen (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Nalocet Oral Tablet 2.5-300 Mg)	Tier 1	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg</i>	Tier 1	QL (13 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-300 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 10-300 Mg)	Tier 1	QL (13 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 5-300 Mg, 7.5-300 Mg)	Tier 3	QL (13 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROLATE ORAL SOLUTION 10-300 MG/5 ML (oxycodone HCl/acetaminophen)	Tier 3	QL (66 ML per 1 day)
oxycodone HCl/acetaminophen (Prolate Oral Tablet 10-300 Mg, 5-300 Mg, 7.5-300 Mg)	Tier 1	QL (13 EA per 1 day)
Analgesic Opioid Partial-Mixed Agonists - Arthritis And Pain Drugs		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (buprenorphine HCl)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
BUPRENEX INJECTION SOLUTION 0.3 MG/ML (buprenorphine HCl)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>buprenorphine hcl injection solution 0.3 mg/ml</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>buprenorphine hcl injection syringe 0.3 mg/ml</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour, 7.5 mcg/hour</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 28 days)
<i>butorphanol injection solution 1 mg/ml, 2 mg/ml</i>	Tier 1	
<i>butorphanol nasal spray, non-aerosol 10 mg/ml</i>	Tier 1	
<i>nalbuphine injection solution 10 mg/ml, 20 mg/ml</i>	Tier 1	
<i>pentazocine-naloxone oral tablet 50-0.5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Analgesic Opioid Tramadol Combinations - Arthritis And Pain Drugs		
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	Tier 1	QL (10 EA per 1 day); Age (Min 12 Years)
Analgesic Or Antipyretic Non-Opioid/Sedative Combinations - Arthritis And Pain Drugs		
butalbital/acetaminophen (Allzital Oral Tablet 25-325 Mg)	Tier 3	ST: Must meet the following requirement: generic Butalbital/acetaminophen 50mg-325mg combination product in 120 days; QL (12 EA per 1 day)
<i>butalbital-acetaminophen oral capsule 50-300 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>butalbital-acetaminophen oral tablet 25-325 mg</i>	Tier 1	ST: Must meet the following requirement: generic Butalbital/acetaminophen 50mg-325mg combination product in 120 days; QL (12 EA per 1 day)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	Tier 1	ST: Must meet the following requirement: generic Butalbital/acetaminophen 50mg-325mg combination product in 120 days; QL (6 EA per 1 day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg, 50-325-40 mg</i>	Tier 1	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
butalbital/acetaminophen/caffeine (Fioricet Oral Capsule 50-300-40 Mg)	Tier 1	
butalbital/acetaminophen (Tencon Oral Tablet 50-325 Mg)	Tier 1	
butalbital/acetaminophen/caffeine (Vanatol Lq Oral Solution 50-325-40 Mg/15 MI)	Tier 1	
butalbital/acetaminophen/caffeine (Vanatol S Oral Solution 50-325-40 Mg/15 MI)	Tier 1	
butalbital/acetaminophen/caffeine (Vtol Lq Oral Solution 50-325-40 Mg/15 MI)	Tier 1	
butalbital/acetaminophen/caffeine (Zebutal Oral Capsule 50-325-40 Mg)	Tier 1	
Anti-Inflammatory - Interleukin-1 Receptor Antagonist - Arthritis And Pain Drugs		
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG (rilonacept)	Tier 4	
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Tnf-Alpha Sel - Arthritis And Pain Drugs		
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 4	PA
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA PEN PSOR-UEVITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 4	PA
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML (golimumab)	Tier 2	
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA
Dmard - Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents - Arthritis And Pain Drugs		
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 4	PA
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML) (etanercept)	Tier 4	PA
ENBREL SUBCUTANEOUS RECON SOLN 25 MG (1 ML) (etanercept)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML (etanercept)	Tier 4	PA
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) (etanercept)	Tier 4	PA
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML) (etanercept)	Tier 4	PA
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA PEN PSOR-UVEITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 4	PA
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML (golimumab)	Tier 2	
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dmard - Antimalarials - Arthritis And Pain Drugs		
<i>hydroxychloroquine oral tablet 100 mg</i>	Tier 1	QL (180 EA per 30 days)
<i>hydroxychloroquine oral tablet 300 mg, 400 mg</i>	Tier 1	QL (60 EA per 30 days)
Dmard - Antimetabolites - Arthritis And Pain Drugs		
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	Tier 1	
<i>methotrexate sodium injection solution 25 mg/ml</i>	Tier 1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML (methotrexate/PF)	Tier 2	QL (1.6 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (0.8 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 12.5 MG/0.25 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 15 MG/0.3 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.2 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 17.5 MG/0.35 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.4 ML per 28 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 20 MG/0.4 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.6 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 22.5 MG/0.45 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.8 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 25 MG/0.5 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (2 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 30 MG/0.6 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (2.4 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 7.5 MG/0.15 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (0.6 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 10 MG/0.4 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.6 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 12.5 MG/0.5 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (2 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 15 MG/0.6 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (2.4 ML per 28 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REDITREX (PF) SUBCUTANEOUS SYRINGE 17.5 MG/0.7 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (2.8 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 20 MG/0.8 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (3.2 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 22.5 MG/0.9 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (3.6 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 25 MG/ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (4 ML per 28 days)
REDITREX (PF) SUBCUTANEOUS SYRINGE 7.5 MG/0.3 ML (methotrexate/PF)	Tier 3	ST: Must meet the following requirement: Otrexup in 120 days; QL (1.2 ML per 28 days)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; ST: Must meet any of the following requirements: Methotrexate Sodium, Methotrexate Sodium/pf, Rheumatrex, or Trexall in 120 days if 12 years of age and older; QL (120 ML per 60 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dmard - Antinflammatory, Select. Costimulation Modulator,T-Cell Inhib. - Arthritis And Pain Drugs		
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR 125 MG/ML (abatacept)	Tier 4	PA
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML (abatacept)	Tier 4	PA
Dmard - Gold Compounds - Arthritis And Pain Drugs		
RIDAURA ORAL CAPSULE 3 MG (auranofin)	Tier 2	
Dmard - Immunosuppressives - Arthritis And Pain Drugs		
azathioprine (Azasan Oral Tablet 100 Mg, 75 Mg)	Tier 3	
<i>cyclosporine oral capsule 100 mg</i>	Tier 1	
cyclosporine, modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1	
cyclosporine, modified (Gengraf Oral Solution 100 Mg/ML)	Tier 1	
SANDIMMUNE ORAL SOLUTION 100 MG/ML (cyclosporine)	Tier 4	
Dmard - Interleukin-1 Receptor Antagonist (IL-1Ra) - Arthritis And Pain Drugs		
KINERET SUBCUTANEOUS SYRINGE 100 MG/0.67 ML (anakinra)	Tier 4	PA
Dmard - Interleukin-6 (IL-6) Receptor Inhibitors, Monoclonal Antibody - Arthritis And Pain Drugs		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML (tocilizumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACTEMRA SUBCUTANEOUS SYRINGE 162 MG/0.9 ML (tocilizumab)	Tier 4	PA
KEVZARA SUBCUTANEOUS PEN INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML (sarilumab)	Tier 4	PA
KEVZARA SUBCUTANEOUS SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML (sarilumab)	Tier 4	PA
Dmard - Janus Kinase (Jak) Inhibitors - Arthritis And Pain Drugs		
OLUMIANT ORAL TABLET 1 MG, 2 MG (baricitinib)	Tier 4	PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG (upadacitinib)	Tier 4	PA
XELJANZ ORAL SOLUTION 1 MG/ML (tofacitinib citrate)	Tier 4	PA
XELJANZ ORAL TABLET 5 MG (tofacitinib citrate)	Tier 4	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG (tofacitinib citrate)	Tier 4	PA
Dmard - Other - Arthritis And Pain Drugs		
CUPRIMINE ORAL CAPSULE 250 MG (penicillamine)	Tier 2	PA
D-PENAMINE ORAL TABLET 125 MG (penicillamine)	Tier 4	PA
Dmard - Phosphodiesterase-4 (Pde4) Inhibitors - Arthritis And Pain Drugs		
OTEZLA ORAL TABLET 30 MG (apremilast)	Tier 4	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47), 10 MG (4)-20 MG (4)-30 MG(19) (apremilast)	Tier 4	PA
Dmard - Pyrimidine Synthesis Inhibitors - Arthritis And Pain Drugs		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Immunomodulator B-Lymphocyte Stimulator (Blys)-Specific Inhibitor Mcab - Arthritis And Pain Drugs		
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML (belimumab)	Tier 4	PA
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML (belimumab)	Tier 4	PA
Nsaid Analgesic And Histamine H2 Receptor Antagonist Combinations - Arthritis And Pain Drugs		
<i>ibuprofen-famotidine oral tablet 800-26.6 mg</i>	Tier 1	ST: Must meet the following requirement: generic prescription strength Ibuprofen 400, 600, or 800mg in 120 days; QL (3 EA per 1 day)
Nsaid Analgesic And Prostaglandin Analog Combinations - Arthritis And Pain Drugs		
<i>diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic 50-200 mg-mcg, 75-200 mg-mcg</i>	Tier 1	
Nsaid Analgesic And Proton Pump Inhibitor Combinations - Arthritis And Pain Drugs		
<i>naproxen-esomeprazole oral tablet,ir,delayed rel,biphasic 375-20 mg, 500-20 mg</i>	Tier 1	ST: Must meet any of the following requirements: Naprelan, Naproxen, or Naproxen Sodium in 120 days
Nsaid Analgesic And Topical Irritant Counter-Irritant Combinations - Arthritis And Pain Drugs		
COMFORT PAC-IBUPROFEN KIT 800 MG (ibuprofen/irritants counter-irritants combination no.2)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT PAC-MELOXICAM KIT 15 MG (meloxicam/irritants counter-irritants combination no.2)	Tier 3	
COMFORT PAC-NAPROXEN KIT 500 MG (naproxen/irritant counter-irritant combination no.2)	Tier 3	
FLEXIPAK KIT 75 MG- 0.025 % (diclofenac sodium/capsaicin)	Tier 3	
INAVIX KIT 75 MG- 0.025 % (diclofenac sodium/capsaicin)	Tier 3	
INFLAMMACIN KIT 75 MG- 0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
INFLATHERM(DICLOFENAC-MENTHOL) KIT, GEL AND TABLET DELAY REL 75 MG-3 %- 3 % (diclofenac sodium/menthol/camphor)	Tier 3	
NUDICLO TABPAK KIT 75 MG- 0.025 % (diclofenac sodium/capsaicin)	Tier 3	
NUDROXIPAK DSDR-50 KIT, LIQUID AND TABLET DEL REL 50 MG-0.025 %- 25 %-6 % (diclofenac sodium/capsaicin/methyl salicylate/menthol)	Tier 3	
NUDROXIPAK DSDR-75 KIT, LIQUID AND TABLET DEL REL 75 MG-0.025 %- 25 %-6 % (diclofenac sodium/capsaicin/methyl salicylate/menthol)	Tier 3	
NUDROXIPAK E-400 KIT, LIQUID AND TABLET 400 MG- 0.025 %- 25 %-6 % (etodolac/capsaicin/methyl salicylate/menthol)	Tier 3	
NUDROXIPAK I-800 KIT, LIQUID AND TABLET 800 MG- 0.025 %- 25 %-6 % (ibuprofen/capsaicin/methyl salicylate/menthol)	Tier 3	
NUDROXIPAK N-500 KIT, LIQUID AND TABLET 500 MG- 0.025 %- 25 %-6 % (nabumetone/capsaicin/methyl salicylate/menthol)	Tier 3	
XENAFLAMM KIT 75 MG- 0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nsaid Analgesic, Cyclooxygenase-2 (Cox-2) Selective Inhibitors - Arthritis And Pain Drugs		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	Tier 1	
NUDROXIPAK KIT, LIQUID AND CAPSULE 200 MG-0.025 %- 25 %-6 % (celecoxib/capsaicin/methyl salicylate/menthol)	Tier 3	
Nsaid Analgesics (Cox Non-Specific) - Anthranilic Acid Derivatives - Arthritis And Pain Drugs		
<i>meclofenamate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>mefenamic acid oral capsule 250 mg</i>	Tier 1	
Nsaid Analgesics (Cox Non-Specific) - Other - Arthritis And Pain Drugs		
<i>ketorolac injection cartridge 15 mg/ml, 30 mg/ml</i>	Tier 1	
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	Tier 1	
<i>ketorolac injection solution 30 mg/ml</i>	Tier 1	
<i>ketorolac injection syringe 15 mg/ml, 30 mg/ml</i>	Tier 3	
<i>ketorolac intramuscular cartridge 60 mg/2 ml</i>	Tier 1	
<i>ketorolac intramuscular solution 60 mg/2 ml</i>	Tier 1	
<i>ketorolac intramuscular syringe 60 mg/2 ml</i>	Tier 1	
<i>ketorolac nasal spray, non-aerosol 15.75 mg/spray</i>	Tier 1	ST: Must meet the following requirement: Generic nonsteroidal anti-inflammatory drug in 120 days; QL (5 EA per 30 days)
<i>ketorolac oral tablet 10 mg</i>	Tier 1	QL (20 EA per 5 days)
<i>nabumetone oral tablet 500 mg, 750 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELAFEN DS ORAL TABLET 1,000 MG (nabumetone)	Tier 3	ST: Must meet the following requirement: Nabumetone in 120 days; QL (2 EA per 1 day); Age (Min 18 Years)
SPRIX NASAL SPRAY, NON-AEROSOL 15.75 MG/SPRAY (ketorolac tromethamine)	Tier 3	ST: Must meet the following requirement: Generic nonsteroidal anti-inflammatory drug in 120 days; QL (5 EA per 30 days)
<i>sulindac oral tablet 150 mg, 200 mg</i>	Tier 1	
<i>tolmetin oral capsule 400 mg</i>	Tier 1	
<i>tolmetin oral tablet 200 mg, 600 mg</i>	Tier 1	
TORONOVA II SUIK KIT 30 MG/ML (ketorolac/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
TORONOVA SUIK KIT 30 MG/ML (ketorolac/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
Nsaid Analgesics (Cox Non-Specific) - Oxicam Derivatives - Arthritis And Pain Drugs		
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	Tier 1	
<i>meloxicam submicronized oral capsule 10 mg, 5 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Diclofenac Potassium, Diclofenac Sodium, or Meloxicam in 365 days; QL (1 EA per 1 day)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVLODEX ORAL CAPSULE 10 MG, 5 MG (meloxicam, submicronized)	Tier 3	ST: Must meet 2 of the following requirements: Diclofenac Potassium, Diclofenac Sodium, or Meloxicam in 365 days; QL (1 EA per 1 day)
Nsaid Analgesics (Cox Non-Specific) - Phenylacetic Acid Derivatives - Arthritis And Pain Drugs		
CAMBIA ORAL POWDER IN PACKET 50 MG (diclofenac potassium)	Tier 3	PA
<i>diclofenac potassium oral tablet 50 mg</i>	Tier 1	
<i>diclofenac sodium oral tablet extended release 24 hr 100 mg</i>	Tier 1	
<i>diclofenac sodium oral tablet, delayed release (dr/ec) 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>diclofenac submicronized oral capsule 35 mg</i>	Tier 1	ST: Must meet any of the following requirements: Diclo Gel, Diclofenac Sodium, Diclofono, Diclozor, Dyloject, Pennsaid, or Vopac Mds in 120 days; QL (3 EA per 1 day)
ZIPSOR ORAL CAPSULE 25 MG (diclofenac potassium)	Tier 3	ST: Must meet any of the following requirements: Diclo Gel, Diclofenac Sodium, Diclofenac Sodium/misoprostol, Diclofono, Diclozor, Dyloject, Pennsaid, or Vopac Mds in 120 days; QL (4 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZORVOLEX ORAL CAPSULE 18 MG, 35 MG (diclofenac submicronized)	Tier 3	ST: Must meet any of the following requirements: Diclo Gel, Diclofenac Sodium, Diclofono, Diclozor, Dyloject, Pennsaid, or Vopac Mds in 120 days; QL (3 EA per 1 day)
Nsaid Analgesics (Cox Non-Specific) - Propionic Acid Derivatives - Arthritis And Pain Drugs		
EC-NAPROXEN ORAL TABLET, DELAYED RELEASE (DR/EC) 375 MG, 500 MG (naproxen)	Tier 1	
<i>fenoprofen oral capsule 200 mg, 400 mg</i>	Tier 1	
<i>fenoprofen oral tablet 600 mg</i>	Tier 1	
<i>flurbiprofen oral tablet 100 mg</i>	Tier 1	
ibuprofen (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg)	Tier 1	
IBUPAK ORAL KIT 600 MG (ibuprofen/glycerin)	Tier 3	
<i>ibuprofen oral suspension 100 mg/5 ml</i>	Tier 1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	Tier 1	
<i>ketoprofen oral capsule 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	Tier 1	
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG (naproxen sodium)	Tier 3	
<i>naproxen oral suspension 125 mg/5 ml</i>	Tier 1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	Tier 1	
<i>naproxen oral tablet, delayed release (dr/ec) 375 mg, 500 mg</i>	Tier 1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg, 750 mg</i>	Tier 1	
<i>oxaprozin oral tablet 600 mg</i>	Tier 1	
Nsaid Analgesics, (Cox Non-Specific) - Indole Acetic Acid Derivatives - Arthritis And Pain Drugs		
<i>etodolac oral capsule 200 mg, 300 mg</i>	Tier 1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	Tier 1	
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg, 600 mg</i>	Tier 1	
INDOCIN ORAL SUSPENSION 25 MG/5 ML (indomethacin)	Tier 2	
INDOCIN RECTAL SUPPOSITORY 50 MG (indomethacin)	Tier 3	PA
<i>indomethacin oral capsule 25 mg, 50 mg</i>	Tier 1	
<i>indomethacin oral capsule, extended release 75 mg</i>	Tier 1	
<i>indomethacin submicronized oral capsule 20 mg</i>	Tier 1	ST: Must meet the following requirement: Generic Indomethacin capsules in 120 days; QL (3 EA per 1 day)
TIVORBEX ORAL CAPSULE 20 MG (indomethacin, submicronized)	Tier 3	ST: Must meet the following requirement: Generic Indomethacin capsules in 120 days; QL (3 EA per 1 day)
Salicylate Analgesic And Sedative Combinations - Arthritis And Pain Drugs		
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	Tier 1	
<i>butalbital-aspirin-caffeine oral tablet 50-325-40 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Salicylate Analgesic Combinations - Arthritis And Pain Drugs		
<i>choline,magnesium salicylate oral liquid 500 mg/5 ml</i>	Tier 1	
Salicylate Analgesics - Arthritis And Pain Drugs		
ADULT ASPIRIN REGIMEN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
ASPIRIN CHILDRENS ORAL TABLET,CHEWABLE 81 MG (aspirin)	Tier 0	
ASPIRIN LOW DOSE ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
<i>aspirin oral tablet 325 mg</i>	Tier 0	
<i>aspirin oral tablet,chewable 81 mg</i>	Tier 0	
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg</i>	Tier 0	
ASPIR-TRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	Tier 0	
CHILDREN'S ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	Tier 0	
<i>diflunisal oral tablet 500 mg</i>	Tier 1	
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG (aspirin)	Tier 3	PA
ECOTRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	Tier 0	
LO-DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
<i>salsalate oral tablet 500 mg, 750 mg</i>	Tier 1	
ST JOSEPH ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ST. JOSEPH ASPIRIN ORAL TABLET, DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
Anesthetics - Drugs For Pain And Fever		
Anesthetic - Non-Parenteral - Drugs For Sedation		
<i>ketamine sublingual troche 100 mg</i>	Tier 1	
Anesthetic, Non-Parenteral-Benzodiazepine-Anti-Emetic Combinations - Drugs For Sedation		
MKO (MIDAZOLAM-KETAMINE-ONDAN) SUBLINGUAL TROCHE 3-25-2 MG (midazolam/ketamine HCl/ondansetron HCl)	Tier 1	
General Anesthetic - Inhalant Volatile - Drugs For Sedation		
<i>desflurane inhalation liquid 100 %</i>	Tier 1	
<i>isoflurane inhalation liquid 99.9 %</i>	Tier 1	
<i>sevoflurane inhalation liquid</i>	Tier 1	
SUPRANE INHALATION LIQUID 100 % (desflurane)	Tier 3	
isoflurane (Terrell Inhalation Liquid 99.9 %)	Tier 1	
General Anesthetic - Parenteral, Benzodiazepines - Drugs For Sedation		
<i>midazolam (pf) injection solution 5 mg/ml</i>	Tier 3	
<i>midazolam injection solution 5 mg/ml</i>	Tier 3	
Local Anesthetic - Amides - Drugs For Sedation		
ACCUCAINE KIT KIT 10 MG/ML (1 %) (lidocaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
<i>lidocaine hcl laryngotracheal solution 4 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine topical ointment 5 %</i>	Tier 1	QL (240 GM per 30 days)
LIDOMARK 1-5 KIT 10 MG/ML (1 %) (lidocaine HCl/PF/adhesive bandage)	Tier 3	
LIDOMARK 2-5 KIT 20 MG/ML (2 %) (lidocaine HCl/PF/adhesive bandage)	Tier 3	
MARVONA SUIK (PF) KIT 0.5 % (5 MG/ML) (bupivacaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
Anorectal Preparations - Rectal Preparations		
Anal Fissure Pain/Treatment Agents - Nitrates - Rectal Preparations		
RECTIV RECTAL OINTMENT 0.4 % (W/W) (nitroglycerin)	Tier 3	
Anorectal - Glucocorticoids - Rectal Preparations		
ANUCORT-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	Tier 1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	Tier 1	
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	Tier 3	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	Tier 1	
hydrocortisone (Procto-Med Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Procto-Pak Topical Cream With Perineal Applicator 1 %)	Tier 3	
hydrocortisone (Proctosol Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Proctozone-Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anorectal - Hemorrhoidal Rectal Glucocorticoid-Local Anesthetic Comb - Rectal Preparations		
ANA-LEX KIT RECTAL KIT 2-2 % (hydrocortisone acetate/lidocaine HCl/aloe vera)	Tier 1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %, 2.5-1 %</i>	Tier 1	
<i>hydrocortisone-pramoxine rectal cream 2.5-1 % (4g)</i>	Tier 3	
<i>lidocaine hcl-hydrocortison ac rectal cream 3-0.5 %</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac rectal gel 3 %-2.5 % (7 gram)</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac rectal kit 2 %-2 % (7 gram)</i>	Tier 3	
<i>lidocaine hcl-hydrocortison ac rectal kit 3-0.5 %, 3-1 % (7 gram)</i>	Tier 1	
<i>lidocaine-hydrocortisone-aloe rectal gel 2.8-0.55 %</i>	Tier 1	
<i>lidocaine-hydrocortisone-aloe rectal kit 3-2.5 % (7 gram)</i>	Tier 1	
PROCORT RECTAL CREAM 1.85-1.15 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	
PROCTOFOAM HC RECTAL FOAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
ZYPRAM RECTAL KIT, CREAM AND TOWELETTE 2.35-1 % (hydrocortisone acetate/pramoxine HCl/skin cleanser no.16)	Tier 3	
Antidotes And Other Reversal Agents - Drugs For Overdose Or Poisoning		
Antidote - Cholinesterase Reactivating Agent - Drugs For Overdose Or Poisoning		
<i>pralidoxime intramuscular pen injector 600 mg/2 ml</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidote - Cholinesterase Reactivating Agent And Muscarinic Antagonist - Drugs For Overdose Or Poisoning		
DUODOTE INTRAMUSCULAR PEN INJECTOR 600-2.1 MG/2ML-MG/0.7ML (pralidoxime chloride/atropine sulfate)	Tier 3	
Antidote - Cyanide Poisoning - Drugs For Overdose Or Poisoning		
<i>amyl nitrite inhalation solution 0.3 ml</i>	Tier 1	
Antidote - Radioactive Agents - Drugs For Overdose Or Poisoning		
RADIOGARDASE ORAL CAPSULE 0.5 GRAM (prussian blue (insoluble))	Tier 3	
Antidote Others - Drugs For Overdose Or Poisoning		
GALZIN ORAL CAPSULE 25 MG (ZINC), 50 MG (ZINC) (zinc acetate)	Tier 3	
RADIOGARDASE ORAL CAPSULE 0.5 GRAM (prussian blue (insoluble))	Tier 3	
WILZIN ORAL CAPSULE 25 MG (ZINC) (zinc acetate)	Tier 3	
Chelating Agents - Copper - Drugs For Overdose Or Poisoning		
CUPRIMINE ORAL CAPSULE 250 MG (penicillamine)	Tier 2	PA
D-PENAMINE ORAL TABLET 125 MG (penicillamine)	Tier 4	PA
<i>penicillamine oral capsule 250 mg</i>	Tier 1	PA
<i>penicillamine oral tablet 250 mg</i>	Tier 1	PA
<i>trientine oral capsule 250 mg</i>	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Chelating Agents - Iron - Drugs For Overdose Or Poisoning		
<i>deferasirox oral granules in packet 180 mg, 360 mg, 90 mg</i>	Tier 4	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	Tier 4	PA
<i>deferasirox oral tablet, dispersible 125 mg, 250 mg, 500 mg</i>	Tier 4	PA
<i>deferiprone oral tablet 500 mg</i>	Tier 4	PA
<i>deferoxamine injection recon soln 2 gram, 500 mg</i>	Tier 1	PA
FERRIPROX (2 TIMES A DAY) ORAL TABLET 1,000 MG (deferiprone)	Tier 4	PA
FERRIPROX ORAL SOLUTION 100 MG/ML (deferiprone)	Tier 4	PA
FERRIPROX ORAL TABLET 1,000 MG, 500 MG (deferiprone)	Tier 4	PA
Chelating Agents - Lead Poisoning - Drugs For Overdose Or Poisoning		
CHEMET ORAL CAPSULE 100 MG (succimer)	Tier 3	
Mu-Opioid Receptor Antagonists, Peripherally-Acting - Drugs For Overdose Or Poisoning		
<i>alvimopan oral capsule 12 mg</i>	Tier 1	
ENTEREG ORAL CAPSULE 12 MG (alvimopan)	Tier 3	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (naloxegol oxalate)	Tier 2	QL (1 EA per 1 day)
RELISTOR ORAL TABLET 150 MG (methylnaltrexone bromide)	Tier 3	PA; QL (3 EA per 1 day)
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML (methylnaltrexone bromide)	Tier 3	PA; QL (0.6 ML per 1 day)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML (methylnaltrexone bromide)	Tier 3	PA; QL (0.6 ML per 1 day)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML (methylnaltrexone bromide)	Tier 3	PA; QL (0.4 ML per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPROIC ORAL TABLET 0.2 MG (naldemedine tosylate)	Tier 3	ST: Must meet the following requirement: Movantik in 120 days; QL (1 EA per 1 day)
Opioid Reversal Agents - Opioid Antagonists - Drugs For Overdose Or Poisoning		
KLOXXADO NASAL SPRAY, NON-AEROSOL 8 MG/ACTUATION (naloxone HCl)	Tier 2	QL (4 EA per 30 days)
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	Tier 3	
<i>naltrexone oral tablet 50 mg</i>	Tier 1	
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION (naloxone HCl)	Tier 2	QL (4 EA per 30 days)
Anti-Infective Agents - Drugs For Infections		
Amebicides - Drugs For Parasites		
<i>paromomycin oral capsule 250 mg</i>	Tier 1	
Aminoglycoside Antibiotic - Antibiotics		
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION 590 MG/8.4 ML (amikacin sulfate liposomal with nebulizer accessories)	Tier 4	PA
<i>neomycin oral tablet 500 mg</i>	Tier 1	
Aminopenicillin Antibiotic - Antibiotics		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml</i>	Tier 1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	Tier 1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	Tier 1	
<i>ampicillin oral capsule 250 mg, 500 mg</i>	Tier 1	
MOXATAG ORAL TABLET, ER MULTIPHASE 24 HR 775 MG (amoxicillin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Aminopenicillin Antibiotic - Beta-Lactamase Inhibitor Combinations - Antibiotics		
<i>amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr 1,000-62.5 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg, 400-57 mg</i>	Tier 1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML (amoxicillin/potassium clavulanate)	Tier 3	ST: Must meet the following requirement: Amoxicillin/Potassium Clavulanate in 120 days; QL (150 ML per 30 days)
Anthelmintic Agents - Benzimidazole Derivatives - Drugs For Parasites		
<i>albendazole oral tablet 200 mg</i>	Tier 1	
EGATEN ORAL TABLET 250 MG (triclabendazole)	Tier 3	
EMVERM ORAL TABLET, CHEWABLE 100 MG (mebendazole)	Tier 3	PA
Anthelmintic Agents - Macrocyclic Lactones - Drugs For Parasites		
<i>ivermectin oral tablet 3 mg</i>	Tier 1	
Anthelmintic Agents Other - Drugs For Parasites		
<i>praziquantel oral tablet 600 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antibacterial Folate Antagonist - Other Combinations - Antibiotics		
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml</i>	Tier 1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	Tier 1	
SULFATRIM ORAL SUSPENSION 200-40 MG/5 ML (sulfamethoxazole/trimethoprim)	Tier 1	
Antibacterial Folate Antagonist Others - Antibiotics		
PRIMSOL ORAL SOLUTION 50 MG/5 ML (trimethoprim)	Tier 2	
<i>trimethoprim oral tablet 100 mg</i>	Tier 1	
Antibacterial Other - Antibiotics		
<i>fosfomycin tromethamine oral packet 3 gram</i>	Tier 1	
Antifungal - Allylamines - Drugs For Fungus		
<i>terbinafine hcl oral tablet 250 mg</i>	Tier 1	
Antifungal - Amphoteric Polyene Macrolides - Drugs For Fungus		
<i>nystatin oral tablet 500,000 unit</i>	Tier 1	
Antifungal - Fluorinated Pyrimidine-Type Agents - Drugs For Fungus		
<i>flucytosine oral capsule 250 mg, 500 mg</i>	Tier 1	
Antifungal - Glucan Synthesis Inhibitor, Triterpenoid - Antibiotics		
BREXAFEMME ORAL TABLET 150 MG (ibrexafungerp citrate)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antifungal - Glucan Synthesis Inhibitors - Antibiotics		
BREXAFEMME ORAL TABLET 150 MG (ibrexafungerp citrate)	Tier 3	PA
Antifungal - Imidazoles - Drugs For Fungus		
<i>ketoconazole oral tablet 200 mg</i>	Tier 1	
ORAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET 50 MG (miconazole)	Tier 3	
Antifungal - Triazoles - Drugs For Fungus		
CRESEMBA ORAL CAPSULE 186 MG (isavuconazonium sulfate)	Tier 3	PA
<i>fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml</i>	Tier 1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Tier 1	
<i>itraconazole oral capsule 100 mg</i>	Tier 1	
<i>itraconazole oral solution 10 mg/ml</i>	Tier 1	
NOXAFIL ORAL SUSPENSION 200 MG/5 ML (40 MG/ML) (posaconazole)	Tier 3	PA
<i>posaconazole oral tablet, delayed release (drlec) 100 mg</i>	Tier 1	PA
TOLSURA ORAL CAPSULE, SOLID DISPERSION 65 MG (itraconazole)	Tier 3	PA
<i>voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)</i>	Tier 1	
<i>voriconazole oral tablet 200 mg, 50 mg</i>	Tier 1	
Antifungal Other - Drugs For Fungus		
<i>griseofulvin microsize oral suspension 125 mg/5 ml</i>	Tier 1	
<i>griseofulvin microsize oral tablet 500 mg</i>	Tier 1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anti-Infective Immunologic Adjuvants - Interferons - Drugs For Infections		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML (interferon gamma-1b, recomb.)	Tier 4	PA
Antileprotic - Immunomodulators - Antibiotics		
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG (thalidomide)	Tier 2	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (2 EA per 1 day)
Antileprotic - Sulfone Agents - Antibiotics		
<i>dapsone oral tablet 100 mg, 25 mg</i>	Tier 1	
Antimalarial Combinations - Drugs For Parasites		
<i>atovaquone-proguanil oral tablet 250-100 mg, 62.5-25 mg</i>	Tier 1	
COARTEM ORAL TABLET 20-120 MG (artemether/lumefantrine)	Tier 3	
Antimalarials - Drugs For Parasites		
ARAKODA ORAL TABLET 100 MG (tafenoquine succinate)	Tier 3	
<i>chloroquine phosphate oral tablet 250 mg</i>	Tier 1	QL (36 EA per 16 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	Tier 1	QL (18 EA per 16 days)
<i>hydroxychloroquine oral tablet 100 mg</i>	Tier 1	QL (180 EA per 30 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	Tier 1	QL (100 EA per 30 days)
<i>hydroxychloroquine oral tablet 300 mg, 400 mg</i>	Tier 1	QL (60 EA per 30 days)
KRINTAFEL ORAL TABLET 150 MG (tafenoquine succinate)	Tier 2	QL (2 EA per 1 FILL)
<i>mefloquine oral tablet 250 mg</i>	Tier 1	
<i>primaquine oral tablet 26.3 mg</i>	Tier 2	
<i>pyrimethamine oral tablet 25 mg</i>	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>quinine sulfate oral capsule 324 mg</i>	Tier 1	
Antiprotozoal Agents - Nitrofurantoin Derivatives - Drugs For Parasites		
LAMPIT ORAL TABLET 120 MG, 30 MG (nifurtimox)	Tier 3	
Antiprotozoal Agents - Nitroimidazole Derivatives - Drugs For Parasites		
<i>benznidazole oral tablet 100 mg, 12.5 mg</i>	Tier 1	
Antiprotozoal Agents - Other - Drugs For Parasites		
<i>atovaquone oral suspension 750 mg/5 ml</i>	Tier 1	
IMPAVIDO ORAL CAPSULE 50 MG (miltefosine)	Tier 3	PA
Antiprotozoal Agents (Antiparasitic) - 5-Nitrothiazolyl Derivatives - Drugs For Parasites		
ALINIA ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML (nitazoxanide)	Tier 3	QL (50 ML per 1 day)
<i>nitazoxanide oral tablet 500 mg</i>	Tier 1	QL (2 EA per 1 day)
Antiprotozoal-Antibacterial 1st Generation 2-Methyl-5-Nitroimidazole - Drugs For Infections		
<i>metronidazole oral capsule 375 mg</i>	Tier 1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiprotozoal-Antibacterial 2Nd Generation 2-Methyl-5-Nitroimidazole - Drugs For Infections		
SOLOSEC ORAL GRANULES DEL RELEASE IN PACKET 2 GRAM (secnidazole)	Tier 3	ST: Must meet 2 of the following requirements: Clindamycin HCL, Clindamycin Palmitate HCL, Clindamycin Phosphate, Metronidazole, Tinidazole, or Vandazole in 365 days; QL (1 EA per 30 days)
<i>tinidazole oral tablet 250 mg, 500 mg</i>	Tier 1	
Antiretroviral - Ccr5 Co-Receptor Antagonist - Drugs For Viral Infections		
SELZENTRY ORAL SOLUTION 20 MG/ML (maraviroc)	Tier 2	
SELZENTRY ORAL TABLET 150 MG, 25 MG, 300 MG, 75 MG (maraviroc)	Tier 2	
Antiretroviral - Cd4 Attachment Inhibitors - Drugs For Viral Infections		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG (fostemsavir tromethamine)	Tier 2	PA
Antiretroviral - Hiv-1 Fusion Inhibitors - Drugs For Viral Infections		
FUZEON SUBCUTANEOUS RECON SOLN 90 MG (enfuvirtide)	Tier 2	
Antiretroviral - Hiv-1 Integrase Strand Transfer Inhibitors - Drugs For Viral Infections		
ISENTRESS HD ORAL TABLET 600 MG (raltegravir potassium)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ISENTRESS ORAL POWDER IN PACKET 100 MG (raltegravir potassium)	Tier 2	
ISENTRESS ORAL TABLET 400 MG (raltegravir potassium)	Tier 2	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG (raltegravir potassium)	Tier 2	
TIVICAY ORAL TABLET 10 MG, 25 MG, 50 MG (dolutegravir sodium)	Tier 2	
TIVICAY PD ORAL TABLET FOR SUSPENSION 5 MG (dolutegravir sodium)	Tier 2	
VOCABRIA ORAL TABLET 30 MG (cabotegravir sodium)	Tier 2	Age (Min 18 Years)
Antiretroviral - Integrase Inhibitor And Nrti Combinations - Drugs For Viral Infections		
JULUCA ORAL TABLET 50-25 MG (dolutegravir sodium/rilpivirine HCl)	Tier 2	
Antiretroviral - Integrase Inhibitor And Nrti Combinations - Drugs For Viral Infections		
DOVATO ORAL TABLET 50-300 MG (dolutegravir sodium/lamivudine)	Tier 2	
Antiretroviral - Non-Nucleoside Reverse Transcriptase Inhib (Nrti) - Drugs For Viral Infections		
EDURANT ORAL TABLET 25 MG (rilpivirine HCl)	Tier 2	
<i>efavirenz oral capsule 200 mg, 50 mg</i>	Tier 1	
<i>efavirenz oral tablet 600 mg</i>	Tier 1	
<i>etravirine oral tablet 100 mg, 200 mg</i>	Tier 1	
INTELENCE ORAL TABLET 25 MG (etravirine)	Tier 2	
<i>nevirapine oral suspension 50 mg/5 ml</i>	Tier 1	
<i>nevirapine oral tablet 200 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nevirapine oral tablet extended release 24 hr 100 mg, 400 mg</i>	Tier 1	
PIFELTRO ORAL TABLET 100 MG (doravirine)	Tier 2	
SUSTIVA ORAL CAPSULE 200 MG, 50 MG (efavirenz)	Tier 2	
Antiretroviral - Nucleoside And Nucleotide Analog Rttis Combinations - Drugs For Viral Infections		
CIMDUO ORAL TABLET 300-300 MG (lamivudine/tenofovir disoproxil fumarate)	Tier 2	
DESCOVY ORAL TABLET 200-25 MG (emtricitabine/tenofovir alafenamide fumarate)	Tier 2	\$0 COPAY IF USED FOR PREVENTION OF HIV; QL (1 EA per 1 day)
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	Tier 1	
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	Tier 1	\$0 COPAY IF USED FOR PREVENTION OF HIV; QL (1 EA per 1 day)
TEMIXYS ORAL TABLET 300-300 MG (lamivudine/tenofovir disoproxil fumarate)	Tier 2	
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (emtricitabine/tenofovir disoproxil fumarate)	Tier 2	
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (Nrti) - Drugs For Viral Infections		
<i>abacavir oral solution 20 mg/ml</i>	Tier 1	
<i>abacavir oral tablet 300 mg</i>	Tier 1	
<i>didanosine oral capsule, delayed release(drlec) 250 mg, 400 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>emtricitabine oral capsule 200 mg</i>	Tier 1	\$0 COPAY IF USED FOR PREVENTION OF HIV; QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION 10 MG/ML (emtricitabine)	Tier 2	
<i>lamivudine oral solution 10 mg/ml</i>	Tier 1	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	Tier 1	
<i>stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>zidovudine oral capsule 100 mg</i>	Tier 1	
<i>zidovudine oral syrup 10 mg/ml</i>	Tier 1	
<i>zidovudine oral tablet 300 mg</i>	Tier 1	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors - Drugs For Viral Infections		
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	Tier 1	\$0 COPAY IF USED FOR PREVENTION OF HIV; QL (1 EA per 1 day)
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM) (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	Tier 2	
Antiretroviral Combinations - Protease Inhibitors - Drugs For Viral Infections		
EVOTAZ ORAL TABLET 300-150 MG (atazanavir sulfate/cobicistat)	Tier 2	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (lopinavir/ritonavir)	Tier 2	
<i>lopinavir-ritonavir oral solution 400-100 mg/5 ml</i>	Tier 1	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	Tier 1	
PREZCOBIX ORAL TABLET 800-150 MG-MG (darunavir ethanolate/cobicistat)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral- Nucleoside And Nucleotide Analogs, Protease Inhibitors - Drugs For Viral Infections		
SYMTUZA ORAL TABLET 800-150-200-10 MG (darunavir eth/cobicistat/emtricitabine/tenofovir alafenamide)	Tier 2	
Antiretroviral-Integrase Inhibitor, Nucleoside And Nucleotide Rti's Comb - Drugs For Viral Infections		
BIKTARVY ORAL TABLET 50-200-25 MG (bictegravir sodium/emtricitabine/tenofovir alafenamide fumar)	Tier 2	
GENVOYA ORAL TABLET 150-150-200-10 MG (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	Tier 2	
STRIBILD ORAL TABLET 150-150-200-300 MG (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil)	Tier 2	
Antiretroviral-Nucleoside Analogs And Integrase Inhibitor Combinations - Drugs For Viral Infections		
TRIUMEQ ORAL TABLET 600-50-300 MG (abacavir sulfate/dolutegravir sodium/lamivudine)	Tier 2	
Antiretroviral-Nucleoside Reverse Transcriptase Inhibitors (Nrti) Comb - Drugs For Viral Infections		
<i>abacavir-lamivudine oral tablet 600-300 mg</i>	Tier 1	
<i>abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg</i>	Tier 1	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral-Nucleoside, Nucleotide Analogs And Non-Nucleoside Rti - Drugs For Viral Infections		
COMPLERA ORAL TABLET 200-25-300 MG (emtricitabine/rilpivirine HCl/tenofovir disoproxil fumarate)	Tier 2	
DELSTRIGO ORAL TABLET 100-300-300 MG (doravirine/lamivudine/tenofovir disoproxil fumarate)	Tier 2	
<i>efavirenz-emtricitabin-tenofov oral tablet 600-200-300 mg</i>	Tier 1	
<i>efavirenz-lamivu-tenofov disop oral tablet 400-300-300 mg, 600-300-300 mg</i>	Tier 1	
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitabine/rilpivirine HCl/tenofovir alafenamide fumarate)	Tier 2	
Antitubercular - Aminobenzoic Acid Analogs - Antibiotics		
PASER ORAL GRANULES DR FOR SUSP IN PACKET 4 GRAM (aminosalicylic acid)	Tier 3	
Antitubercular - D-Alanine Analogs - Antibiotics		
<i>cycloserine oral capsule 250 mg</i>	Tier 1	
Antitubercular - Diarylquinoline Antibiotics - Antibiotics		
SIRTURO ORAL TABLET 100 MG, 20 MG (bedaquiline fumarate)	Tier 4	PA
Antitubercular - Isonicotinic Acid Derivatives - Antibiotics		
<i>isoniazid oral solution 50 mg/5 ml</i>	Tier 1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	Tier 1	
Antitubercular - Niacinamide Derivatives - Antibiotics		
<i>pyrazinamide oral tablet 500 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antitubercular - Nitroimidazole Derivatives - Antibiotics		
<i>pretomanid oral tablet 200 mg</i>	Tier 3	QL (1 EA per 1 day)
Antitubercular - Rifamycin And Derivatives - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (rifapentine)	Tier 3	
<i>rifabutin oral capsule 150 mg</i>	Tier 1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	Tier 1	
Antitubercular Agents Other - Antibiotics		
<i>ethambutol oral tablet 100 mg, 400 mg</i>	Tier 1	
TRECTOR ORAL TABLET 250 MG (ethionamide)	Tier 3	
Cephalosporin Antibiotics - 1St Generation - Antibiotics		
<i>cefadroxil oral capsule 500 mg</i>	Tier 1	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	Tier 1	
<i>cefadroxil oral tablet 1 gram</i>	Tier 1	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	Tier 1	
Cephalosporin Antibiotics - 2Nd Generation - Antibiotics		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	Tier 1	
<i>cefaclor oral tablet extended release 12 hr 500 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	Tier 1	
Cephalosporin Antibiotics - 3Rd Generation - Antibiotics		
<i>cefdinir oral capsule 300 mg</i>	Tier 1	
<i>cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cefditoren pivoxil oral tablet 200 mg, 400 mg</i>	Tier 1	
<i>cefixime oral capsule 400 mg</i>	Tier 1	
<i>cefixime oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	Tier 1	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml, 50 mg/5 ml</i>	Tier 1	
<i>cefpodoxime oral tablet 100 mg, 200 mg</i>	Tier 1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML (cefixime)	Tier 2	
SUPRAX ORAL TABLET,CHEWABLE 100 MG, 200 MG (cefixime)	Tier 2	
Cmv Antiviral Agent - Nucleoside Analogs - Drugs For Viral Infections		
<i>valganciclovir oral recon soln 50 mg/ml</i>	Tier 1	
<i>valganciclovir oral tablet 450 mg</i>	Tier 1	
Cmv Antiviral Agent - Terminase Complex Inhibitors - Drugs For Viral Infections		
PREVYMIS ORAL TABLET 240 MG, 480 MG (letermovir)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluoroquinolone Antibiotics - Antibiotics		
BAXDELA ORAL TABLET 450 MG (delafloxacin meglumine)	Tier 3	PA
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON 250 MG/5 ML, 500 MG/5 ML (ciprofloxacin)	Tier 2	
CIPRO XR ORAL TABLET, ER MULTIPHASE 24 HR 1,000 MG, 500 MG (ciprofloxacin/ciprofloxacin HCl)	Tier 3	
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml, 500 mg/5 ml</i>	Tier 1	
FACTIVE ORAL TABLET 320 MG (gemifloxacin mesylate)	Tier 3	
<i>levofloxacin oral solution 250 mg/10 ml</i>	Tier 1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>moxifloxacin oral tablet 400 mg</i>	Tier 1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 1	
Glycopeptide Antibiotics - Antibiotics		
FIRVANQ ORAL RECON SOLN 25 MG/ML (vancomycin HCl)	Tier 2	QL (300 ML per 1 FILL)
<i>vancomycin oral capsule 125 mg</i>	Tier 1	QL (56 EA per 1 FILL)
<i>vancomycin oral capsule 250 mg</i>	Tier 1	QL (112 EA per 1 FILL)
<i>vancomycin oral recon soln 50 mg/ml</i>	Tier 1	QL (600 ML per 1 FILL)
Hepatitis B Treatment- Nucleoside Analogs (Antiviral) - Drugs For Viral Infections		
BARACLUDE ORAL SOLUTION 0.05 MG/ML (entecavir)	Tier 2	QL (630 ML per 30 days)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	Tier 1	QL (1 EA per 1 day)
EPIVIR HBV ORAL SOLUTION 25 MG/5 ML (5 MG/ML) (lamivudine)	Tier 2	QL (720 ML per 30 days)
<i>lamivudine oral tablet 100 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis B Treatment- Nucleotide Analogs (Antiviral) - Drugs For Viral Infections		
<i>adefovir oral tablet 10 mg</i>	Tier 1	QL (1 EA per 1 day)
VEMLIDY ORAL TABLET 25 MG (tenofovir alafenamide)	Tier 2	ST: Must meet the following requirement: Tenofovir 300mg in 120 days; QL (1 EA per 1 day)
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM) (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	Tier 2	
Hepatitis C - Interferons - Drugs For Viral Infections		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	Tier 2	PA
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML (peginterferon alfa-2a)	Tier 2	PA
Hepatitis C - Ns5a Inhibitor And Ns3/4A Protease Inhibitor Combination - Drugs For Viral Infections		
MAVYRET ORAL TABLET 100-40 MG (glecaprevir/pibrentasvir)	Tier 4	PA
ZEPATIER ORAL TABLET 50-100 MG (elbasvir/grazoprevir)	Tier 4	PA
Hepatitis C - Ns5a, Ns3/4A Protease, Nucleo.Ns5b Polymerase Inhib Comb - Drugs For Viral Infections		
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuvir/velpatasvir/voxilaprevir)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis C - Ns5b Polymerase And Ns5a Inhibitor Combinations - Drugs For Viral Infections		
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (sofosbuvir/velpatasvir)	Tier 2	PA
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG (ledipasvir/sofosbuvir)	Tier 2	PA
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (ledipasvir/sofosbuvir)	Tier 2	PA
Hepatitis C - Nucleos(T)ide Analog Ns5b Polymerase Inhibitors - Drugs For Viral Infections		
SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG (sofosbuvir)	Tier 4	PA
SOVALDI ORAL TABLET 200 MG, 400 MG (sofosbuvir)	Tier 4	PA
Hepatitis C - Nucleoside Analogs - Drugs For Viral Infections		
<i>ribavirin oral capsule 200 mg</i>	Tier 1	
<i>ribavirin oral tablet 200 mg</i>	Tier 1	
Hepatitis C- Ns5a, Ns3/4A Protease And Non-Nucleo.Ns5b Poly Inh. Comb - Drugs For Viral Infections		
VIEKIRA PAK ORAL TABLETS,DOSE PACK 12.5 MG-75 MG -50 MG/250 MG (ombitasvir/paritaprevir/ritonavir/dasabuvir sodium)	Tier 4	PA
Herpes Antiviral Agent - Purine Analogs - Drugs For Viral Infections		
<i>acyclovir oral capsule 200 mg</i>	Tier 1	
<i>acyclovir oral suspension 200 mg/5 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acyclovir oral tablet 400 mg, 800 mg</i>	Tier 1	
ACYCLOVIR KIT, GEL AND CAPSULE 200 MG- 10 % (acyclovir/benzyl alcohol)	Tier 3	
SITAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET 50 MG (acyclovir)	Tier 3	ST: Must meet the following requirement: Generic Acyclovir (tablets/capsules/suspension), Famciclovir tablets, or Valacyclovir tablets in 120 days; QL (4 EA per 365 days)
<i>valacyclovir oral tablet 1 gram, 500 mg</i>	Tier 1	
Herpes Antiviral Agent - Thymidine Analogs - Drugs For Viral Infections		
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	Tier 1	
Influenza Antiviral Agents - Neuraminidase Inhibitors - Drugs For Viral Infections		
<i>oseltamivir oral capsule 30 mg</i>	Tier 1	QL (40 EA per 180 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	Tier 1	QL (20 EA per 180 days)
<i>oseltamivir oral suspension for reconstitution 6 mg/ml</i>	Tier 1	QL (360 ML per 180 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION (zanamivir)	Tier 3	QL (40 EA per 180 days)
Influenza Antiviral Agents - Pa Endonuclease Inhibitor - Drugs For Viral Infections		
XOFLUZA ORAL TABLET 20 MG, 40 MG (baloxavir marboxil)	Tier 2	QL (4 EA per 180 days)
XOFLUZA ORAL TABLET 80 MG (baloxavir marboxil)	Tier 2	QL (2 EA per 180 days)
Influenza-A Antiviral Agents - Drugs For Viral Infections		
<i>rimantadine oral tablet 100 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lincosamide Antibiotics - Antibiotics		
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	Tier 1	
clindamycin palmitate HCl (Clindamycin Pediatric Oral Recon Soln 75 Mg/5 MI)	Tier 1	
Macrolide Antibiotics - Antibiotics		
<i>azithromycin oral packet 1 gram</i>	Tier 1	
<i>azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	Tier 1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	Tier 1	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	Tier 1	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML (fidaxomicin)	Tier 2	ST: Must meet the following requirement: Vancomycin oral capsules in 120 days; QL (10 ML per 1 day)
DIFICID ORAL TABLET 200 MG (fidaxomicin)	Tier 2	ST: Must meet the following requirement: Vancomycin oral capsules in 120 days; QL (20 EA per 30 days)
erythromycin ethylsuccinate (E.E.S. 400 Oral Tablet 400 Mg)	Tier 1	
erythromycin base (Ery-Tab Oral Tablet, Delayed Release (Dr/Ec) 250 Mg, 500 Mg)	Tier 1	
erythromycin stearate (Erythrocin (As Stearate) Oral Tablet 250 Mg)	Tier 1	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml, 400 mg/5 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	Tier 1	
<i>erythromycin oral capsule, delayed release (dr/ec) 250 mg</i>	Tier 1	
<i>erythromycin oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 333 mg, 500 mg</i>	Tier 1	
Misc Anti-Infective - Drugs For Infections		
<i>methenamine hippurate oral tablet 1 gram</i>	Tier 1	
<i>methenamine mandelate oral tablet 0.5 g, 1 gram</i>	Tier 1	
NEBUPENT INHALATION RECON SOLN 300 MG (pentamidine isethionate)	Tier 2	
<i>pentamidine inhalation recon soln 300 mg</i>	Tier 1	
UROQID-ACID NO.2 ORAL TABLET 500-500 MG (methenamine mandelate/sodium phosphate, monobasic)	Tier 3	
Misc Anti-Infective Combinations - Drugs For Infections		
HYOPHEN ORAL TABLET 81.6-0.12-10.8 MG (methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin)	Tier 1	
<i>methen-sod phos-meth blue-hyos oral tablet 81.6-40.8-0.12 mg</i>	Tier 1	
PHOSPHASAL ORAL TABLET 81.6-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 2	
URETRON D-S ORAL TABLET 81.6-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 2	
URIMAR-T ORAL TABLET 120-0.12-10.8 MG (methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URO-458 ORAL TABLET 81-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	
UROGESIC-BLUE ORAL TABLET 81.6-40.8-0.12 MG (methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)	Tier 1	
URO-MP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	
USTELL ORAL CAPSULE 120-0.12 MG (methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)	Tier 1	
Oxazolidinone Antibiotics - Antibiotics		
<i>linezolid oral suspension for reconstitution 100 mg/5 ml</i>	Tier 1	
<i>linezolid oral tablet 600 mg</i>	Tier 1	
SIVEXTRO ORAL TABLET 200 MG (tedizolid phosphate)	Tier 2	ST: Must meet the following requirement: Linezolid 600mg tablets in 120 days; QL (6 EA per 6 days)
Penicillin Antibiotic - Natural - Antibiotics		
<i>penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	Tier 1	
Penicillin Antibiotic - Penicillinase-Resistant - Antibiotics		
<i>dicloxacillin oral capsule 250 mg, 500 mg</i>	Tier 1	
Pleuromutilin Antibiotics - Antibiotics		
XENLETA ORAL TABLET 600 MG (lefamulin acetate)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Protease Inhibitors (Non-Peptidic) Antiretroviral - Drugs For Viral Infections		
APTIVUS ORAL CAPSULE 250 MG (tipranavir)	Tier 2	
PREZCOBIX ORAL TABLET 800-150 MG-MG (darunavir ethanolate/cobicistat)	Tier 2	
PREZISTA ORAL SUSPENSION 100 MG/ML (darunavir ethanolate)	Tier 2	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG (darunavir ethanolate)	Tier 2	
Protease Inhibitors (Peptidic) Antiretroviral - Drugs For Viral Infections		
<i>atazanavir oral capsule 150 mg, 200 mg, 300 mg</i>	Tier 1	
EVOTAZ ORAL TABLET 300-150 MG (atazanavir sulfate/cobicistat)	Tier 2	
<i>fosamprenavir oral tablet 700 mg</i>	Tier 1	
INVIRASE ORAL TABLET 500 MG (saquinavir mesylate)	Tier 2	
LEXIVA ORAL SUSPENSION 50 MG/ML (fosamprenavir calcium)	Tier 2	
NORVIR ORAL POWDER IN PACKET 100 MG (ritonavir)	Tier 2	
NORVIR ORAL SOLUTION 80 MG/ML (ritonavir)	Tier 2	
REYATAZ ORAL POWDER IN PACKET 50 MG (atazanavir sulfate)	Tier 2	
<i>ritonavir oral tablet 100 mg</i>	Tier 1	
VIRACEPT ORAL TABLET 250 MG, 625 MG (nelfinavir mesylate)	Tier 2	
Respiratory Syncytial Virus (Rsv) Antiviral Agents - Drugs For Viral Infections		
<i>ribavirin inhalation recon soln 6 gram</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Rifamycins And Related Derivative Antibiotics - Antibiotics		
AEMCOLO ORAL TABLET, DELAYED RELEASE (DR/EC) 194 MG (rifamycin sodium)	Tier 3	ST: Must meet any of the following requirements: Azithromycin, Cipro, Cipro XR, Ciprofloxacin HCL, Ciprofloxacin, Ciprofloxacin/ciprofloxacin HCL, Levofloxacin, or Ofloxacin in 120 days; QL (12 EA per 1 FILL)
<i>rifabutin oral capsule 150 mg</i>	Tier 1	
XIFAXAN ORAL TABLET 200 MG (rifaximin)	Tier 3	PA
XIFAXAN ORAL TABLET 550 MG (rifaximin)	Tier 2	PA
Sulfonamide Antibiotic - Antibiotics		
<i>sulfadiazine oral tablet 500 mg</i>	Tier 1	
Tetracycline And Tetracycline Antibiotic Combinations - Antibiotics		
AVIDOXY DK KIT 100 MG-2 % -SPF 30 (doxycycline monohydrate/salicylic acid/octinoxate/zinc oxide)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)
BENZODOX 30 KIT, CLEANSER ER AND TABLET 100-4.4 MG-% (doxycycline monohydrate/benzoyl peroxide)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENZODOX 60 KIT, CLEANSER ER AND TABLET 100-4.4 MG-% (doxycycline monohydrate/benzoyl peroxide)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)
Tetracycline Antibiotics - Antibiotics		
minocycline HCl (Coremino Oral Tablet Extended Release 24 Hr 135 Mg, 45 Mg, 90 Mg)	Tier 1	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
<i>demeclocycline oral tablet 150 mg, 300 mg</i>	Tier 1	
DORYX MPC ORAL TABLET, DELAYED RELEASE (DR/EC) 120 MG (doxycycline hyclate)	Tier 3	ST: Must meet the following requirement: Doxycycline Monohydrate or Hyclate 100mg tablets or capsules in 120 days; QL (2 EA per 1 day)
DORYX ORAL TABLET, DELAYED RELEASE (DR/EC) 80 MG (doxycycline hyclate)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 75mg tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline hyclate oral tablet 150 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 150mg tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet 50 mg</i>	Tier 1	ST: Must meet the following requirement: Doxycycline Hyclate 50mg capsules or Doxycycline Monohydrate 50mg capsules or tablets in 120 days; QL (4 EA per 1 day)
<i>doxycycline hyclate oral tablet 75 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 75mg tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg</i>	Tier 1	ST: Must meet the following requirement: Doxycycline Monohydrate or Hyclate 100mg tablets or capsules in 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 150 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 150mg tablets in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 200 mg</i>	Tier 1	ST: Must meet the following requirement: Doxycycline Monohydrate or Hyclate 100mg tablets or capsules in 120 days; QL (1 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 50 mg</i>	Tier 1	ST: Must meet the following requirement: Doxycycline Hyclate 50mg tablets or Doxycycline Monohydrate 50mg capsules or tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 75 mg, 80 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 75mg tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule 75 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 75mg tablets in 120 days; QL (2 EA per 1 day)
<i>doxycycline monohydrate oral suspension for reconstitution 25 mg/5 ml</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>minocycline oral capsule,extended release 24hr 135 mg, 45 mg, 90 mg</i>	Tier 1	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
MINOLIRA ER ORAL TABLET, IR - ER, BIPHASIC 24HR 105 MG, 135 MG (minocycline HCl)	Tier 3	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
doxycycline monohydrate (Mondoxyme NI Oral Capsule 100 Mg)	Tier 1	QL (2 EA per 1 day)
doxycycline monohydrate (Mondoxyme NI Oral Capsule 75 Mg)	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 75mg tablets in 120 days; QL (2 EA per 1 day)
MORGIDOX 1X 50 KIT 50 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)
MORGIDOX 1X100 KIT 100 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MORGIDOX 2X100 KIT 100 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Must meet the following requirement: generic Doxycycline Monohydrate 100mg capsules in 120 days; QL (1 EA per 30 days)
NUZYRA ORAL TABLET 150 MG (omadacycline tosylate)	Tier 3	PA
SEYSARA ORAL TABLET 100 MG, 150 MG, 60 MG (sarecycline HCl)	Tier 3	ST: Must meet any of the following requirements: Doryx Mpc, Doxycycline Hyclate, Doxycycline Monohydrate, Minocycline HCL, or Vibramycin in 120 days; QL (1 EA per 1 day); Age (Min 9 Years)
<i>tetracycline oral capsule 250 mg, 500 mg</i>	Tier 1	
VIBRAMYCIN ORAL SYRUP 50 MG/5 ML (doxycycline calcium)	Tier 2	
Variola (Smallpox) Virus Antiviral Agents - Drugs For Viral Infections		
TPOXX (NATIONAL STOCKPILE) ORAL CAPSULE 200 MG (tecovirimat)	Tier 3	
Antineoplastics		
Antineoplastic - Hypoxia Inducible Factor (Hif) Inhibitors		
WELIREG ORAL TABLET 40 MG (belzutifan)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastics - Drugs For Cancer		
Antineoplastic-Epiderm.Growth Factor-Egfr (ErbB1),Her-2 (ErbB2)R.Inhib - Drugs For Cancer		
EXKIVITY ORAL CAPSULE 40 MG (mobocertinib succinate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>lapatinib oral tablet 250 mg</i>	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Cyp17 (17 Alpha-Hydroxylase/C17,20-Lyase) Inhibitor - Drugs For Cancer		
YONSA ORAL TABLET 125 MG (abiraterone acetate, submicronized)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - 1St Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
<i>erlotinib oral tablet 100 mg, 150 mg, 25 mg</i>	Tier 1	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
IRESSA ORAL TABLET 250 MG (gefitinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - 2Nd Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (afatinib dimaleate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NERLYNX ORAL TABLET 40 MG (neratinib maleate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (dacomitinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - 3Rd Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
TAGRISSO ORAL TABLET 40 MG, 80 MG (osimertinib mesylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Alkylating Agent - Alkyl Sulfonates - Drugs For Cancer		
MYLERAN ORAL TABLET 2 MG (busulfan)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Alkylating Agent - Methylhydrazines - Drugs For Cancer		
MATULANE ORAL CAPSULE 50 MG (procarbazine HCl)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Alkylating Agent - Nitrogen Mustards - Drugs For Cancer		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>cyclophosphamide oral tablet 25 mg, 50 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEUKERAN ORAL TABLET 2 MG (chlorambucil)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>melphalan oral tablet 2 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Alkylating Agent - Nitrosoureas - Drugs For Cancer		
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (lomustine)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Alkylating Agent - Triazenes - Drugs For Cancer		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Anaplastic Lymphoma Kinase (Alk) Inhibitors - Drugs For Cancer		
ALECENSA ORAL CAPSULE 150 MG (alectinib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG (brigatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23) (brigatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
LORBRENA ORAL TABLET 100 MG, 25 MG (lorlatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XALKORI ORAL CAPSULE 200 MG, 250 MG (crizotinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ZYKADIA ORAL TABLET 150 MG (ceritinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antiadrenals - Drugs For Cancer		
LYSODREN ORAL TABLET 500 MG (mitotane)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antiandrogens - Drugs For Cancer		
<i>abiraterone oral tablet 250 mg, 500 mg</i>	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>bicalutamide oral tablet 50 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ERLEADA ORAL TABLET 60 MG (apalutamide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>flutamide oral capsule 125 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>nilutamide oral tablet 150 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
NUBEQA ORAL TABLET 300 MG (darolutamide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XTANDI ORAL CAPSULE 40 MG (enzalutamide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
XTANDI ORAL TABLET 40 MG, 80 MG (enzalutamide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
YONSA ORAL TABLET 125 MG (abiraterone acetate, submicronized)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antimetabolite - Folic Acid Analogs - Drugs For Cancer		
<i>methotrexate sodium (pf) injection recon soln 1 gram</i>	Tier 1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antimetabolite - Purine Analogs - Drugs For Cancer		
<i>mercaptopurine oral tablet 50 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
PURIXAN ORAL SUSPENSION 20 MG/ML (mercaptopurine)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; ST: Must meet the following requirement: Mercaptopurine in 120 days
TABLOID ORAL TABLET 40 MG (thioguanine)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Antimetabolite - Pyrimidine Analogs - Drugs For Cancer		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	Tier 1	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ONUREG ORAL TABLET 200 MG, 300 MG (azacitidine)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antimetabolite - Urea Derivatives - Drugs For Cancer		
<i>hydroxyurea oral capsule 500 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Antimetabolites - Pyrimidine Analog Combinations - Drugs For Cancer		
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG (trifluridine/tipiracil HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Aromatase Inhibitors - Drugs For Cancer		
<i>anastrozole oral tablet 1 mg</i>	Tier 0	QL (1 EA per 1 day)
<i>exemestane oral tablet 25 mg</i>	Tier 0	QL (1 EA per 1 day)
<i>letrozole oral tablet 2.5 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Asparaginase Enzyme Therapy Agents - Drugs For Cancer		
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML (asparaginase Erwinia chrysanthemi (recombinant)-rywn)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - B-Cell Lymphoma-2 (Bcl-2) Inhibitors - Drugs For Cancer		
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG (venetoclax)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG (venetoclax)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Braf Kinase Inhibitors - Drugs For Cancer		
BRAFTOVI ORAL CAPSULE 50 MG, 75 MG (encorafenib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (dabrafenib mesylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ZELBORAF ORAL TABLET 240 MG (vemurafenib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (8 EA per 1 day)
Antineoplastic - Bruton's Tyrosine Kinase (Btk) Inhibitor - Drugs For Cancer		
BRUKINSA ORAL CAPSULE 80 MG (zanubrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
CALQUENCE ORAL CAPSULE 100 MG (acalabrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
IMBRUVICA ORAL CAPSULE 70 MG (ibrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG (ibrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Cyclin-Dependent Kinase (Cdk) 4/6 Inhibitors - Drugs For Cancer		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (palbociclib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (palbociclib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3) (ribociclib succinate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (abemaciclib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Epidermal Growth Factor Receptor-2 (Her2) Inhibitor - Drugs For Cancer		
TUKYSA ORAL TABLET 150 MG, 50 MG (tucatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Epipodophyllotoxins - Drugs For Cancer		
<i>etoposide oral capsule 50 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Estrogens - Drugs For Cancer		
EMCYT ORAL CAPSULE 140 MG (estramustine phosphate sodium)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Ezh2 Histone Methyltransferase (Hmt) Inhibitor - Drugs For Cancer		
TAZVERIK ORAL TABLET 200 MG (tazemetostat hydrobromide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Fibroblast Growth Factor Receptor (Fgfr) Kinase Inhib - Drugs For Cancer		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG (erdafitinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (pemigatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1), 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2), 75 MG/DAY (25 MG X 3) (infigratinib phosphate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Fms-Like Tyrosine Kinase 3 (Flt3) Inhibitors - Drugs For Cancer		
XOSPATA ORAL TABLET 40 MG (gilteritinib fumarate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Hedgehog Pathway Inhibitor - Drugs For Cancer		
DAURISMO ORAL TABLET 100 MG, 25 MG (glasdegib maleate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ERIVEDGE ORAL CAPSULE 150 MG (vismodegib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (1 EA per 1 day)
ODOMZO ORAL CAPSULE 200 MG (sonidegib phosphate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Histone Deacetylase (Hdac) Inhibitors - Drugs For Cancer		
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG (panobinostat lactate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ZOLINZA ORAL CAPSULE 100 MG (vorinostat)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Interferons - Drugs For Cancer		
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML), 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML) (interferon alfa-2b, recomb.)	Tier 2	PA
Antineoplastic - Janus Kinase (Jak) Inhibitors - Drugs For Cancer		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (ruxolitinib phosphate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Janus Kinase(Jak),Fms-Like Tyrosine Kinase(Flt) Inhib - Drugs For Cancer		
INREBIC ORAL CAPSULE 100 MG (fedratinib dihydrochloride)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Kinase Inhibitor And Aromatase Inhibitor Combination - Drugs For Cancer		
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG (ribociclib succinate/letrozole)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Kirsten Rat Sarcoma (Kras) Protein Inhibitor - Drugs For Cancer		
LUMAKRAS ORAL TABLET 120 MG (sotorasib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Lhrh (Gnrh) Agonist Analog Pituitary Suppressants - Drugs For Cancer		
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG (leuprolide acetate)	Tier 4	PA
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG (leuprolide acetate)	Tier 4	PA
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG (leuprolide acetate)	Tier 4	PA
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH) (leuprolide acetate)	Tier 4	PA
<i>leuprolide subcutaneous kit 1 mg/0.2 ml</i>	Tier 1	PA
Antineoplastic - Lhrh (Gnrh) Antagonist Pituitary Suppressants - Drugs For Cancer		
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG (degarelix acetate)	Tier 4	QL (2 EA per 365 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG (degarelix acetate)	Tier 4	QL (1 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIRMAGON SUBCUTANEOUS RECON SOLN 120 MG (degarelix acetate)	Tier 4	QL (2 EA per 365 days)
ORGOVYX ORAL TABLET 120 MG (relugolix)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Mast Cell Stabilizers - Drugs For Cancer		
<i>cromolyn oral concentrate 100 mg/5 ml</i>	Tier 1	
Antineoplastic - Mek1 And Mek2 Kinase Inhibitors - Drugs For Cancer		
COTELLIC ORAL TABLET 20 MG (cobimetinib fumarate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (63 EA per 28 days)
KOSELUGO ORAL CAPSULE 10 MG, 25 MG (selumetinib sulfate/vitamin E TPGS)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
MEKINIST ORAL TABLET 0.5 MG, 2 MG (trametinib dimethyl sulfoxide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
MEKTOVI ORAL TABLET 15 MG (binimetinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (6 EA per 1 day)
Antineoplastic - Mtor Kinase Inhibitors - Drugs For Cancer		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG (everolimus)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AFINITOR ORAL TABLET 10 MG (everolimus)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 mg</i>	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Multikinase Inhibitors - Drugs For Cancer		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (cabozantinib s-malate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY) (cabozantinib s-malate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (112 EA per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG (ponatinib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
NEXAVAR ORAL TABLET 200 MG (sorafenib tosylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (4 EA per 1 day)
STIVARGA ORAL TABLET 40 MG (regorafenib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (3 EA per 1 day)
UKONIQ ORAL TABLET 200 MG (umbralisib tosylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Mutant Isocitrate Dehydrogenase 1 (Midh1) Inhibitors - Drugs For Cancer		
TIBSOVO ORAL TABLET 250 MG (ivosidenib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Mutant Isocitrate Dehydrogenase 2 (Midh2) Inhibitors - Drugs For Cancer		
IDHIFA ORAL TABLET 100 MG, 50 MG (enasidenib mesylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors - Drugs For Cancer		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (duvelisib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ZYDELIG ORAL TABLET 100 MG, 150 MG (idelalisib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Pi3k-Alpha Inhibitors - Drugs For Cancer		
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2) (alpelisib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Pi3k-Delta And Gamma Inhibitors - Drugs For Cancer		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (duvelisib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Pi3k-Delta Inhibitors - Drugs For Cancer		
ZYDELIG ORAL TABLET 100 MG, 150 MG (idelalisib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Poly (Adp-Ribose) Polymerase (Parp) Inhibitors - Drugs For Cancer		
LYNPARZA ORAL TABLET 100 MG, 150 MG (olaparib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (rucaparib camsylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG (talazoparib tosylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ZEJULA ORAL CAPSULE 100 MG (niraparib tosylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Progestins - Drugs For Cancer		
<i>megestrol oral tablet 20 mg, 40 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Proteasome Enzyme Inhibitors - Drugs For Cancer		
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (ixazomib citrate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Protein-Tyrosine Kinase Inhibitors - Drugs For Cancer		
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (avapritinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
BOSULIF ORAL TABLET 100 MG (bosutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (3 EA per 1 day)
BOSULIF ORAL TABLET 400 MG, 500 MG (bosutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (1 EA per 1 day)
BRUKINSA ORAL CAPSULE 80 MG (zanubrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
CALQUENCE ORAL CAPSULE 100 MG (acalabrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
CAPRELSA ORAL TABLET 100 MG (vandetanib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (2 EA per 1 day)
CAPRELSA ORAL TABLET 300 MG (vandetanib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (1 EA per 1 day)
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (tivozanib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>imatinib oral tablet 100 mg, 400 mg</i>	Tier 1	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG (ibrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG (ibrutinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
INLYTA ORAL TABLET 1 MG, 5 MG (axitinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2) (lenvatinib mesylate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
OFEV ORAL CAPSULE 100 MG, 150 MG (nintedanib esylate)	Tier 4	PA
QINLOCK ORAL TABLET 50 MG (ripretinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (entrectinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
RYDAPT ORAL CAPSULE 25 MG (midostaurin)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG (dasatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>sunitinib oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TABRECTA ORAL TABLET 150 MG, 200 MG (capmatinib hydrochloride)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (nilotinib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (4 EA per 1 day)
TEPMETKO ORAL TABLET 225 MG (tepotinib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
TURALIO ORAL CAPSULE 200 MG (pexidartinib hydrochloride)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
VOTRIENT ORAL TABLET 200 MG (pazopanib HCl)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Radiopharmaceuticals - Drugs For Cancer		
HICON ORAL KIT 1,000 MCI/ML (1 ML), 250 MCI/0.25 ML, 500 MCI/0.5 ML (sodium iodide-131)	Tier 3	
Antineoplastic - Retinoids - Drugs For Cancer		
<i>tretinoin (antineoplastic) oral capsule 10 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Selective Estrogen Receptor Modulators (Serms) - Drugs For Cancer		
SOLTAMOX ORAL SOLUTION 20 MG/10 ML (tamoxifen citrate)	Tier 2	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>tamoxifen oral tablet 10 mg, 20 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>toremifene oral tablet 60 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Selective Inhibitors Of Nuclear Export (Sine) - Drugs For Cancer		
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK) (selinexor)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Selective Ret Kinase Inhibitor - Drugs For Cancer		
GAVRETO ORAL CAPSULE 100 MG (pralsetinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
RETEVMO ORAL CAPSULE 40 MG, 80 MG (selpercatinib)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Selective Retinoid X Receptor Agonists - Drugs For Cancer		
<i>bexarotene oral capsule 75 mg</i>	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Thalidomide Analogs - Drugs For Cancer		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG (lenalidomide)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG (thalidomide)	Tier 2	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (2 EA per 1 day)
Antineoplastic - Topoisomerase I Inhibitors - Drugs For Cancer		
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG (topotecan HCl)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic - Tropomyosin Receptor Kinase (Trk) Inhibitor - Drugs For Cancer		
VITRAKVI ORAL CAPSULE 100 MG, 25 MG (larotrectinib sulfate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
VITRAKVI ORAL SOLUTION 20 MG/ML (larotrectinib sulfate)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antineoplastic Antibiotic - Others - Drugs For Cancer		
JELMYTO INTRA-PYELOCALYCEAL KIT 40 MG (mitomycin)	Tier 4	PA
Antineoplastic -Cephalotaxines - Drugs For Cancer		
SYNRIBO SUBCUTANEOUS RECON SOLN 3.5 MG (omacetaxine mepesuccinate)	Tier 4	PA
Antineoplastic-Pyrimidine Analog And Cytidine Deaminase Inhibitor Comb - Drugs For Cancer		
INQOVI ORAL TABLET 35-100 MG (decitabine/cedazuridine)	Tier 4	PA; COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluorouracil And Related Rescue Agents - Drugs For Cancer		
VISTOGARD ORAL GRANULES IN PACKET 10 GRAM (uridine triacetate)	Tier 4	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY; QL (24 EA per 14 days)
Methotrexate Rescue Agents - Folic Acid Antagonist Type - Drugs For Cancer		
<i>leucovorin calcium oral tablet 10 mg, 15 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
<i>leucovorin calcium oral tablet 25 mg, 5 mg</i>	Tier 1	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Urinary Tract Protective Agents Used In Conjunction With Chemotherapy - Drugs For Cancer		
MESNEX ORAL TABLET 400 MG (mesna)	Tier 3	COST SHARE NOT TO EXCEED \$200 PER 30-DAY SUPPLY
Antiseptics And Disinfectants - Antiseptics And Disinfectants		
Antiseptic - Chlorine Releasing - Antiseptics And Disinfectants		
ATRAPRO DERMAL SPRAY TOPICAL SPRAY, NON-AEROSOL 0.003-0.004 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
DELUO TOPICAL SPRAY, NON-AEROSOL 0.018 %-0.004 % -0.06 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYCLODEX TOPICAL SPRAY, NON-AEROSOL 0.012 %-0.002 % -0.046 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
MICROCYN TOPICAL SPRAY, NON-AEROSOL 0.003 %-0.004 % -0.023 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
Antiseptic - Iodine/Iodophores - Antiseptics And Disinfectants		
IODOFLEX TOPICAL PADS, MEDICATED 0.9 % (cadexomer iodine)	Tier 3	
IODOSORB TOPICAL GEL 0.9 % (cadexomer iodine)	Tier 3	
LUGOLS TOPICAL SOLUTION 5-10 % (iodine/potassium iodide)	Tier 1	
STRONG IODINE TOPICAL SOLUTION 5-10 % (iodine/potassium iodide)	Tier 1	
Antiseptic - Others - Antiseptics And Disinfectants		
<i>glutaraldehyde solution 25 %</i>	Tier 1	
Antiseptic - Oxidizing Agents - Antiseptics And Disinfectants		
<i>hydrogen peroxide (bulk) solution 30 %</i>	Tier 3	
<i>hydrogen peroxide solution 3 %</i>	Tier 3	
Antiseptic - Phenol Derivatives - Antiseptics And Disinfectants		
<i>phenol liquid</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Biologicals - Biological Agents		
Allergenic Extracts - Grass Pollen - Biological Agents		
GRASTEK SUBLINGUAL TABLET 2,800 BAU (allergenic extract,grass pollen-timothy,standard)	Tier 2	PA
ORALAIR SUBLINGUAL TABLET 100 INDX REACTIVITY, 300 INDX REACTIVITY (grass pollen-orchard/sweet vernal/rye/Kentucky/timothy, std.)	Tier 2	PA
ORALAIR SUBLINGUAL TABLET 100 IR (3) /300 IR (6) (grass pollen-orchard/sweet vernal/rye/Kentucky/timothy, std.)	Tier 3	PA
Allergenic Extracts - Mite Extracts - Biological Agents		
ODACTRA SUBLINGUAL TABLET 12 SQ-HDM (allergenic extract, mite-D.farinae-D.pteronyssinus,standard)	Tier 2	PA
Allergenic Extracts - Weed Pollen - Biological Agents		
RAGWITEK SUBLINGUAL TABLET 12 AMB A 1 UNIT (allergenic extract-weed pollen-short ragweed)	Tier 2	PA
Antivenoms - Scorpion Antivenoms - Biological Agents		
ANASCORP INTRAVENOUS RECON SOLN 120 MG (centruroides (scorpion) polyvalent antivenom)	Tier 3	
Chemicals, Irritant/Allergenic - Biological Agents		
T.R.U.E. TEST ALLERGEN TOPICAL ADHESIVE PATCH,MEDICATED (chemical allergens)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis A And Hepatitis B Vaccine Combinations - Vaccines		
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML (hepatitis A virus and hepatitis B virus vaccine/PF)	Tier 0	QL (4 ML per 365 days); Age (Min 18 Years)
Hepatitis A Vaccine - Single Agents - Vaccines		
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML (hepatitis A virus vaccine/PF)	Tier 0	QL (2 ML per 365 days); Age (Min 18 Years)
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML (hepatitis A virus vaccine/PF)	Tier 0	QL (2 ML per 365 days); Age (Min 18 Years)
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML (hepatitis A virus vaccine/PF)	Tier 0	QL (2 ML per 365 days); Age (Min 18 Years)
Hepatitis B Vaccines - Single Agents - Vaccines		
ENGRIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML (hepatitis B virus vaccine recombinant/PF)	Tier 0	QL (3 ML per 365 days); Age (Min 18 Years)
ENGRIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML (hepatitis B virus vaccine recombinant/PF)	Tier 0	QL (3 ML per 365 days); Age (Min 18 Years)
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML (hepatitis B vaccine recombinant/vaccine adjuvant CpG 1018/PF)	Tier 0	QL (1 ML per 365 days); Age (Min 18 Years)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML (hepatitis B virus vaccine recombinant/PF)	Tier 0	QL (3 ML per 365 days); Age (Min 18 Years)
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML (hepatitis B virus vaccine recombinant/PF)	Tier 0	QL (3 ML per 365 days); Age (Min 18 Years)
Immune Globulin - Gamma Globulin (Igg), Human - Biological Agents		
CUTAQUIG SUBCUTANEOUS SOLUTION 16.5 % (immune globulin,gamma(IgG)-hipp human/maltose)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CUVITRU SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), 8 GRAM/40 ML (20 %) (immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL)	Tier 4	PA
GAMMAGARD LIQUID INJECTION SOLUTION 10 % (immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL)	Tier 4	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 20 GRAM/200 ML (10 %), 5 GRAM/50 ML (10 %) (immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL)	Tier 4	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %) (immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL)	Tier 4	PA
HIZENTRA SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)/proline/IgA 0 to 50 mcg/mL)	Tier 4	PA
HIZENTRA SUBCUTANEOUS SYRINGE 1 GRAM/5 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)/proline/IgA 0 to 50 mcg/mL)	Tier 4	PA
HYQVIA IG COMPONENT SUBCUTANEOUS SOLUTION 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 30 GRAM/300 ML (10 %), 5 GRAM/50 ML (10 %) (immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL)	Tier 4	PA
HYQVIA SUBCUTANEOUS SOLUTION 10 GRAM /100 ML (10 %), 2.5 GRAM /25 ML (10 %), 20 GRAM /200 ML (10 %), 30 GRAM /300 ML (10 %), 5 GRAM /50 ML (10 %) (immune globulin,gamma(IgG) human/hyaluronidase, human recomb)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XEMBIFY SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)-klhw human)	Tier 4	PA
Live Vaccine And Live Virus Formulations - Vaccines		
<i>adenovirus vac live type-4, 7 oral tablet,delayed release (dr/ec)</i>	Tier 3	
<i>adenovirus vaccine live type-4 oral tablet,delayed release (dr/ec)</i>	Tier 3	
<i>adenovirus vaccine live type-7 oral tablet,delayed release (dr/ec)</i>	Tier 3	
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION 10EXP6 CCID50/ML (rotavirus vaccine, live oral attenuated,89-12 strain, G1P(8))	Tier 3	
ROTATEQ VACCINE ORAL SOLUTION 2 ML (rotavirus vaccine, live oral pentavalent)	Tier 3	
Peanut Desensitization Agents - Biological Agents		
PALFORZIA (LEVEL 1) ORAL CAPSULE, SPRINKLE 3 MG (1 MG X 3) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 2) ORAL CAPSULE, SPRINKLE 6 MG (1 MG X 6) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 3) ORAL CAPSULE, SPRINKLE 12 MG (1 MG X 2, 10 MG X 1) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 4) ORAL CAPSULE, SPRINKLE 20 MG (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 5) ORAL CAPSULE, SPRINKLE 40 MG (20 MG X 2) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 6) ORAL CAPSULE, SPRINKLE 80 MG (20 MG X 4) (peanut allergen powder-dnfp)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PALFORZIA (LEVEL 7) ORAL CAPSULE, SPRINKLE 120 MG (20 MG X 1, 100 MG X 1) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 8) ORAL CAPSULE, SPRINKLE 160 MG (20 MG X 3, 100 MG X1) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 9) ORAL CAPSULE, SPRINKLE 200 MG (100 MG X 2) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 10) ORAL CAPSULE, SPRINKLE 240 MG (20 MG X 2, 100 MG X 2) (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA (LEVEL 11 UP-DOSE) ORAL POWDER IN PACKET 300 MG (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA INITIAL DOSE ORAL CAPSULE, SPRINKLE 0.5/1/1.5/3/6 MG (peanut allergen powder-dnfp)	Tier 4	PA
PALFORZIA LEVEL 11 MAINTENANCE ORAL POWDER IN PACKET 300 MG (peanut allergen powder-dnfp)	Tier 4	PA
Toxoid Vaccine Combinations - Vaccines		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML (diphtheria,pertussis(acellular),tetanus vaccine/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML (diphtheria,pertussis(acellular),tetanus vaccine/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML (diphtheria,pertussis(acellular),tetanus vaccine)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML (diphtheria,pertussis(acellular),tetanus vaccine)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF UNIT/0.5 ML (tetanus and diphtheria toxoids, adult)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML (tetanus and diphtheria toxoids, adsorbed, adult/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML (tetanus and diphtheria toxoids, adsorbed, adult/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
Vaccine Bacterial - Gram Negative Cocci - Vaccines		
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML (meningococcal vaccine A,C,Y,W-135,diphtheria toxoid conj/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 11 Years and Max 23 Years)
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML (meningococcal vaccine A,C,Y and W-135,conj tetanus toxoid/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 11 Years and Max 23 Years)
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML (meningococcal vaccine A,C,Y,W-135,diphtheria toxoid conj/PF)	Tier 0	QL (1 EA per 365 days); Age (Min 11 Years and Max 23 Years)
Vaccine Bacterial - Gram Positive Cocci - Vaccines		
PNEUMOVAX-23 INJECTION SOLUTION 25 MCG/0.5 ML (pneumococcal 23-valent polysaccharide vaccine)	Tier 3	QL (0.5 ML per 365 days)
PNEUMOVAX-23 INJECTION SYRINGE 25 MCG/0.5 ML (pneumococcal 23-valent polysaccharide vaccine)	Tier 3	QL (0.5 ML per 365 days)
Vaccine Bacterial - Meningococcal Group B Vaccines - Vaccines		
BEXSERO INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML (meningococcal group B vaccine, 4-component)	Tier 0	QL (1 ML per 365 days); Age (Min 10 Years and Max 25 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML (Neisseria meningitidis group B, lipidated fHBP recombinant)	Tier 0	QL (1.5 ML per 365 days); Age (Min 10 Years and Max 25 Years)
Vaccine Viral - Adenovirus - Vaccines		
<i>adenovirus vac live type-4, 7 oral tablet, delayed release (dr/ec)</i>	Tier 3	
<i>adenovirus vaccine live type-4 oral tablet, delayed release (dr/ec)</i>	Tier 3	
<i>adenovirus vaccine live type-7 oral tablet, delayed release (dr/ec)</i>	Tier 3	
Vaccine Viral - Covid-19 (Sars-Cov-2) - Vaccines		
JANSSEN COVID-19 VACCINE (EUA) INTRAMUSCULAR SUSPENSION 0.5 ML (COVID-19 vac, Ad26.COVS2.S (Janssen)/PF)	Tier 0	QL (0.5 ML per 365 days); Age (Min 18 Years)
MODERNA COVID-19 VACCINE (EUA) INTRAMUSCULAR SUSPENSION 100 MCG/0.5 ML (COVID-19 vaccine, mRNA, cx-024414, LNP-S (Moderna)/PF)	Tier 0	QL (0.5 ML per 24 days); Age (Min 18 Years)
PFIZER COVID19 TRIS VAC(UNAPP) INTRAMUSCULAR SUSPENSION 30 MCG/0.3 ML (COVID-19 vac mRNA, tris(Pfizer)/PF)	Tier 0	
PFIZER COVID19 TRIS VAC(UNAPP) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 10 MCG/0.2 ML (COVID-19 vac mRNA, tris(Pfizer)/PF)	Tier 0	
PFIZER COVID-19 VACCINE (EUA) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 30 MCG/0.3 ML (COVID-19 vaccine, mRNA, BNT162b2, LNP-S (Pfizer)/PF)	Tier 0	QL (0.3 ML per 17 days); Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaccine Viral - Human Papillomavirus (Hpv) Vaccines - Vaccines		
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML (human papillomavirus vaccine, 9-valent/PF)	Tier 3	\$0 COPAY IF AGE 9-26 YEARS; QL (1.5 ML per 365 days); Age (Min 9 Years and Max 44 Years)
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML (human papillomavirus vaccine, 9-valent/PF)	Tier 3	\$0 COPAY IF AGE 9-26 YEARS; QL (1.5 ML per 365 days); Age (Min 9 Years and Max 44 Years)
Vaccine Viral - Influenza A And B - Vaccines		
AFLURIA QD 2021-22(3YR UP)(PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-22 (36 mos up)/PF)	Tier 0	QL (0.5 ML per 180 days)
AFLURIA QD 2021-22(6-35MO)(PF) INTRAMUSCULAR SYRINGE 30 MCG (7.5 MCG X 4)/0.25 ML (influenza virus vaccine quadrivalent 2021-22 (6 mos-35 mos)/PF)	Tier 0	QL (0.25 ML per 180 days)
AFLURIA QUAD 2021-2022(6MO UP) INTRAMUSCULAR SUSPENSION 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-22 (6 mos and up))	Tier 0	QL (0.5 ML per 180 days)
FLUAD QUAD 2021-22(65Y UP)(PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza vaccine quadrivalent 2021-22 (65 yr up)/MF59C.1/PF)	Tier 0	QL (0.5 ML per 180 days); Age (Min 65 Years)
FLUARIX QUAD 2021-2022 (PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-2022(6 mos and up)/PF)	Tier 0	QL (0.5 ML per 180 days)
FLUBLOK QUAD 2021-2022 (PF) INTRAMUSCULAR SYRINGE 180 MCG (45 MCG X 4)/0.5 ML (influenza virus vaccine qv 2021-22(18 yrs and older)rcmb/PF)	Tier 0	QL (0.5 ML per 180 days); Age (Min 18 Years)
FLUCELVAX QUAD 2021-2022 (PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (flu vaccine quad 2021-2022(2 years and older)cell derived/PF)	Tier 0	QL (0.5 ML per 180 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUCELVAX QUAD 2021-2022 INTRAMUSCULAR SUSPENSION 60 MCG (15 MCG X 4)/0.5 ML (flu vaccine quadriv 2021-2022(2 years and older)cell derived)	Tier 0	QL (0.5 ML per 180 days)
FLULAVAL QUAD 2021-2022 (PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-2022(6 mos and up)/PF)	Tier 0	QL (0.5 ML per 180 days)
FLUMIST QUAD 2021-2022 NASAL NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML (influenza vaccine quadrivalent live 2021-2022 (2 yrs-49 yrs))	Tier 0	QL (1 EA per 180 days)
FLUZONE HIGHDOSE QUAD 21-22 PF INTRAMUSCULAR SYRINGE 240 MCG/0.7 ML (influenza virus vaccine quadrivalent split 2021-22(65 yr up)/PF)	Tier 0	QL (0.7 ML per 180 days); Age (Min 65 Years)
FLUZONE QUAD 2021-2022 (PF) INTRAMUSCULAR SUSPENSION 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-2022(6 mos and up)/PF)	Tier 0	QL (0.5 ML per 180 days)
FLUZONE QUAD 2021-2022 (PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-2022(6 mos and up)/PF)	Tier 0	QL (0.5 ML per 180 days)
FLUZONE QUAD 2021-2022 INTRAMUSCULAR SUSPENSION 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vaccine quadrivalent 2021-22 (6 mos and up))	Tier 0	QL (0.5 ML per 180 days)
FLUZONE QUAD SOUTH HEM2021(PF) INTRAMUSCULAR SYRINGE 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vacc quad 2021 south hem (6 mos and up)/PF)	Tier 2	
FLUZONE QUAD SOUTHERN HEM 2021 INTRAMUSCULAR SUSPENSION 60 MCG (15 MCG X 4)/0.5 ML (influenza virus vacc quad 2021 south hem (6 months and up))	Tier 2	
Vaccine Viral - Varicella - Vaccines		
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML (varicella-zoster virus glycoprotein E,rec/AS01B adjuvant/PF)	Tier 0	QL (2 EA per 365 days); Age (Min 50 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SHINGRIX GE ANTIGEN COMPONENT INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG (varicella-zoster virus glycoprotein E,rec,component 2 of 2)	Tier 0	QL (2 EA per 365 days); Age (Min 50 Years)
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML (varicella virus vaccine live/PF)	Tier 0	QL (2 EA per 365 days); Age (Min 18 Years)
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 19,400 UNIT/0.65 ML (zoster vaccine live/PF)	Tier 0	QL (1 EA per 365 days); Age (Min 60 Years)
Vaccine Viral Combinations - Vaccines		
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	Tier 0	QL (2 EA per 365 days); Age (Min 18 Years)
Cardiovascular Therapy Agents - Drugs For The Heart		
Ace Inhibitor And Calcium Channel Blocker Combinations - Drugs For High Blood Pressure		
<i>amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRESTALIA ORAL TABLET 14-10 MG, 3.5-2.5 MG, 7-5 MG (perindopril arginine/amlodipine besylate)	Tier 3	ST: Must meet 2 of the following requirements: Amlodipine Besylate, Amlodipine Besylate/benazepril, Benazepril HCL, Captopril, Enalapril Maleate, Epaned, Fosinopril Sodium, Lisinopril, Moexipril HCL, Perindopril Erbumine, Qbrelis, Quinapril HCL, Ramipril, or Trandolapril in 365 days; QL (1 EA per 1 day)
<i>trandolapril-verapamil oral tablet, ir - er, biphasic 24hr 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	Tier 1	
Ace Inhibitor And Diuretic Combinations - Drugs For High Blood Pressure		
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	Tier 1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	Tier 1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	Tier 1	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg</i>	Tier 1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Tier 1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Tier 1	
Ace Inhibitors - Drugs For High Blood Pressure		
<i>benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>enalapril maleate oral solution 1 mg/ml</i>	Tier 1	ST: Must meet the following requirement: Enalapril tablets in 120 days if 12 years of age and older; QL (1200 ML per 30 days)
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
<i>fosinopril oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Tier 1	
<i>moexipril oral tablet 15 mg, 7.5 mg</i>	Tier 1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	Tier 1	
QBRELIS ORAL SOLUTION 1 MG/ML (lisinopril)	Tier 3	ST: Must meet the following requirement: Lisinopril in 120 days if 12 years of age and older; QL (1200 ML per 30 days)
<i>quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	
Aldosterone Receptor Antagonists - Drugs For High Blood Pressure		
CAROSPIR ORAL SUSPENSION 25 MG/5 ML (spironolactone)	Tier 3	ST: Must meet the following requirement: Spironolactone tablets in 120 days; QL (600 ML per 30 days)
<i>eplerenone oral tablet 25 mg, 50 mg</i>	Tier 1	
KERENDIA ORAL TABLET 10 MG, 20 MG (finerenone)	Tier 3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alpha-Beta Blockers - Drugs For High Blood Pressure		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	Tier 1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	Tier 1	
Angiotensin II Receptor Blocker (Arb)-Calcium Channel Blocker Comb. - Drugs For High Blood Pressure		
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	Tier 1	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	Tier 1	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	Tier 1	
Angiotensin II Receptor Blocker (Arb)-Calcium Channel Blocker-Diuretic - Drugs For High Blood Pressure		
<i>amlodipine-valsartan-hcthidiazid oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	Tier 1	
<i>olmesartan-amlodipin-hcthidiazid oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	Tier 1	
Angiotensin II Receptor Blocker (Arb)-Diuretic Combinations - Drugs For High Blood Pressure		
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (azilsartan medoxomil/chlorthalidone)	Tier 2	ST: Must meet any of the following requirements: ACE inhibitor, ACE inhibitor combination, ARB, or ARB combination in 120 days
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	Tier 1	
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	Tier 1	
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	Tier 1	
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	Tier 1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	Tier 1	
Angiotensin II Receptor Blocker-Neprilysin Inhibitor Comb. (Arni) - Drugs For High Blood Pressure		
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (sacubitril/valsartan)	Tier 2	QL (2 EA per 1 day)
Angiotensin II Receptor Blockers (Arbs) - Drugs For High Blood Pressure		
<i>candesartan oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
EDARBI ORAL TABLET 40 MG, 80 MG (azilsartan medoxomil)	Tier 2	ST: Must meet any of the following requirements: ACE inhibitor, ACE inhibitor combination, ARB, or ARB combination in 120 days
<i>eprosartan oral tablet 600 mg</i>	Tier 1	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	Tier 1	
<i>losartan oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olmesartan oral tablet 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	Tier 1	
Antianginal - Coronary Vasodilators (Nitrates) - Drugs For Angina		
<i>amyl nitrite inhalation solution 0.3 ml</i>	Tier 1	
GONITRO SUBLINGUAL POWDER IN PACKET 400 MCG (nitroglycerin)	Tier 3	ST: Must meet the following requirements: Two generic sublingual Nitroglycerin products in 365 days
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Tier 1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg</i>	Tier 1	
nitroglycerin (Minitran Transdermal Patch 24 Hour 0.1 Mg/Hr, 0.2 Mg/Hr, 0.4 Mg/Hr, 0.6 Mg/Hr)	Tier 1	
nitroglycerin (Nitro-Bid Transdermal Ointment 2 %)	Tier 2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (nitroglycerin)	Tier 2	
<i>nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg</i>	Tier 1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	Tier 1	
<i>nitroglycerin translingual spray, non-aerosol 400 mcg/spray</i>	Tier 1	
NITROMIST TRANSLINGUAL AEROSOL, SPRAY 400 MCG/SPRAY (nitroglycerin)	Tier 3	
NITRO-TIME ORAL CAPSULE, EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (nitroglycerin)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antianginal And Anti-Ischemic Agents - Drugs For Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (vericiguat)	Tier 3	PA
Antianginal And Anti-Ischemic Agents, Non-Hemodynamic - Drugs For Angina		
<i>ranolazine oral tablet extended release 12 hr 1,000 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>ranolazine oral tablet extended release 12 hr 500 mg</i>	Tier 1	QL (120 EA per 30 days)
Antiarrhythmic - Class Ia - Drugs For Abnormal Heart Rhythms		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	Tier 1	
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE 100 MG, 150 MG (disopyramide phosphate)	Tier 2	
<i>quinidine gluconate oral tablet extended release 324 mg</i>	Tier 1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	Tier 1	
Antiarrhythmic - Class Ib - Drugs For Abnormal Heart Rhythms		
<i>mexiletine oral capsule 150 mg, 200 mg, 250 mg</i>	Tier 1	
Antiarrhythmic - Class Ic - Drugs For Abnormal Heart Rhythms		
<i>flecainide oral tablet 100 mg, 150 mg, 50 mg</i>	Tier 1	
<i>propafenone oral capsule, extended release 12 hr 225 mg, 325 mg, 425 mg</i>	Tier 1	
<i>propafenone oral tablet 150 mg, 225 mg, 300 mg</i>	Tier 1	
Antiarrhythmic - Class II - Drugs For Abnormal Heart Rhythms		
sotalol HCl (Sorine Oral Tablet 120 Mg, 160 Mg, 240 Mg, 80 Mg)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sotalol HCl (Sotalol Af Oral Tablet 120 Mg, 160 Mg, 80 Mg)	Tier 1	
<i>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	Tier 1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol HCl)	Tier 3	QL: 8 BOTTLES IN 30 DAYS; ST: Must meet the following requirement: Sotalol HCL in 120 days
Antiarrhythmic - Class Iii - Drugs For Abnormal Heart Rhythms		
<i>amiodarone oral tablet 100 mg, 200 mg, 400 mg</i>	Tier 1	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	Tier 1	
MULTAQ ORAL TABLET 400 MG (dronedarone HCl)	Tier 2	
amiodarone HCl (Pacerone Oral Tablet 100 Mg, 200 Mg, 400 Mg)	Tier 1	
Antiarrhythmic - Class Iv - Drugs For Abnormal Heart Rhythms		
<i>verapamil oral tablet 120 mg, 40 mg, 80 mg</i>	Tier 1	
Antihyperlipidemic - Atp-Citrate Lyase (Acly) Inhibitor - Drugs For Cholesterol		
NEXLETOL ORAL TABLET 180 MG (bempedoic acid)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days
Antihyperlipidemic - Bile Acid Sequestrants - Drugs For Cholesterol		
<i>cholestyramine (with sugar) oral powder 4 gram</i>	Tier 1	
<i>cholestyramine (with sugar) oral powder in packet 4 gram</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cholestyramine/aspartame (Cholestyramine Light Oral Powder 4 Gram)	Tier 1	
cholestyramine/aspartame (Cholestyramine Light Oral Powder In Packet 4 Gram)	Tier 1	
<i>cholestyramine-aspartame oral powder in packet 4 gram</i>	Tier 1	
<i>colesevelam oral powder in packet 3.75 gram</i>	Tier 1	
<i>colesevelam oral tablet 625 mg</i>	Tier 1	
COLESTID FLAVORED ORAL PACKET 7.5 GRAM (colestipol HCl)	Tier 3	
<i>colestipol oral granules 5 gram</i>	Tier 1	
<i>colestipol oral packet 5 gram</i>	Tier 1	
<i>colestipol oral tablet 1 gram</i>	Tier 1	
cholestyramine/aspartame (Prevalite Oral Powder 4 Gram)	Tier 1	
cholestyramine/aspartame (Prevalite Oral Powder In Packet 4 Gram)	Tier 1	
Antihyperlipidemic - Fibric Acid Derivatives - Drugs For Cholesterol		
ANTARA ORAL CAPSULE 30 MG, 90 MG (fenofibrate,micronized)	Tier 3	ST: Must meet any of the following requirements: Antara, Fenofibrate Nanocrystallized, Fenofibrate, Fenofibrate micronized, Gemfibrozil, or Triglide in 120 days
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	Tier 1	
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	Tier 1	
<i>fenofibrate oral capsule 150 mg, 50 mg</i>	Tier 1	
<i>fenofibrate oral tablet 120 mg, 160 mg, 40 mg, 54 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fenofibric acid (choline) oral capsule, delayed release (drlec) 135 mg, 45 mg</i>	Tier 1	
<i>fenofibric acid oral tablet 105 mg, 35 mg</i>	Tier 1	
<i>gemfibrozil oral tablet 600 mg</i>	Tier 1	
Antihyperlipidemic - Hmg Coa Reductase Inhibitors (Statins) - Drugs For Cholesterol		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG, 40 MG, 60 MG (lovastatin)	Tier 3	ST: Must meet 2 of the following requirements: Altoprev, Atorvastatin Calcium, Lovastatin, Pravastatin Sodium, or Simvastatin in 365 days; QL (1 EA per 1 day)
<i>atorvastatin oral tablet 10 mg, 20 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>atorvastatin oral tablet 40 mg, 80 mg</i>	Tier 1	QL (1 EA per 1 day)
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (rosuvastatin calcium)	Tier 3	ST: Must meet the following requirement: Generic Rosuvastatin Calcium in 120 days; QL (1 EA per 1 day)
FLOLIPID ORAL SUSPENSION 20 MG/5 ML (4 MG/ML), 40 MG/5 ML (8 MG/ML) (simvastatin)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluvastatin oral capsule 20 mg, 40 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; ST: Must meet 2 of the following requirements: Altoprev, Atorvastatin Calcium, Lovastatin, Pravastatin Sodium, or Simvastatin in 365 days; QL (2 EA per 1 day)
<i>fluvastatin oral tablet extended release 24 hr 80 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; ST: Must meet 2 of the following requirements: Altoprev, Atorvastatin Calcium, Lovastatin, Pravastatin Sodium, or Simvastatin in 365 days; QL (1 EA per 1 day)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (pitavastatin calcium)	Tier 2	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (2 EA per 1 day)
<i>pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>rosuvastatin oral tablet 10 mg, 5 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>rosuvastatin oral tablet 20 mg, 40 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	\$0 COPAY IF AGE 40-75 YEARS AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>simvastatin oral tablet 80 mg</i>	Tier 1	PA; QL (1 EA per 1 day)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (pitavastatin magnesium)	Tier 3	ST: Must meet the following requirement: Livalo in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperlipidemic - Nicotinic Acid Derivatives - Drugs For Cholesterol		
<i>niacin oral tablet 500 mg</i>	Tier 3	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg</i>	Tier 1	
niacin (Niacor Oral Tablet 500 Mg)	Tier 1	
Antihyperlipidemic - Omega-3 Fatty Acid Type - Drugs For Cholesterol		
<i>omega-3 acid ethyl esters oral capsule 1 gram</i>	Tier 1	QL (4 EA per 1 day)
VASCEPA ORAL CAPSULE 0.5 GRAM (icosapent ethyl)	Tier 1	QL (8 EA per 1 day)
VASCEPA ORAL CAPSULE 1 GRAM (icosapent ethyl)	Tier 1	QL (4 EA per 1 day)
Antihyperlipidemic - Pcsk9 Inhibitors - Drugs For Cholesterol		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML (alirocumab)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML (evolocumab)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML (evolocumab)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML (evolocumab)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days
Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor - Drugs For Cholesterol		
<i>ezetimibe oral tablet 10 mg</i>	Tier 1	QL (1 EA per 1 day)
Antihyperlipidemic Agents - Dietary Source Combinations - Drugs For Cholesterol		
ANTARCTIC KRILL OIL ORAL CAPSULE 500-115-30-64 MG (krill oil/omega-3 fatty acids/dha/epa/phospholipids/astaxan)	Tier 3	
FISH OIL ORAL CAPSULE 1,000 MG (120 MG-180 MG), 1,200 (144-216) MG, 300-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
FISH OIL ORAL CAPSULE 300-500 MG (omega-3 fatty acids/fish oil)	Tier 3	
FISH OIL ORAL CAPSULE 350-600 MG (omega-3 fatty acids/dha/epa/other omega-3s/fish oil)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FISH OIL ORAL CAPSULE,DELAYED RELEASE(DR/EC) 300-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
LIPOCHOL PLUS ORAL TABLET 0.5 MG (methionine/inositol/choline/folic acid)	Tier 3	
LUVIRA ORAL CAPSULE 840 MG (375 MG- 465MG)-1,220 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
MEGARED ADV TOTAL BODY REFRESH ORAL CAPSULE 375-350-500-30 MG (omega-3 fatty acids/dha/epa/fish oil/krill/lutein/zeaxanth)	Tier 3	
MEGARED ADVANCED 4-IN-1 ORAL CAPSULE 339 MG-314 MG- 500 MG, 700 MG-600 MG- 900 MG (omega-3 fatty acids/dha/epa/fish oil/krill oil)	Tier 3	
MEGARED ADVANCED TOTAL BODY ORAL CAPSULE 339-314-500-24 MG (omega-3 fatty acids/dha/epa/fish oil/krill/lutein/zeaxanth)	Tier 3	
MEGARED OMEGA-3 KRILL OIL ORAL CAPSULE 1,000-230-60 MG, 350-90-24-50 MG, 500-115-30-64 MG, 750-225-180-390 MG (krill oil/omega-3 fatty acids/dha/epa/phospholipids/astaxan)	Tier 3	
<i>omega 3-dha-epa-fish oil oral capsule 300 mg (120 mg-180mg)-1,000 mg</i>	Tier 3	
<i>omega 3-dha-epa-fish oil-krill oral capsule 339 mg-314 mg-500 mg</i>	Tier 3	
OMEGA MONOPURE DHA EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 790 MG-675 MG-118 MG-1,300 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGA MONOPURE EPA EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 910-1,300 MG (eicosapentaenoic acid (epa)/fish oil)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMEGA-3 2100 ORAL CAPSULE 1,050 MG(300 MG -675 MG-75 MG) (omega-3 fatty acids/dha/epa/dpa/fish oil)	Tier 3	
<i>omega-3 fatty acids-fish oil oral capsule 300-1,000 mg</i>	Tier 3	
OMEGA-3 KRILL OIL ORAL CAPSULE 350-90-24-50 MG (krill oil/omega-3 fatty acids/dha/epa/phospholipids/astaxan)	Tier 3	
OMEGAPURE 600 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 650 MG-240 MG- 360 MG-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE 780 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 910 MG-330 MG- 450 MG-1,400 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE 900 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 967 MG-385 MG- 515 MG-1,290 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
TRIPLE OMEGA 3-6-9 ORAL CAPSULE 400-400-400 MG (fish oil/borage oil/flaxseed oil/omega 3,6,9 combination no1)	Tier 3	
Antihyperlipidemic- Atp-Citrate Lyase And Cholesterol Absorption Inhib - Drugs For Cholesterol		
NEXLIZET ORAL TABLET 180-10 MG (bempedoic acid/ezetimibe)	Tier 2	ST: Must meet any of the following requirements: Atorvastatin Calcium, Flolipid, Fluvastatin Sodium, Lovastatin, Pravastatin Sodium, Rosuvastatin Calcium, or Simvastatin in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperlipidemic Hmg Coa Reduct Inhib And Calcium Channel Blocker - Drugs For Cholesterol		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	Tier 1	QL (1 EA per 1 day)
Antihyperlipidemic-Hmg Coa Reduct Inhib And Cholesterol Absorp Inhibit - Drugs For Cholesterol		
<i>ezetimibe-rosuvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-5 mg</i>	Tier 1	ST: Must meet the following requirements: Atorvastatin Calcium and Rosuvastatin Calcium in 365 days; QL (1 EA per 1 day)
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>ezetimibe-simvastatin oral tablet 10-80 mg</i>	Tier 1	PA; QL (1 EA per 1 day)
ROSZET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG (ezetimibe/rosuvastatin calcium)	Tier 3	ST: Must meet the following requirements: Atorvastatin Calcium and Rosuvastatin Calcium in 365 days; QL (1 EA per 1 day)
Antihyperlipidemic-Microsomal Triglyceride Transfer Protein (Mtp)Inhib - Drugs For Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG (lomitapide mesylate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Beta Blockers Cardiac Selective - Drugs For High Blood Pressure		
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	Tier 1	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (nebivolol HCl)	Tier 2	
KAPSPARGO SPRINKLE ORAL CAPSULE, SPRINKLE, ER 24HR 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	Tier 3	
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>metoprolol tartrate oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>metoprolol tartrate oral tablet 25 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity - Drugs For High Blood Pressure		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	Tier 1	
Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity - Drugs For High Blood Pressure		
LEVATOL ORAL TABLET 20 MG (penbutolol sulfate)	Tier 3	
<i>pindolol oral tablet 10 mg, 5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Beta Blockers Non-Cardiac Selective - Drugs For High Blood Pressure		
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (propranolol HCl)	Tier 3	ST: Must meet the following requirement: Propranolol HCL in 120 days if 1 year of age and older; QL (360 ML per 30 days)
INDERAL XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG (propranolol HCl)	Tier 3	ST: Must meet the following requirement: Propranolol HCL in 120 days
INNOPRAN XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG (propranolol HCl)	Tier 3	ST: Must meet the following requirement: Propranolol HCL in 120 days
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg</i>	Tier 1	
<i>propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
Bradykinin B2 Receptor Antagonists - Drugs For The Heart		
<i>icatibant subcutaneous syringe 30 mg/3 ml</i>	Tier 4	PA
icatibant acetate (Sajazir Subcutaneous Syringe 30 Mg/3 MI)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Calcium Channel Blocker - Nsaid, Cox-2 Selective Inhibitor Combination - Drugs For High Blood Pressure		
CONSENSI ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG (amlodipine besylate/celecoxib)	Tier 3	PA
Calcium Channel Blockers - Benzothiazepines - Drugs For High Blood Pressure		
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG (diltiazem HCl)	Tier 3	
diltiazem HCl (Cartia Xt Oral Capsule, Extended Release 24Hr 120 Mg, 180 Mg, 240 Mg, 300 Mg)	Tier 1	
<i>diltiazem hcl oral capsule, ext. rel 24h degradable 120 mg, 180 mg, 240 mg</i>	Tier 1	
<i>diltiazem hcl oral capsule, extended release 12 hr 120 mg, 60 mg, 90 mg</i>	Tier 1	
<i>diltiazem hcl oral capsule, extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 1	
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	Tier 1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 1	
DILT-XR ORAL CAPSULE, EXT. REL 24H DEGRADABLE 120 MG, 180 MG, 240 MG (diltiazem HCl)	Tier 1	
diltiazem HCl (Matzim La Oral Tablet Extended Release 24 Hr 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1	
diltiazem HCl (Taztia Xt Oral Capsule, Extended Release 24 Hr 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	Tier 1	
diltiazem HCl (Tiadyt Er Oral Capsule, Extended Release 24 Hr 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific - Drugs For High Blood Pressure		
<i>nimodipine oral capsule 30 mg</i>	Tier 1	
NYMALIZE ORAL SOLUTION 60 MG/10 ML (nimodipine)	Tier 4	PA
NYMALIZE ORAL SYRINGE 30 MG/5 ML, 60 MG/10 ML (nimodipine)	Tier 4	PA
Calcium Channel Blockers - Dihydropyridines - Drugs For High Blood Pressure		
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
CONJUPRI ORAL TABLET 2.5 MG, 5 MG (levamlodipine maleate)	Tier 3	PA
<i>felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	Tier 1	
KATERZIA ORAL SUSPENSION 1 MG/ML (amlodipine benzoate)	Tier 3	PA
<i>nicardipine oral capsule 20 mg, 30 mg</i>	Tier 1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	Tier 1	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nisoldipine oral tablet extended release 24 hr 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	Tier 1	
Calcium Channel Blockers - Phenylalkylamines - Drugs For High Blood Pressure		
<i>verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>verapamil oral capsule, ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg, 360 mg</i>	Tier 1	
<i>verapamil oral tablet extended release 120 mg, 180 mg, 240 mg</i>	Tier 1	
Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	Tier 1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	Tier 1	
DUTOPROL ORAL TABLET EXTENDED RELEASE 24 HR 100-12.5 MG (metoprolol succinate/hydrochlorothiazide)	Tier 3	QL (2 EA per 1 day)
DUTOPROL ORAL TABLET EXTENDED RELEASE 24 HR 25-12.5 MG, 50-12.5 MG (metoprolol succinate/hydrochlorothiazide)	Tier 3	QL (1 EA per 1 day)
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	Tier 1	
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents - Drugs For Serious Allergic Reaction		
AUVI-Q INJECTION AUTO-INJECTOR 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML (epinephrine)	Tier 3	QL (2 EA per 365 days)
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	Tier 1	QL (4 EA per 1 FILL)
SYMJEPI INJECTION SYRINGE 0.15 MG/0.3 ML, 0.3 MG/0.3 ML (epinephrine)	Tier 2	QL (4 EA per 1 FILL)
Cardiovascular Sympathomimetics - Drugs For Serious Allergic Reaction		
<i>droxidopa oral capsule 100 mg, 200 mg, 300 mg</i>	Tier 4	PA
<i>midodrine oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Central Alpha-2 Agonists-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg</i>	Tier 1	
Central Alpha-2 Receptor Agonists - Drugs For High Blood Pressure		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	Tier 1	
<i>clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr</i>	Tier 1	
<i>guanfacine oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	Tier 1	
Digitalis Glycosides - Drugs For The Heart		
<i>digoxin (Digitek Oral Tablet 125 Mcg (0.125 Mg), 250 Mcg (0.25 Mg))</i>	Tier 1	
<i>digoxin (Digox Oral Tablet 125 Mcg (0.125 Mg), 250 Mcg (0.25 Mg))</i>	Tier 1	
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	Tier 2	
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	Tier 1	
LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG) (digoxin)	Tier 3	
Direct Acting Vasodilators - Drugs For High Blood Pressure		
<i>hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	Tier 1	
Diuretic - Carbonic Anhydrase Inhibitors - Drugs For High Blood Pressure		
<i>acetazolamide oral capsule, extended release 500 mg</i>	Tier 1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methazolamide oral tablet 25 mg, 50 mg</i>	Tier 1	
Diuretic - Loop - Drugs For High Blood Pressure		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>ethacrynic acid oral tablet 25 mg</i>	Tier 1	
<i>furosemide oral solution 10 mg/ml</i>	Tier 1	
<i>furosemide oral solution 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	Tier 1	
Diuretic - Potassium Sparing - Drugs For High Blood Pressure		
<i>amiloride oral tablet 5 mg</i>	Tier 1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	Tier 1	
Diuretic - Potassium Sparing-Thiazide And Related Combinations - Drugs For High Blood Pressure		
ALDACTAZIDE ORAL TABLET 50-50 MG (spironolactone/hydrochlorothiazide)	Tier 3	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	Tier 1	
<i>spironolacton-hydrochlorothiazid oral tablet 25-25 mg</i>	Tier 1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	Tier 1	
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	Tier 1	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists - Drugs For High Blood Pressure		
<i>tolvaptan oral tablet 15 mg</i>	Tier 4	QL (30 EA per 365 days)
<i>tolvaptan oral tablet 30 mg</i>	Tier 4	QL (60 EA per 365 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diuretic - Thiazides And Related - Drugs For High Blood Pressure		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	
DIURIL ORAL SUSPENSION 250 MG/5 ML (chlorothiazide)	Tier 3	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	Tier 1	
<i>hydrochlorothiazide oral tablet 12.5 mg</i>	Tier 1	
<i>hydrochlorothiazide oral tablet 25 mg, 50 mg</i>	Tier 1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	Tier 1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
THALITONE ORAL TABLET 15 MG (chlorthalidone)	Tier 3	
Ganglionic Blocking, Non-Depolarizing - Drugs For High Blood Pressure		
VECAMYL ORAL TABLET 2.5 MG (mecamylamine HCl)	Tier 3	PA
Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Inhibitors - Drugs For High Blood Pressure		
CORLANOR ORAL SOLUTION 5 MG/5 ML (ivabradine HCl)	Tier 2	QL (20 ML per 1 day)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (ivabradine HCl)	Tier 2	ST: Must meet any of the following requirements: Bisoprolol Fumarate, Carvedilol, or Metoprolol Succinate in 120 days; QL (2 EA per 1 day)
Hypertrophic Cardiomyopathy Treatment Agents, Ablative - Drugs For The Heart		
ABLYSINOL INTRA-ARTERIAL SOLUTION 99 % (ethyl alcohol)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Muscarinic Receptor Antagonists (Anticholinergic) - Drugs For Abnormal Heart Rhythms		
ATROPEN INTRAMUSCULAR PEN INJECTOR 0.5 MG/0.7 ML, 1 MG/0.7 ML (atropine sulfate)	Tier 3	
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>nadolol-bendroflumethiazide oral tablet 80-5 mg</i>	Tier 1	
<i>propranolol-hydrochlorothiazid oral tablet 40-25 mg, 80-25 mg</i>	Tier 1	
Pah Agents - Selective Prostacyclin Receptor (Ip) Agonists - Drugs For High Blood Pressure		
UPTRA VI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (selexipag)	Tier 4	PA
UPTRA VI ORAL TABLETS,DOSE PACK 200 MCG (140)-800 MCG (60) (selexipag)	Tier 4	PA
Peripheral Alpha-1 Receptor Blockers - Drugs For High Blood Pressure		
CARDURA XL ORAL TABLET EXTENDED RELEASE 24HR 4 MG, 8 MG (doxazosin mesylate)	Tier 3	
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>phenoxybenzamine oral capsule 10 mg</i>	Tier 4	PA
<i>prazosin oral capsule 1 mg, 2 mg, 5 mg</i>	Tier 1	
<i>terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
Peripheral Vasodilators, Single Agents - Drugs For High Blood Pressure		
<i>isoxsuprine oral tablet 10 mg, 20 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>papaverine injection solution 30 mg/ml</i>	Tier 1	
Pheochromocytoma, Agents To Treat - Drugs For High Blood Pressure		
DEMSEER ORAL CAPSULE 250 MG (metyrosine)	Tier 3	
<i>metyrosine oral capsule 250 mg</i>	Tier 1	
Plasma Kallikrein Inhibitor Agents, Recombinant Monoclonal Antibody - Drugs For The Heart		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2 ML (150 MG/ML) (lanadelumab-flyo)	Tier 4	PA
Plasma Kallikrein Inhibitor Agents, Small Molecule - Drugs For The Heart		
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (berotralstat hydrochloride)	Tier 4	PA
Pulmonary Antihypertensive Agents - Prostacyclin-Type - Drugs For High Blood Pressure		
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	Tier 4	PA
<i>treprostinil sodium injection solution 1 mg/ml, 10 mg/ml, 2.5 mg/ml, 5 mg/ml</i>	Tier 4	PA
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML) (treprostinil)	Tier 4	PA
TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (treprostinil/nebulizer and accessories)	Tier 4	PA
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML) (treprostinil/nebulizer accessories)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (treprostinil/nebulizer and accessories)	Tier 4	PA
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION 10 MCG/ML, 20 MCG/ML (iloprost tromethamine)	Tier 4	PA
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator - Drugs For High Blood Pressure		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (riociguat)	Tier 4	PA
Pulmonary Arterial Hypertension - Endothelin Receptor Antagonists - Drugs For High Blood Pressure		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	Tier 4	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	Tier 4	PA
OPSUMIT ORAL TABLET 10 MG (macitentan)	Tier 4	PA
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG (bosentan)	Tier 4	PA
Pulmonary Arterial Hypertension Agents-Selective Cgmp-Pde5 Inhibitors - Drugs For High Blood Pressure		
tadalafil (Alyq Oral Tablet 20 Mg)	Tier 4	PA
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution 10 mg/ml</i>	Tier 4	PA
<i>sildenafil (pulm.hypertension) oral tablet 20 mg</i>	Tier 1	PA
<i>tadalafil (pulm. hypertension) oral tablet 20 mg</i>	Tier 4	PA
Renin Inhibitor, Direct - Drugs For High Blood Pressure		
<i>aliskiren oral tablet 150 mg, 300 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Renin Inhibitor, Direct And Diuretic Combinations - Drugs For High Blood Pressure		
TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG (aliskiren hemifumarate/hydrochlorothiazide)	Tier 3	
Vasodilator Combinations - Drugs For High Blood Pressure		
BIDIL ORAL TABLET 20-37.5 MG (isosorbide dinitrate/hydralazine HCl)	Tier 2	
Central Nervous System Agents - Drugs For The Nervous System		
Agents To Treat Episodic Cluster Headaches - Drugs For Migraine Headaches		
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3) (galcanezumab-gnlm)	Tier 2	PA
Antianxiety Agent - Antihistamine Type - Drugs For Anxiety		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antianxiety Agent - Benzodiazepines - Drugs For Anxiety		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (alprazolam)	Tier 2	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg</i>	Tier 1	
<i>alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	Tier 1	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	Tier 1	
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)	Tier 1	
<i>diazepam oral concentrate 5 mg/ml</i>	Tier 1	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Tier 1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Tier 1	
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	Tier 1	
<i>lorazepam oral concentrate 2 mg/ml</i>	Tier 1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 1 MG, 2 MG, 3 MG (lorazepam)	Tier 3	
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	Tier 1	
Antianxiety Agent - Dicarbamate Type - Drugs For Anxiety		
<i>meprobamate oral tablet 200 mg, 400 mg</i>	Tier 1	
Antianxiety Agent - Non-Benzodiazepine - Drugs For Anxiety		
<i>buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsant - Ampa-Type Glutamate Receptor Antagonists - Drugs For Seizures /Personality Disorder/Nerve Pain		
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (perampanel)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (680 ML per 28 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG (perampanel)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (30 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FYCOMPA ORAL TABLET 2 MG (perampanel)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (120 EA per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG (perampanel)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (60 EA per 30 days)
Anticonvulsant - Barbiturates And Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>primidone oral tablet 250 mg, 50 mg</i>	Tier 1	
Anticonvulsant - Benzodiazepines - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>clobazam oral suspension 2.5 mg/ml</i>	Tier 1	QL (480 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobazam oral tablet 10 mg, 20 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	Tier 1	QL (1 EA per 1 FILL)
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML) (midazolam)	Tier 3	QL (10 EA per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (clobazam)	Tier 2	
VALTOCO NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML) (diazepam)	Tier 3	QL (10 EA per 30 days)
Anticonvulsant - Cannabinoid Type - Drugs For Seizures /Personality Disorder/Nerve Pain		
EPIDIOLEX ORAL SOLUTION 100 MG/ML (cannabidiol (CBD))	Tier 4	PA
Anticonvulsant - Carbamates - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>felbamate oral suspension 600 mg/5 ml</i>	Tier 1	QL (30 ML per 1 day)
<i>felbamate oral tablet 400 mg</i>	Tier 1	QL (9 EA per 1 day)
<i>felbamate oral tablet 600 mg</i>	Tier 1	QL (6 EA per 1 day)
Anticonvulsant - Carboxylic Acid Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>divalproex oral capsule, delayed rel sprinkle 125 mg</i>	Tier 1	
<i>divalproex oral tablet extended release 24 hr 250 mg, 500 mg</i>	Tier 1	
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	Tier 1	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	Tier 1	
<i>valproic acid (as sodium salt) oral solution 500 mg/10 ml (10 ml)</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>valproic acid oral capsule 250 mg</i>	Tier 1	
Anticonvulsant - Functionalized Amino Acid - Drugs For Seizures /Personality Disorder/Nerve Pain		
VIMPAT ORAL SOLUTION 10 MG/ML (lacosamide)	Tier 2	QL (1200 ML per 30 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (lacosamide)	Tier 2	QL (2 EA per 1 day)
VIMPAT ORAL TABLETS,DOSE PACK 50 MG (14)- 100 MG (14) (lacosamide)	Tier 3	
Anticonvulsant - Gaba Analogs - Drugs For Seizures /Personality Disorder/Nerve Pain		
ACTIVE-PAC KIT,GEL AND CAPSULE 300-4-1 MG-%-% (gabapentin/lidocaine HCl/menthol)	Tier 3	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	Tier 1	
<i>gabapentin oral solution 250 mg/5 ml</i>	Tier 1	
<i>gabapentin oral solution 250 mg/5 ml (5 ml), 300 mg/6 ml (6 ml)</i>	Tier 1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	Tier 1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (pregabalin)	Tier 3	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	Tier 3	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	Tier 1	
<i>pregabalin oral solution 20 mg/ml</i>	Tier 1	
Anticonvulsant - Gaba Re-Uptake Inhibitor, Nipecotic Acid Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>tiagabine oral tablet 12 mg, 2 mg, 4 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>tiagabine oral tablet 16 mg</i>	Tier 1	QL (3 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsant - Gaba Transaminase (Gaba-T) Inhibitor - Drugs For Seizures /Personality Disorder/Nerve Pain		
SABRIL ORAL TABLET 500 MG (vigabatrin)	Tier 4	QL (6 EA per 1 day)
<i>vigabatrin oral powder in packet 500 mg</i>	Tier 4	QL (6 EA per 1 day)
<i>vigabatrin oral tablet 500 mg</i>	Tier 4	QL (6 EA per 1 day)
vigabatrin (Vigadrone Oral Powder In Packet 500 Mg)	Tier 4	QL (6 EA per 1 day)
Anticonvulsant - Hydantoins - Drugs For Seizures /Personality Disorder/Nerve Pain		
DILANTIN ORAL CAPSULE 30 MG (phenytoin sodium extended)	Tier 2	
<i>phenytoin oral suspension 100 mg/4 ml</i>	Tier 1	
<i>phenytoin oral suspension 125 mg/5 ml</i>	Tier 1	
<i>phenytoin oral tablet, chewable 50 mg</i>	Tier 1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsant - Iminostilbene Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
APTIOM ORAL TABLET 200 MG, 400 MG (eslicarbazepine acetate)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 365 days; QL (1 EA per 1 day)
APTIOM ORAL TABLET 600 MG, 800 MG (eslicarbazepine acetate)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 365 days; QL (2 EA per 1 day)
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbamazepine oral tablet 200 mg</i>	Tier 1	
<i>carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg</i>	Tier 1	
<i>carbamazepine oral tablet, chewable 100 mg</i>	Tier 1	
carbamazepine (Eptol Oral Tablet 200 Mg)	Tier 1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	
<i>oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)</i>	Tier 1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	Tier 1	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG (oxcarbazepine)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG (oxcarbazepine)	Tier 3	ST: Must meet 2 of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid, or Zonisamide in 365 days; QL (4 EA per 1 day)
Anticonvulsant - Monosaccharide Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	Tier 1	
<i>topiramate oral capsule, sprinkle, er 24hr 100 mg, 25 mg, 50 mg</i>	Tier 1	ST: Must meet the following requirement: Immediate-release Topiramate tablets or sprinkles in 120 days; QL (1 EA per 1 day)
<i>topiramate oral capsule, sprinkle, er 24hr 150 mg, 200 mg</i>	Tier 1	ST: Must meet the following requirement: Immediate-release Topiramate tablets or sprinkles in 120 days; QL (2 EA per 1 day)
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
TROKENDI XR ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 200 MG (topiramate)	Tier 2	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 25 MG (topiramate)	Tier 2	QL (8 EA per 1 day)
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 50 MG (topiramate)	Tier 2	QL (4 EA per 1 day)
Anticonvulsant - Phenyltriazine Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
LAMICTAL XR STARTER (BLUE) ORAL TABLET EXTENDED REL,DOSE PACK 25 MG (21) -50 MG (7) (lamotrigine)	Tier 3	
LAMICTAL XR STARTER (GREEN) ORAL TABLET EXTENDED REL,DOSE PACK 50 MG(14)-100MG (14)-200 MG (7) (lamotrigine)	Tier 3	
LAMICTAL XR STARTER (ORANGE) ORAL TABLET EXTENDED REL,DOSE PACK 25MG (14)-50 MG (14)-100MG (7) (lamotrigine)	Tier 3	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	
<i>lamotrigine oral tablet disintegrating, dose pk 25 mg (21) - 50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) - 100 mg (14)</i>	Tier 1	
<i>lamotrigine oral tablet extended release 24hr 100 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>lamotrigine oral tablet extended release 24hr 200 mg, 250 mg, 300 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>lamotrigine oral tablet extended release 24hr 25 mg, 50 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg</i>	Tier 1	
<i>lamotrigine oral tablet,disintegrating 100 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>lamotrigine oral tablet,disintegrating 200 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>lamotrigine oral tablet,disintegrating 25 mg, 50 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>lamotrigine oral tablets,dose pack 25 mg (35), 25 mg (42) - 100 mg (7), 25 mg (84) -100 mg (14)</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamotrigine (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	Tier 1	
lamotrigine (Subvenite Starter (Blue) Kit Oral Tablets,Dose Pack 25 Mg (35))	Tier 1	
lamotrigine (Subvenite Starter (Green) Kit Oral Tablets,Dose Pack 25 Mg (84) -100 Mg (14))	Tier 1	
lamotrigine (Subvenite Starter (Orange) Kit Oral Tablets,Dose Pack 25 Mg (42) -100 Mg (7))	Tier 1	
Anticonvulsant - Pyrrolidine Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
BRIVIACT ORAL SOLUTION 10 MG/ML (brivaracetam)	Tier 3	QL (600 ML per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (brivaracetam)	Tier 3	QL (2 EA per 1 day)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HR 1,000 MG (levetiracetam)	Tier 3	ST: Must meet the following requirement: Levetiracetam in 120 days; QL (3 EA per 1 day); Age (Min 12 Years)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HR 1,500 MG (levetiracetam)	Tier 3	ST: Must meet the following requirement: Levetiracetam in 120 days; QL (2 EA per 1 day); Age (Min 12 Years)
<i>levetiracetam oral solution 100 mg/ml</i>	Tier 1	
<i>levetiracetam oral solution 500 mg/5 ml (5 ml)</i>	Tier 1	
<i>levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG (levetiracetam)	Tier 3	ST: Must meet the following requirement: Levetiracetam in 120 days; QL (2 EA per 1 day)
SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG, 750 MG (levetiracetam)	Tier 3	ST: Must meet the following requirement: Levetiracetam in 120 days; QL (4 EA per 1 day)
Anticonvulsant - Succinimides - Drugs For Seizures /Personality Disorder/Nerve Pain		
CELONTIN ORAL CAPSULE 300 MG (methsuximide)	Tier 3	
<i>ethosuximide oral capsule 250 mg</i>	Tier 1	
<i>ethosuximide oral solution 250 mg/5 ml</i>	Tier 1	
Anticonvulsant - Sulfonamide Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Anticonvulsant - Triazole Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
BANZEL ORAL TABLET 200 MG (rufinamide)	Tier 3	ST: Must meet any of the following requirements: Divalproex Sodium, Lamictal Xr, Lamotrigine, Topiramate, Trokendi XR, or Valproic Acid in 120 days; QL (16 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANZEL ORAL TABLET 400 MG (rufinamide)	Tier 3	ST: Must meet any of the following requirements: Divalproex Sodium, Lamictal Xr, Lamotrigine, Topiramate, Trokendi XR, or Valproic Acid in 120 days; QL (8 EA per 1 day)
<i>rufinamide oral suspension 40 mg/ml</i>	Tier 1	ST: Must meet any of the following requirements: Divalproex Sodium, Lamictal Xr, Lamotrigine, Topiramate, Trokendi XR, or Valproic Acid in 120 days; QL (80 ML per 1 day)
<i>rufinamide oral tablet 200 mg</i>	Tier 1	ST: Must meet any of the following requirements: Divalproex Sodium, Lamictal Xr, Lamotrigine, Topiramate, Trokendi XR, or Valproic Acid in 120 days; QL (16 EA per 1 day)
<i>rufinamide oral tablet 400 mg</i>	Tier 1	ST: Must meet any of the following requirements: Divalproex Sodium, Lamictal Xr, Lamotrigine, Topiramate, Trokendi XR, or Valproic Acid in 120 days; QL (8 EA per 1 day)
Anticonvulsant Others - Drugs For Seizures /Personality Disorder/Nerve Pain		
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (stiripentol)	Tier 4	PA
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG (stiripentol)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FINTEPLA ORAL SOLUTION 2.2 MG/ML (fenfluramine HCl)	Tier 4	PA
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1) (cenobamate)	Tier 2	ST: Must meet any of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 120 days; QL (1 EA per 1 day)
XCOPRI ORAL TABLET 100 MG, 150 MG, 50 MG (cenobamate)	Tier 2	ST: Must meet any of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XCOPRI ORAL TABLET 200 MG (cenobamate)	Tier 2	ST: Must meet any of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 120 days; QL (2 EA per 1 day)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14), 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14) (cenobamate)	Tier 2	ST: Must meet any of the following requirements: Carbamazepine, Divalproex Sodium, Elepsia XR, Equetro, Gabapentin, Gralise, Lamictal XR, Lamotrigine, Levetiracetam, Neuraptine, Oxcarbazepine, Oxtellar XR, Spritam, Topiramate, Trokendi XR, Valproic Acid (as Sodium Salt), Valproic Acid, or Zonisamide in 120 days; QL (1 EA per 1 day)
Antidepressant - Alpha-2 Receptor Antagonists (Nassa) - Drugs For Depression		
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	Tier 1	
<i>mirtazapine oral tablet 7.5 mg</i>	Tier 1	
<i>mirtazapine oral tablet,disintegrating 15 mg, 30 mg, 45 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidepressant - Mao Inhibitor Nonselective And Irreversible-Types A,B - Drugs For Depression		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR (selegiline)	Tier 3	ST: Must meet any of the following requirements: Marplan, Phenelzine Sulfate, or Tranylcypromine Sulfate in 120 days; QL (1 EA per 1 day)
MARPLAN ORAL TABLET 10 MG (isocarboxazid)	Tier 3	
<i>phenelzine oral tablet 15 mg</i>	Tier 1	
<i>tranylcypromine oral tablet 10 mg</i>	Tier 1	
Antidepressant - N-Methyl D-Aspartate (Nmda) Receptor Antagonist - Drugs For Depression		
SPRAVATO NASAL SPRAY, NON-AEROSOL 28 MG, 56 MG (28 MG X 2), 84 MG (28 MG X 3) (esketamine HCl)	Tier 4	PA
Antidepressant - Selective Serotonin Reuptake Inhibitors (Ssris) - Drugs For Depression		
<i>citalopram oral solution 10 mg/5 ml</i>	Tier 1	
<i>citalopram oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>escitalopram oxalate oral solution 5 mg/5 ml</i>	Tier 1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
<i>fluoxetine oral capsule 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>fluoxetine oral capsule, delayed release (dr/ec) 90 mg</i>	Tier 1	
<i>fluoxetine oral solution 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>fluoxetine oral tablet 60 mg</i>	Tier 1	
<i>fluvoxamine oral capsule, extended release 24hr 100 mg, 150 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluvoxamine oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>paroxetine hcl oral suspension 10 mg/5 ml</i>	Tier 1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg</i>	Tier 1	
PEXEVA ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (paroxetine mesylate)	Tier 3	ST: Must meet the following requirement: Paroxetine HCL in 120 days; QL (1 EA per 1 day)
<i>sertraline oral concentrate 20 mg/ml</i>	Tier 1	
<i>sertraline oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antidepressant - Serotonin-2 Antagonist-Reuptake Inhibitors (Saris) - Drugs For Depression		
<i>nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	Tier 1	
<i>trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	Tier 1	
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (Snris) - Drugs For Depression		
<i>desvenlafaxine oral tablet extended release 24 hr 100 mg, 50 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 365 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg</i>	Tier 1	
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG (duloxetine HCl)	Tier 3	ST: Must meet the following requirement: Generic Duloxetine in 120 days; QL (1 EA per 1 day)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 60 MG (duloxetine HCl)	Tier 3	ST: Must meet the following requirement: Generic Duloxetine in 120 days; QL (2 EA per 1 day)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	Tier 1	
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	Tier 1	ST: Must meet the following requirement: Generic Duloxetine two 20mg capsules in 120 days; QL (1 EA per 1 day)
FETZIMA ORAL CAPSULE, EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26) (levomilnacipran HCl)	Tier 2	ST: Must meet 2 of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fetzima, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 365 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG (levomilnacipran HCl)	Tier 2	ST: Must meet 2 of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fetzima, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 365 days; QL (1 EA per 1 day)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran HCl)	Tier 2	
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42) (milnacipran HCl)	Tier 2	
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	Tier 1	
<i>venlafaxine oral tablet extended release 24hr 150 mg, 225 mg, 37.5 mg, 75 mg</i>	Tier 1	
Antidepressant - Ssri And 5Ht1a Partial Agonist - Drugs For Depression		
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (vilazodone HCl)	Tier 2	ST: Must meet any of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23) (vilazodone HCl)	Tier 2	ST: Must meet any of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 120 days; QL (1 EA per 1 day)
Antidepressant - Ssri And Serotonin (5-Ht) Receptor Modulator - Drugs For Depression		
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (vortioxetine hydrobromide)	Tier 2	ST: Must meet any of the following requirements: Bupropion HCL, Citalopram Hydrobromide, Escitalopram Oxalate, Fluoxetine HCL, Mirtazapine, Paroxetine HCL, Sertraline HCL, or Venlafaxine HCL in 120 days; QL (1 EA per 1 day)
Antidepressant - Tricyclic And Antipsychotic, Phenothiazine Comb - Drugs For Depression		
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	Tier 1	
Antidepressant - Tricyclic-Benzodiazepine Combinations - Drugs For Depression		
<i>amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidepressant-Norepinephrine And Dopamine Reuptake Inhibitors (Ndris) - Drugs For Depression		
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HR 174 MG, 348 MG, 522 MG (bupropion HBr)	Tier 3	ST: Must meet the following requirement: Bupropion HCL in 120 days; QL (1 EA per 1 day)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	Tier 1	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i>	Tier 1	
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	Tier 1	ST: Must meet the following requirement: Bupropion HCL in 120 days; QL (1 EA per 1 day)
<i>bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg</i>	Tier 1	
Antidepressant-Tricyclics And Related (Non-Select Reuptake Inhibitors) - Drugs For Depression		
<i>amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	Tier 1	
<i>clomipramine oral capsule 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>doxepin oral concentrate 10 mg/ml</i>	Tier 1	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	Tier 1	
<i>maprotiline oral tablet 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>nortriptyline oral solution 10 mg/5 ml</i>	Tier 1	
<i>protriptyline oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>trimipramine oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antiparkinson - Dopaminergic-Periph Comt-Dopa-Decarboxylase Inhib Comb - Drugs For Parkinson		
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	Tier 1	
Antiparkinson - Dopaminerg-Peripheral Dopa-Decarboxylase Inhibit Comb - Drugs For Parkinson		
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
<i>carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg</i>	Tier 1	
<i>carbidopa-levodopa oral tablet, disintegrating 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
DUOPA J-TUBE INTESTINAL PUMP SUSPENSION 4.63-20 MG/ML (carbidopa/levodopa)	Tier 4	PA
RYTARY ORAL CAPSULE, EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG (carbidopa/levodopa)	Tier 3	ST: Must meet the following requirement: Carbidopa/levodopa in 120 days; QL (10 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiparkinson Adjuvant - Adenosine Receptor Antagonist - Drugs For Parkinson		
NOURIANZ ORAL TABLET 20 MG, 40 MG (istradefylline)	Tier 3	PA
Antiparkinson Adjuvant - Central/Peripheral Comt Inhibitors - Drugs For Parkinson		
<i>tolcapone oral tablet 100 mg</i>	Tier 1	ST: Must meet the following requirement: Entacapone in 120 days; QL (3 EA per 1 day)
Antiparkinson Adjuvant - Peripheral Comt Inhibitors - Drugs For Parkinson		
<i>entacapone oral tablet 200 mg</i>	Tier 1	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG (opicapone)	Tier 3	PA
Antiparkinson Adjuvant - Peripheral Dopa-Decarboxylase Inhibitors - Drugs For Parkinson		
<i>carbidopa oral tablet 25 mg</i>	Tier 1	
Antiparkinson Therapy - Anticholinergic Agents - Drugs For Parkinson		
<i>benztropine oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>trihexyphenidyl oral elixir 0.4 mg/ml</i>	Tier 1	
<i>trihexyphenidyl oral tablet 2 mg, 5 mg</i>	Tier 1	
Antiparkinson Therapy - Dopamine Precursors - Drugs For Parkinson		
INBRIJA INHALATION CAPSULE 42 MG (levodopa)	Tier 4	PA
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE 42 MG (levodopa)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiparkinson Therapy - Ergot Alkaloids And Derivatives - Drugs For Parkinson		
<i>bromocriptine oral capsule 5 mg</i>	Tier 1	
<i>bromocriptine oral tablet 2.5 mg</i>	Tier 1	
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(Mao-B) - Drugs For Parkinson		
<i>rasagiline oral tablet 0.5 mg, 1 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>selegiline hcl oral capsule 5 mg</i>	Tier 1	
<i>selegiline hcl oral tablet 5 mg</i>	Tier 1	
XADAGO ORAL TABLET 100 MG, 50 MG (safinamide mesylate)	Tier 3	ST: Must meet any of the following requirements: Carbidopa/levodopa, Duopa, or Rytary in 120 days; QL (1 EA per 1 day)
ZELAPAR ORAL TABLET,DISINTEGRATING 1.25 MG (selegiline HCl)	Tier 3	ST: Must meet the following requirement: Selegiline capsules or tablets in 120 days; QL (2 EA per 1 day)
Antiparkinson Therapy - Non-Ergot Dopamine Agonist Agents - Drugs For Parkinson		
<i>amantadine hcl oral capsule 100 mg</i>	Tier 1	
<i>amantadine hcl oral solution 50 mg/5 ml</i>	Tier 1	
<i>amantadine hcl oral tablet 100 mg</i>	Tier 1	
APOKYN SUBCUTANEOUS CARTRIDGE 10 MG/ML (apomorphine HCl)	Tier 4	PA
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG (amantadine HCl)	Tier 4	PA
KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG (apomorphine HCl)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR (rotigotine)	Tier 2	ST: Must meet the following requirement: Immediate-release Pramipexole or immediate-release Ropinirole in 120 days; QL (1 EA per 1 day)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1) (amantadine HCl)	Tier 3	PA
<i>pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	Tier 1	
<i>pramipexole oral tablet extended release 24 hr 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	Tier 1	ST: Must meet the following requirement: Immediate-release Pramipexole or immediate-release Ropinirole in 120 days; QL (1 EA per 1 day)
<i>ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	Tier 1	
<i>ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	Tier 1	ST: Must meet the following requirement: Immediate-release Pramipexole or immediate-release Ropinirole in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles - Drugs For Severe Mental Disorders		
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR (asenapine)	Tier 3	ST: Must meet 2 of the following requirements: Aripiprazole, Asenapine Maleate, Clozapine, Olanzapine, Paliperidone, Quetiapine Fumarate, Risperidone, or Ziprasidone HCL in 365 days; QL (1 EA per 1 day)
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisothiazolones - Drugs For Severe Mental Disorders		
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG (lurasidone HCl)	Tier 2	QL (30 EA per 30 days)
LATUDA ORAL TABLET 80 MG (lurasidone HCl)	Tier 2	QL (60 EA per 30 days)
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv - Drugs For Severe Mental Disorders		
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (iloperidone)	Tier 3	QL (2 EA per 1 day)
FANAPT ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)-4MG(2)-6MG(2) (iloperidone)	Tier 3	QL (8 EA per 28 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>risperidone oral solution 1 mg/ml</i>	Tier 1	QL (8 ML per 1 day)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risperidone oral tablet,disintegrating 0.25 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>risperidone oral tablet,disintegrating 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	QL (2 EA per 1 day)
Antipsychotic - Atypical Dopamine-Serotonin Antag-Butyrophenone Deriv - Drugs For Severe Mental Disorders		
CAPLYTA ORAL CAPSULE 42 MG (lumateperone tosylate)	Tier 3	ST: Must meet 2 of the following requirements: Aripiprazole, Asenapine Maleate, Clozapine, Olanzapine, Paliperidone, Quetiapine Fumarate, Risperidone, or Ziprasidone HCL in 365 days; QL (1 EA per 1 day)
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzodiazepine Der - Drugs For Severe Mental Disorders		
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	QL (3 EA per 1 day)
VERSACLOZ ORAL SUSPENSION 50 MG/ML (clozapine)	Tier 3	ST: Must meet 2 of the following requirements: Aripiprazole, Asenapine Maleate, Clozapine, Olanzapine, Paliperidone, Quetiapine Fumarate, Risperidone, or Ziprasidone HCL in 365 days; QL (18 ML per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antipsychotic - Butyrophenone Derivatives - Drugs For Severe Mental Disorders		
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	Tier 1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	Tier 1	
Antipsychotic - Dibenzoxazepine Derivatives - Drugs For Severe Mental Disorders		
ADASUVE INHALATION AEROSOL POWDR BREATH ACTIVATED 10 MG (loxapine)	Tier 4	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	
Antipsychotic - Dihydroindolones - Drugs For Severe Mental Disorders		
<i>molindone oral tablet 10 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>molindone oral tablet 25 mg</i>	Tier 1	QL (9 EA per 1 day)
<i>molindone oral tablet 5 mg</i>	Tier 1	
Antipsychotic - Diphenylbutylpiperidine Derivatives - Drugs For Severe Mental Disorders		
<i>pimozide oral tablet 1 mg, 2 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Aliphatic - Drugs For Severe Mental Disorders		
<i>chlorpromazine oral concentrate 100 mg/ml, 30 mg/ml</i>	Tier 1	
<i>chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Piperazine - Drugs For Severe Mental Disorders		
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	Tier 1	
<i>fluphenazine hcl oral elixir 2.5 mg/5 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Piperidine - Drugs For Severe Mental Disorders		
<i>thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antipsychotic - Thioxanthenes - Drugs For Severe Mental Disorders		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der - Drugs For Severe Mental Disorders		
SEROQUEL XR ORAL TABLET, EXT REL 24HR DOSE PACK 50 MG(3)-200 MG (1)-300 MG(11) (quetiapine fumarate)	Tier 3	
Antipsychotic-Atyp Selective Serotonin 5-Ht2a Inverse Agonists (Ssia) - Drugs For Severe Mental Disorders		
NUPLAZID ORAL CAPSULE 34 MG (pimavanserin tartrate)	Tier 4	PA
NUPLAZID ORAL TABLET 10 MG (pimavanserin tartrate)	Tier 4	PA
Antipsychotic-Atypical,D2 Receptor Partial Agonist-5Ht Serotonin Mixed - Drugs For Severe Mental Disorders		
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ABILIFY MYCITE ORAL TABLET WITH SENSOR AND PATCH 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA
ABILIFY MYCITE STARTER KIT ORAL TABLET WITH SENSOR, STRIP, POD 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (brexpiprazole)	Tier 2	QL (1 EA per 1 day)
Antipsychotic-Atypical,D3/D2 Receptor Partial Agonist-Serotonin Mixed - Drugs For Severe Mental Disorders		
VRAYLAR ORAL CAPSULE 4.5 MG, 6 MG (cariprazine HCl)	Tier 2	QL (1 EA per 1 day)
VRAYLAR ORAL CAPSULE,DOSE PACK 1.5 MG (1)- 3 MG (6) (cariprazine HCl)	Tier 2	QL (7 EA per 28 days)
Attention Deficit-Hyperact. Disorder (Adhd)- Alpha-2 Receptor Agonist - Drugs For Attention Deficit Disorder		
<i>clonidine hcl oral tablet extended release 12 hr 0.1 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	QL (1 EA per 1 day)
Attention Deficit-Hyperactivity (Adhd) Therapy, Stimulant-Type - Drugs For Attention Deficit Disorder		
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 1	QL (1 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 20 MG, 25 MG, 30 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 1	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADHANSIA XR ORAL CAPSULE, ER BIPHASIC 20-80 25 MG, 35 MG, 45 MG, 55 MG, 70 MG, 85 MG (methylphenidate HCl)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
ADZENYS ER ORAL SUSPEN, IR - ER, BIPHASIC 24HR 1.25 MG/ML (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (450 ML per 30 days)
ADZENYS XR-ODT ORAL TABLET, DISINTEG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (1 EA per 1 day)
<i>amphetamine oral suspen, ir - er, biphasic 24hr 1.25 mg/ml</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (450 ML per 30 days)
AZSTARYS ORAL CAPSULE 26.1 MG- 5.2 MG, 39.2 MG- 7.8 MG, 52.3 MG- 10.4 MG (serdexmethylphenidate chloride/dexmethylphenidate HCl)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 54 MG (methylphenidate HCl)	Tier 1	QL (1 EA per 1 day)
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR 36 MG (methylphenidate HCl)	Tier 1	QL (2 EA per 1 day)
COTEMPLA XR-ODT ORAL TABLET, DISINTEG ER BIPHASE 24H 17.3 MG, 8.6 MG (methylphenidate)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COTEMPLA XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 25.9 MG (methylphenidate)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (2 EA per 1 day)
DAYTRANA TRANSDERMAL PATCH 24 HOUR 10 MG/9 HR, 15 MG/9 HR, 20 MG/9 HR, 30 MG/9 HR (methylphenidate)	Tier 3	ST: Must meet any of the following requirements: Methylphenidate HCL, Quillivant XR, or Ritalin LA in 120 days; QL (1 EA per 1 day)
<i>dexmethylphenidate oral capsule,er biphasic 50-50 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>dextroamphetamine oral tablet 15 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (3 EA per 1 day)
<i>dextroamphetamine oral tablet 20 mg, 30 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR 2.5 MG/ML (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (240 ML per 30 days)
JORNAY PM ORAL CAPSULE,DEL REL,EXT REL SPRINK 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (methylphenidate HCl)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
methylphenidate HCl (Metadate Er Oral Tablet Extended Release 20 Mg)	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral cap,er sprinkle,biphasic 40-60 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg, 20 mg, 40 mg, 60 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml</i>	Tier 1	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet extended release 24hr 72 mg</i>	Tier 1	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl oral tablet,chewable 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR 12.5 MG, 25 MG, 37.5 MG, 50 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 2	QL (1 EA per 1 day)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 40 MG (methylphenidate HCl)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG (methylphenidate HCl)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (2 EA per 1 day)
QUILLIVANT XR ORAL SUSPENSION,EXT REL 24HR,RECON 5 MG/ML (25 MG/5 ML) (methylphenidate HCl)	Tier 3	60mL BOTTLE; ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (60 ML per 30 days)
methylphenidate HCl (Relexxii Oral Tablet Extended Release 24Hr 72 Mg)	Tier 3	ST: Must meet the following requirement: Methylphenidate HCL or Ritalin LA in 120 days; QL (1 EA per 1 day)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (lisdexamfetamine dimesylate)	Tier 2	QL (1 EA per 1 day)
VYVANSE ORAL TABLET,CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (lisdexamfetamine dimesylate)	Tier 2	QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Attention Deficit-Hyperactivity Disorder (Adhd) Therapy, Nri-Type - Drugs For Attention Deficit Disorder		
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	Tier 1	QL (30 EA per 30 days)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG (viloxazine HCl)	Tier 3	ST: Must meet 2 of the following requirements: Atomoxetine HCL, Clonidine HCL, or Guanfacine HCL in 365 days; QL (1 EA per 1 day); Age (Min 6 Years and Max 17 Years)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 200 MG (viloxazine HCl)	Tier 3	ST: Must meet 2 of the following requirements: Atomoxetine HCL, Clonidine HCL, or Guanfacine HCL in 365 days; QL (2 EA per 1 day); Age (Min 6 Years and Max 17 Years)
Benzodiazepines - Drugs For Seizures /Personality Disorder/Nerve Pain		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (alprazolam)	Tier 2	
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)	Tier 1	
<i>diazepam oral concentrate 5 mg/ml</i>	Tier 1	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Tier 1	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	Tier 1	QL (1 EA per 1 FILL)
<i>flurazepam oral capsule 15 mg, 30 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	Tier 1	
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 2 MG, 3 MG (lorazepam)	Tier 3	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML) (diazepam)	Tier 3	QL (10 EA per 30 days)
Bipolar Therapy Agents - Anticonvulsant Type - Drugs For Seizures /Personality Disorder/Nerve Pain		
carbamazepine (Epilex Oral Tablet 200 Mg)	Tier 1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	
<i>lamotrigine oral tablet disintegrating, dose pk 25 mg (21) - 50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) - 100 mg (14)</i>	Tier 1	
<i>lamotrigine oral tablets,dose pack 25 mg (35), 25 mg (42) - 100 mg (7), 25 mg (84) -100 mg (14)</i>	Tier 1	
lamotrigine (Subvenite Starter (Blue) Kit Oral Tablets,Dose Pack 25 Mg (35))	Tier 1	
lamotrigine (Subvenite Starter (Green) Kit Oral Tablets,Dose Pack 25 Mg (84) -100 Mg (14))	Tier 1	
lamotrigine (Subvenite Starter (Orange) Kit Oral Tablets,Dose Pack 25 Mg (42) -100 Mg (7))	Tier 1	
<i>valproic acid (as sodium salt) oral solution 500 mg/10 ml (10 ml)</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bipolar Therapy Agents - Atypical Antipsychotics - Drugs For Severe Mental Disorders		
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA
ABILIFY MYCITE ORAL TABLET WITH SENSOR AND PATCH 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA
ABILIFY MYCITE STARTER KIT ORAL TABLET WITH SENSOR, STRIP, POD 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 4	PA
<i>aripiprazole oral solution 1 mg/ml</i>	Tier 1	QL (30 ML per 1 day)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>aripiprazole oral tablet,disintegrating 10 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>aripiprazole oral tablet,disintegrating 15 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (olanzapine/samidorphan malate)	Tier 3	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (cariprazine HCl)	Tier 2	QL (1 EA per 1 day)
VRAYLAR ORAL CAPSULE,DOSE PACK 1.5 MG (1)- 3 MG (6) (cariprazine HCl)	Tier 2	QL (7 EA per 28 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Tier 1	QL (2 EA per 1 day)
Bipolar Therapy Agents - Lithium - Drugs For Severe Mental Disorders		
lithium carbonate oral capsule 150 mg, 600 mg	Tier 1	
lithium carbonate oral capsule 300 mg	Tier 1	
lithium carbonate oral tablet 300 mg	Tier 1	
lithium carbonate oral tablet extended release 300 mg, 450 mg	Tier 1	
Cannabis And Cannabinoid Receptor Agonists - Drugs For Seizures /Personality Disorder/Nerve Pain		
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Cns Stimulant - Amphetamine Combinations - Drugs For Attention Deficit Disorder		
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 1	QL (1 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 20 MG, 25 MG, 30 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 1	QL (2 EA per 1 day)
ADZENYS ER ORAL SUSPEN, IR - ER, BIPHASIC 24HR 1.25 MG/ML (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (450 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADZENYS XR-ODT ORAL TABLET, DISINTEG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (1 EA per 1 day)
<i>amphetamine oral suspen, ir - er, biphasic 24hr 1.25 mg/ml</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (450 ML per 30 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (2 EA per 1 day)
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR 2.5 MG/ML (amphetamine)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (240 ML per 30 days)
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR 12.5 MG, 25 MG, 37.5 MG, 50 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 2	QL (1 EA per 1 day)
Cns Stimulant - Amphetamines - Drugs For Attention Deficit Disorder		
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	PA
<i>dextroamphetamine oral capsule, extended release 10 mg, 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>dextroamphetamine oral capsule, extended release 15 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>dextroamphetamine oral solution 5 mg/5 ml</i>	Tier 1	QL (1800 ML per 30 days)
<i>dextroamphetamine oral tablet 10 mg</i>	Tier 1	QL (180 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine oral tablet 15 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (3 EA per 1 day)
<i>dextroamphetamine oral tablet 20 mg, 30 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (2 EA per 1 day)
<i>dextroamphetamine oral tablet 5 mg</i>	Tier 1	QL (90 EA per 30 days)
EVEKEO ODT ORAL TABLET,DISINTEGRATING 10 MG (amphetamine sulfate)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (4 EA per 1 day)
EVEKEO ODT ORAL TABLET,DISINTEGRATING 15 MG, 20 MG (amphetamine sulfate)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (2 EA per 1 day)
EVEKEO ODT ORAL TABLET,DISINTEGRATING 5 MG (amphetamine sulfate)	Tier 3	ST: Must meet the following requirement: Dextroamphetamine/amphetamine in 120 days; QL (8 EA per 1 day)
<i>methamphetamine oral tablet 5 mg</i>	Tier 1	QL (150 EA per 30 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg)	Tier 1	QL (180 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg)	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (3 EA per 1 day)
ZENZEDI ORAL TABLET 2.5 MG, 7.5 MG (dextroamphetamine sulfate)	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (90 EA per 30 days)
dextroamphetamine sulfate (Zenzedi Oral Tablet 20 Mg, 30 Mg)	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (2 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 5 Mg)	Tier 1	QL (90 EA per 30 days)
Cns Stimulant - Analeptics, Methylxanthine-Type - Drugs For The Nervous System		
<i>caffeine citrate oral solution 60 mg/3 ml (20 mg/ml)</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diabetic Peripheral Neuropathy Agents - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (3 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (2 EA per 1 day)
Fibromyalgia Agents - Gaba Analogs - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA ORAL CAPSULE 200 MG, 225 MG, 25 MG, 300 MG (pregabalin)	Tier 3	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	Tier 3	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (Snris) - Drugs For Seizures /Personality Disorder/Nerve Pain		
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG (duloxetine HCl)	Tier 3	ST: Must meet the following requirement: Generic Duloxetine in 120 days; QL (1 EA per 1 day)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 60 MG (duloxetine HCl)	Tier 3	ST: Must meet the following requirement: Generic Duloxetine in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran HCl)	Tier 2	
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42) (milnacipran HCl)	Tier 2	
Hypnotics - Melatonin - Single Agents - Drugs For Insomnia		
CHILDREN'S SLEEP (MELATONIN) ORAL LIQUID 1 MG/ML (melatonin)	Tier 3	
CHILDREN'S SLEEP (MELATONIN) ORAL TABLET,CHEWABLE 1 MG (melatonin)	Tier 3	
<i>melatonin oral capsule 10 mg</i>	Tier 3	
<i>melatonin oral lozenge 5 mg</i>	Tier 3	
<i>melatonin oral tablet 1 mg, 10 mg, 12 mg, 5 mg</i>	Tier 3	
<i>melatonin oral tablet 3 mg</i>	Tier 3	
<i>melatonin oral tablet,chewable 2.5 mg</i>	Tier 3	
<i>melatonin oral tablet,chewable 5 mg</i>	Tier 3	
<i>melatonin oral tablet,disintegrating 12 mg, 3 mg, 5 mg</i>	Tier 3	
Hypnotics - Melatonin Combinations - Drugs For Insomnia		
<i>melatonin-pyridoxine hcl (b6) oral tablet 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet extended release 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet, ir and er, biphasic 5-10 mg</i>	Tier 3	
SOPORDREN ORAL CAPSULE 1-50-25-200 MG (melatonin/GABA/5-HTP/theanine/magnesium citrate,oxide/herbs)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hypnotics - Melatonin M1/M2 Receptor Agonists - Drugs For Insomnia		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (tasimelteon)	Tier 4	PA
HETLIOZ ORAL CAPSULE 20 MG (tasimelteon)	Tier 4	PA
<i>ramelteon oral tablet 8 mg</i>	Tier 1	ST: Must meet any of the following requirements: Eszopiclone, Zaleplon, or Zolpidem Tartrate in 120 days; QL (1 EA per 1 day)
Migraine Therapy - Cgrp Ligand Blocker, Monoclonal Antibody - Drugs For Migraine Headaches		
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 225 MG/1.5 ML (fremanezumab-vfrm)	Tier 3	PA
AJOVY SYRINGE SUBCUTANEOUS SYRINGE 225 MG/1.5 ML (fremanezumab-vfrm)	Tier 3	PA
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR 120 MG/ML (galcanezumab-gnlm)	Tier 2	PA
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML (galcanezumab-gnlm)	Tier 2	PA
Migraine Therapy - Cgrp Receptor Blockers (Gepants And Mab) - Drugs For Migraine Headaches		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML, 70 MG/ML (erenumab-aooe)	Tier 2	PA
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG (rimegepant sulfate)	Tier 2	PA
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (atogepant)	Tier 3	PA
UBRELVY ORAL TABLET 100 MG, 50 MG (ubrogepant)	Tier 2	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Migraine Therapy - Ergot Alkaloids And Derivatives - Drugs For Migraine Headaches		
<i>dihydroergotamine injection solution 1 mg/ml</i>	Tier 1	QL (15 ML per 14 days)
<i>dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (8 ML per 28 days)
ERGOMAR SUBLINGUAL TABLET 2 MG (ergotamine tartrate)	Tier 3	QL (10 EA per 7 days)
TRUDHESA NASAL SPRAY, NON-AEROSOL 0.725 MG/PUMP ACT. (4 MG/ML) (dihydroergotamine mesylate)	Tier 3	QL (12 ML per 28 days); Age (Min 18 Years)
Migraine Therapy - Ergot Combinations - Drugs For Migraine Headaches		
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	Tier 1	QL (10 EA per 7 days)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (ergotamine tartrate/caffeine)	Tier 3	QL (5 EA per 7 days)
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1) - Drugs For Migraine Headaches		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eletriptan oral tablet 20 mg, 40 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)
<i>frovatriptan oral tablet 2.5 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (18 EA per 30 days)
MIGRANOW KIT,GEL AND TABLET 50 MG- 10 %-4 % (sumatriptan succinate/menthol/camphor)	Tier 3	
<i>naratriptan oral tablet 1 mg, 2.5 mg</i>	Tier 1	QL (18 EA per 30 days)
ONZETRA XSAIL NASAL AEROSOL POWDR BREATH ACTIVATED 11 MG (sumatriptan succinate)	Tier 3	ST: Must meet the following requirement: Generic Sumatriptan nasal spray in 120 days; QL (16 EA per 30 days)
<i>rizatriptan oral tablet 10 mg, 5 mg</i>	Tier 1	QL (18 EA per 30 days)
<i>rizatriptan oral tablet,disintegrating 10 mg, 5 mg</i>	Tier 1	QL (18 EA per 30 days)
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation</i>	Tier 1	QL (6 EA per 15 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	Tier 1	QL (9 EA per 30 days)
<i>sumatriptan succinate oral tablet 25 mg, 50 mg</i>	Tier 1	QL (3 EA per 5 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml</i>	Tier 1	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml</i>	Tier 1	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5 ml</i>	Tier 1	QL (5 ML per 28 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	Tier 1	QL (4 ML per 28 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOSYMRA NASAL SPRAY, NON-AEROSOL 10 MG/ACTUATION (sumatriptan)	Tier 3	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)
ZEMBRACE SYMTOUCH SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML (sumatriptan succinate)	Tier 3	ST: Must meet the following requirement: Generic Sumatriptan injection in 120 days; QL (8 ML per 28 days)
<i>zolmitriptan nasal spray, non-aerosol 2.5 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)
<i>zolmitriptan nasal spray, non-aerosol 5 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (6 EA per 15 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zolmitriptan oral tablet, disintegrating 2.5 mg, 5 mg</i>	Tier 1	ST: Must meet the following requirement: Rizatriptan Benzoate or Sumatriptan Succinate in 180 days; QL (12 EA per 30 days)
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1F) - Drugs For Migraine Headaches		
REYVOW ORAL TABLET 100 MG, 50 MG (lasmiditan succinate)	Tier 2	PA
Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Comb. - Drugs For Migraine Headaches		
<i>sumatriptan-naproxen oral tablet 85-500 mg</i>	Tier 1	ST: Must meet any of the following requirements: Almotriptan Malate, Eletriptan Hydrobromide, Frovatriptan Succinate, Naratriptan HCL, Onzetra Xsail, Rizatriptan Benzoate, Sumatriptan Succinate/Naproxen Sodium, Sumatriptan Succinate, Sumatriptan, Sumavel Dosepro, Tosymra, Treximet, Zembrace Symtouch, or Zolmitriptan in 180 days; QL (9 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Movement Disorder Drug Therapy - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (deutetrabenazine)	Tier 4	PA
INGREZZA INITIATION PACK ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21) (valbenazine tosylate)	Tier 4	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 4	PA
tetrabenazine oral tablet 12.5 mg, 25 mg	Tier 4	PA
Movement Disorder Therapy - Huntington's Disease - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (deutetrabenazine)	Tier 4	PA
Movement Disorder Therapy - Restless Legs Syndrome - Drugs For The Nervous System		
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG (gabapentin enacarbil)	Tier 3	ST: Must meet any of the following requirements: Gabapentin, Gralise, Neuraptine, Pramipexole Di-HCL, or Ropinirole HCL in 120 days; QL (30 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG (gabapentin enacarbil)	Tier 3	ST: Must meet any of the following requirements: Gabapentin, Gralise, Neuraptine, Pramipexole Di-HCL, or Ropinirole HCL in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Movement Disorder Therapy - Tardive Dyskinesia - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (deutetrabenazine)	Tier 4	PA
INGREZZA INITIATION PACK ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21) (valbenazine tosylate)	Tier 4	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 4	PA
Narcolepsy And Cataplexy Therapy Agents - Sedative-Type - Drugs For Sleep Disorder		
XYREM ORAL SOLUTION 500 MG/ML (sodium oxybate)	Tier 4	PA
XYWAV ORAL SOLUTION 0.5 GRAM/ML (sodium oxybate/calcium oxybate/magnesium oxybate/pot oxybate)	Tier 4	PA
Narcolepsy Therapy Agents - Dopamine And Ne Reuptake Inhibitor (Dnri) - Drugs For Sleep Disorder		
SUNOSI ORAL TABLET 150 MG, 75 MG (solriamfetol HCl)	Tier 3	PA
Narcolepsy Therapy Agents - H3-Receptor Antagonist/Inverse Agonist - Drugs For Sleep Disorder		
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (pitolisant HCl)	Tier 4	PA
Narcolepsy Therapy Agents - Non-Sympathomimetic - Drugs For Sleep Disorder		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>armodafinil oral tablet 50 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>modafinil oral tablet 100 mg, 200 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Narcolepsy Therapy Agents - Stimulant-Type, Piperadine Derivative - Drugs For Sleep Disorder		
<i>methylphenidate hcl oral tablet 5 mg</i>	Tier 1	QL (90 EA per 30 days)
Narcolepsy Therapy Agents- Stimulant-Type,Sympathomimetic,Amphetamines - Drugs For Sleep Disorder		
<i>dextroamphetamine oral tablet 15 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (3 EA per 1 day)
<i>dextroamphetamine oral tablet 20 mg, 30 mg</i>	Tier 1	ST: Must meet the following requirement: Dextroamphetamine Sulfate immediate release (5mg or 10mg) tablets or Dextroamphetamine solution in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Neuropathic Pain Therapy - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (3 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (2 EA per 1 day)
Postherpetic Neuralgia Agents - Drugs For Seizures /Personality Disorder/Nerve Pain		
ACTIVE-PAC KIT,GEL AND CAPSULE 300-4-1 MG-%-% (gabapentin/lidocaine HCl/menthol)	Tier 3	
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG (gabapentin)	Tier 3	ST: Must meet the following requirement: Gabapentin immediate release in 120 days; QL (3 EA per 1 day)
GRALISE ORAL TABLET, EXT REL 24HR DOSE PACK 300 MG (9)- 600 MG (24) (gabapentin)	Tier 3	ST: Must meet the following requirement: Gabapentin immediate release in 120 days; QL (33 EA per 15 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (3 EA per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (3 EA per 1 day)
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Amitriptyline HCL, Desipramine HCL, Divalproex Sodium, Doxepin HCL, Drizalma Sprinkle, Duloxetine HCL, Gabapentin, Gralise, Imipramine HCL, Imipramine Pamoate, Maprotiline HCL, Neuraptine, Nortriptyline HCL, Pregabalin, Valproic Acid (as Sodium Salt), Valproic Acid, or Venlafaxine HCL in 365 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pseudobulbar Affect (Pba) Agents, Nmda Antagonists Type - Drugs For Severe Mental Disorders		
NUDEXTA ORAL CAPSULE 20-10 MG (dextromethorphan Hbr/quinidine sulfate)	Tier 3	PA
Sedative-Hypnotic - Barbiturates - Drugs For Insomnia		
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>phenobarbital oral tablet 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</i>	Tier 1	
<i>phenobarbital oral tablet 15 mg, 30 mg, 60 mg</i>	Tier 1	
SECONAL SODIUM ORAL CAPSULE 100 MG (secobarbital sodium)	Tier 3	
Sedative-Hypnotic - Benzodiazepines - Drugs For Insomnia		
<i>estazolam oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>flurazepam oral capsule 15 mg, 30 mg</i>	Tier 1	
<i>midazolam oral syrup 2 mg/ml</i>	Tier 1	
<i>quazepam oral tablet 15 mg</i>	Tier 1	ST: Must meet any of the following requirements: Eszopiclone, Flurazepam HCL, Temazepam, Zaleplon, or Zolpidem Tartrate in 120 days
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	Tier 1	
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sedative-Hypnotic - Gaba-Receptor Modulators - Drugs For Insomnia		
EDLUAR SUBLINGUAL TABLET 10 MG, 5 MG (zolpidem tartrate)	Tier 3	ST: Must meet the following requirement: Edluar or Zolpidem Tartrate in 180 days; QL (1 EA per 1 day)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem oral tablet 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem oral tablet,ext release multiphase 12.5 mg, 6.25 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem sublingual tablet 1.75 mg, 3.5 mg</i>	Tier 1	QL (1 EA per 1 day)
ZOLPIMIST ORAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML) (zolpidem tartrate)	Tier 3	ST: Must meet the following requirement: Zolpidem Tartrate in 120 days; QL (7.7 ML per 30 days)
Sedative-Hypnotic - Orexin Receptor Antagonist - Drugs For Insomnia		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (suvorexant)	Tier 2	QL (1 EA per 1 day)
DAYVIGO ORAL TABLET 10 MG, 5 MG (lemborexant)	Tier 3	ST: Must meet any of the following requirements: Eszopiclone, Zaleplon, or Zolpidem Tartrate in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sedative-Hypnotic - Tricyclic Antidepressant Type - Drugs For Insomnia		
<i>doxepin oral tablet 3 mg, 6 mg</i>	Tier 1	ST: Must meet any of the following requirements: Doxepin solution or 10mg capsules, Eszopiclone, Zaleplon, or Zolpidem Tartrate in 120 days; QL (1 EA per 1 day)
Chemical Dependency, Agents To Treat - Drugs For Addiction		
Agents For Opioid Withdrawal, Central Alpha-2 Adrenergic Agonist-Type - Drugs For Opioid Addiction		
LUCEMYRA ORAL TABLET 0.18 MG (lofexidine HCl)	Tier 3	PA
Agents For Opioid Withdrawal, Opioid-Type - Drugs For Opioid Addiction		
BUNAVAIL BUCCAL FILM 2.1-0.3 MG, 4.2-0.7 MG, 6.3-1 MG (buprenorphine HCl/naloxone HCl)	Tier 3	
<i>buprenorphine hcl sublingual tablet 2 mg, 8 mg</i>	Tier 1	
<i>buprenorphine-naloxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	Tier 1	
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg</i>	Tier 1	
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (buprenorphine HCl/naloxone HCl)	Tier 2	
Alcohol Abstinence Therapy - Glutamate And Gaba System Type - Drugs For Alcohol Addiction		
<i>acamprosate oral tablet, delayed release (dr/ec) 333 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alcohol Deterrents - Drugs For Alcohol Addiction		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	Tier 1	
Smoking Deterrents - Ne And Dopamine Reuptake Inhibitor (Ndri)-Type - Drugs For Smoking Addiction		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg</i>	Tier 0	QL (2 EA per 1 day); Age (Min 18 Years)
Smoking Deterrents - Nicotine-Type - Drugs For Smoking Addiction		
<i>nicotine (polacrilex) buccal gum 2 mg, 4 mg</i>	Tier 0	QL (24 EA per 1 day); Age (Min 18 Years)
<i>nicotine (polacrilex) buccal lozenge 2 mg, 4 mg</i>	Tier 0	QL (20 EA per 1 day); Age (Min 18 Years)
<i>nicotine (polacrilex) buccal mini lozenge 2 mg, 4 mg</i>	Tier 0	QL (20 EA per 1 day); Age (Min 18 Years)
<i>nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 7 mg/24 hr</i>	Tier 0	QL (1 EA per 1 day); Age (Min 18 Years)
<i>nicotine transdermal patch, td daily, sequential 21-14-7 mg/24 hr</i>	Tier 0	QL (1 EA per 1 day); Age (Min 18 Years)
NICOTROL INHALATION CARTRIDGE 10 MG (nicotine)	Tier 0	Age (Min 18 Years)
NICOTROL NS NASAL SPRAY, NON-AEROSOL 10 MG/ML (nicotine)	Tier 0	Age (Min 18 Years)
QUIT 2 BUCCAL GUM 2 MG (nicotine polacrilex)	Tier 0	QL (24 EA per 1 day); Age (Min 18 Years)
QUIT 2 BUCCAL LOZENGE 2 MG (nicotine polacrilex)	Tier 0	QL (20 EA per 1 day); Age (Min 18 Years)
QUIT 4 BUCCAL GUM 4 MG (nicotine polacrilex)	Tier 0	QL (24 EA per 1 day); Age (Min 18 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUIT 4 BUCCAL LOZENGE 4 MG (nicotine polacrilex)	Tier 0	QL (20 EA per 1 day); Age (Min 18 Years)
STOP SMOKING AID BUCCAL LOZENGE 2 MG, 4 MG (nicotine polacrilex)	Tier 0	QL (20 EA per 1 day); Age (Min 18 Years)
Smoking Deterrents - Nicotinic Receptor Partial Agonist, Alpha4beta2 - Drugs For Smoking Addiction		
<i>varenicline oral tablet 0.5 mg, 1 mg</i>	Tier 0	QL (2 EA per 1 day); Age (Min 18 Years)
Chemicals-Pharmaceutical Adjuvants		
Bulk Chemicals		
<i>alum, ammonium (bulk) powder</i>	Tier 3	
<i>balsam peru (bulk) liquid</i>	Tier 3	
<i>benzoin (bulk) topical tincture</i>	Tier 3	
<i>citric acid (bulk) powder</i>	Tier 3	
<i>citric acid anhydrous (bulk) granules 100 %</i>	Tier 3	
<i>citric acid monohydrate (bulk) granules 100 %</i>	Tier 3	
<i>glutathione (bulk) powder 100 %</i>	Tier 3	
<i>guaiacol liquid</i>	Tier 3	
<i>hydrogen peroxide (bulk) solution 30 %</i>	Tier 3	
<i>hydroxyethyl methacrylate, bulk liquid 96 %</i>	Tier 3	
TECHNA NAT UNSWT TROCHE BASEG2 POWDER (troche base no.247)	Tier 3	
<i>vitamin e acetate (bulk) liquid 125 unit/ml</i>	Tier 3	
Chemicals - Acids		
<i>hydrochloric acid (bulk) liquid 10 %</i>	Tier 3	
Chemicals - Cryopreservative Agents		
CRYOSERV SOLUTION 99 % (dimethyl sulfoxide)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Chemicals - Essential Oils		
<i>anise oil</i>	Tier 3	
Chemicals - Fixed Oils		
<i>olive oil oil</i>	Tier 3	
Chemicals - Solvents		
<i>acetone liquid</i>	Tier 3	
<i>isopropyl alcohol solution 70 %, 91 %, 99 %</i>	Tier 3	
MURI-LUBE OIL (mineral oil, light sterile)	Tier 3	
<i>sesame oil oil</i>	Tier 3	
<i>sodium succinate powder</i>	Tier 3	
Pharmaceutical Adjuvant - Anticorrosive Agents		
<i>butylated hydroxytoluene granules</i>	Tier 3	
<i>butylated hydroxytoluene powder</i>	Tier 3	
Pharmaceutical Adjuvant - Cream/Ointment Vehicles		
<i>petrolatum, yellow (bulk) gel 100 %</i>	Tier 3	
WHITE WAX (BEESWAX) WAX 100 %	Tier 3	
Pharmaceutical Adjuvant - Flavoring Agents		
<i>ethyl acetate liquid</i>	Tier 3	
Pharmaceutical Adjuvant - Gelatin Capsules (Empty)		
CAPSULE #1 ORAL CAPSULE (gelatin capsules (empty))	Tier 3	
Pharmaceutical Adjuvant - Inhalation Vehicles		
HYPER-SAL INHALATION SOLUTION FOR NEBULIZATION 3.5 % (sodium chloride for inhalation)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 3 % (sodium chloride for inhalation)	Tier 1	
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 6 % (sodium chloride for inhalation)	Tier 3	
<i>sodium chloride inhalation solution for nebulization 0.9 %, 10 %, 3 %, 7 %</i>	Tier 1	
Pharmaceutical Adjuvant - Oral Thickening Agents		
SIMPLYTHICK ORAL GEL IN PACKET 4 GRAM (xanthan gum)	Tier 3	
THICK AND EASY ORAL POWDER (starch)	Tier 3	
THICK AND EASY ORAL POWDER IN PACKET (starch)	Tier 3	
Pharmaceutical Adjuvant - Oral Vehicles		
UNISPEND ANHYDROUS SWEET ORAL SUSPENSION (compound vehicle suspension sugar-free no.24)	Tier 3	
Pharmaceutical Adjuvant - Surfactants		
<i>glyceryl monostearate flakes</i>	Tier 3	
<i>polysorbate 80 solution</i>	Tier 3	
Pharmaceutical Adjuvant - Suspending Agents		
<i>hydroxypropyl cellulose powder</i>	Tier 3	
<i>hypromellose powder</i>	Tier 3	
METHOCEL E 4 M POWDER (hypromellose)	Tier 3	
Pharmaceutical Adjuvant - Tableting		
<i>cellulose (bulk) powder</i>	Tier 3	
<i>zinc stearate powder</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pharmaceutical Adjuvant - Troche/Soft Lozenge Base		
TECHNA NAT UNSWT TROCHE BASEG2 POWDER (troche base no.247)	Tier 3	
Pharmaceutical Adjuvant - Vaccine Adjuvants		
SHINGRIX ADJUVANT COMPONENT-PF INTRAMUSCULAR SUSPENSION (vaccine adjuvant system, AS01B/PF, component vial 1 of 2)	Tier 0	QL (1 ML per 365 days); Age (Min 50 Years)
Cognitive Disorder Therapy - Drugs For The Nervous System		
Alzheimer's Disease Therapy - Cholinesterase Inhibitors - Drugs For Alzheimer's Disease		
<i>donepezil oral tablet 10 mg, 23 mg, 5 mg</i>	Tier 1	
<i>donepezil oral tablet, disintegrating 10 mg, 5 mg</i>	Tier 1	
<i>galantamine oral capsule, ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg</i>	Tier 1	QL (30 EA per 30 days)
<i>galantamine oral solution 4 mg/ml</i>	Tier 1	QL (200 ML per 30 days)
<i>galantamine oral tablet 12 mg, 4 mg, 8 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	Tier 1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hour, 9.5 mg/24 hour</i>	Tier 1	QL (30 EA per 30 days)
Alzheimer's Disease Therapy - Nmda Receptor Antagonists - Drugs For Alzheimer's Disease		
<i>memantine oral capsule, sprinkle, er 24hr 14 mg, 21 mg, 28 mg, 7 mg</i>	Tier 1	ST: Must meet the following requirement: Memantine immediate release tablets in 120 days; QL (30 EA per 30 days)
<i>memantine oral solution 2 mg/ml</i>	Tier 1	QL (300 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>memantine oral tablet 10 mg, 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>memantine oral tablets,dose pack 5-10 mg</i>	Tier 1	QL (49 EA per 28 days)
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7-14-21-28 MG (memantine HCl)	Tier 2	ST: Must meet the following requirement: Memantine immediate release tablets in 120 days; QL (28 EA per 28 days)
Alzheimer's Thx - Nmda Receptor Antag. And Cholinesterase Inhib. Comb - Drugs For Alzheimer's Disease		
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7/14/21/28 MG-10 MG (memantine HCl/donepezil HCl)	Tier 2	ST: Must meet 2 of the following requirements: Donepezil HCL, Memantine HCL, or Namenda XR in 365 days; QL (28 EA per 28 days)
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (memantine HCl/donepezil HCl)	Tier 2	ST: Must meet 2 of the following requirements: Donepezil HCL, Memantine HCL, or Namenda XR in 365 days; QL (1 EA per 1 day)
Cognitive Disorder Therapy - Cerebral Vasodilators - Drugs For Alzheimer's Disease		
<i>ergoloid oral tablet 1 mg</i>	Tier 1	
Contraceptives - Drugs For Women		
Contraceptive - Vaginal Ph Modulator - Medical Supplies And Durable Medical Equipment		
PHEXXI VAGINAL GEL 1.8-1-0.4 % (lactic acid/citric acid/potassium bitartrate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Contraceptive Implant - Progestin - Birth Control Pills		
NEXPLANON SUBDERMAL IMPLANT 68 MG (etonogestrel)	Tier 0	QL (1 EA per 365 days)
Contraceptive Injectable - Progestin - Birth Control Pills		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML (medroxyprogesterone acetate)	Tier 0	
<i>medroxyprogesterone intramuscular suspension 150 mg/ml</i>	Tier 0	
<i>medroxyprogesterone intramuscular syringe 150 mg/ml</i>	Tier 0	
Contraceptive Intrauterine - Copper IUD - Birth Control Pills		
PARAGARD T 380A INTRAUTERINE INTRAUTERINE DEVICE 380 SQUARE MM (copper)	Tier 0	
Contraceptive Intrauterine - Progesterone IUD - Birth Control Pills		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 17.5 MCG/24 HRS (5 YRS) 19.5 MG (levonorgestrel)	Tier 0	
LILETTA INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/24 HRS (6 YRS) 52 MG (levonorgestrel)	Tier 0	
MIRENA INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/24 HOURS (7 YRS) 52 MG (levonorgestrel)	Tier 0	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 14 MCG/24 HRS (3 YRS) 13.5 MG (levonorgestrel)	Tier 0	
Contraceptive Oral - Biphaseic - Birth Control Pills		
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Amethia Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Ashlyna Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	Tier 0	
desogestrel-ethinyl estradiol/ethinyl estradiol (Azurette (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	
CAMRESE LO ORAL TABLETS,DOSE PACK,3 MONTH 0.10 MG-20 MCG (84)/10 MCG (7) (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	Tier 0	
CAMRESE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7) (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	Tier 0	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Daysee Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	Tier 0	
<i>desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	Tier 0	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Jaimiess Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	Tier 0	
desogestrel-ethinyl estradiol/ethinyl estradiol (Kariva (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	Tier 0	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG (24)/10 MCG (2) (norethindrone acetate-ethinyl estradiol/ferrous fumarate)	Tier 0	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Lojaimiess Oral Tablets,Dose Pack,3 Month 0.10 Mg-20 Mcg (84)/10 Mcg (7))	Tier 0	
desogestrel-ethinyl estradiol/ethinyl estradiol (Pimtrea (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desogestrel-ethinyl estradiol/ethinyl estradiol (Simliya (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Simpesse Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	Tier 0	
desogestrel-ethinyl estradiol/ethinyl estradiol (Viorele (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	
desogestrel-ethinyl estradiol/ethinyl estradiol (Volnea (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	Tier 0	
Contraceptive Oral - Monophasic - Birth Control Pills		
levonorgestrel/ethinyl estradiol (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Altavera (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
norethindrone-ethinyl estradiol (Alyacen 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Amethyst (28) Oral Tablet 90-20 Mcg (28))	Tier 0	
desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-0.03 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Aubra Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Aurovela 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Aurovela 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela Fe 1-20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
levonorgestrel/ethinyl estradiol (Aviane Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Ayuna Oral Tablet 0.15-0.03 Mg)	Tier 0	
BALCOLTRA ORAL TABLET 0.1 MG-0.02 MG (21)/36.5 MG(7) (levonorgestrel/ethinyl estradiol/ferrous bisglycinate)	Tier 0	
norethindrone-ethinyl estradiol (Balziva (28) Oral Tablet 0.4-35 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone-ethinyl estradiol (Briellyn Oral Tablet 0.4-35 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Charlotte 24 Fe Oral Tablet,Chewable 1 Mg-20 Mcg(24) /75 Mg (4))	Tier 0	
levonorgestrel/ethinyl estradiol (Chateal (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Chateal Eq (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norgestrel-ethinyl estradiol (Cryselle (28) Oral Tablet 0.3-30 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Cyclafem 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-0.03 Mg)	Tier 0	
desogestrel-ethinyl estradiol (Cyred Oral Tablet 0.15-0.03 Mg)	Tier 0	
norethindrone-ethinyl estradiol (Dasetta 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg</i>	Tier 0	
levonorgestrel/ethinyl estradiol (Dolishale Oral Tablet 90-20 Mcg (28))	Tier 0	
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4), 3-0.03-0.451 mg (21) (7)</i>	Tier 0	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	Tier 0	
norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)	Tier 0	
desogestrel-ethinyl estradiol (Emoquette Oral Tablet 0.15-0.03 Mg)	Tier 0	
desogestrel-ethinyl estradiol (Enskyce Oral Tablet 0.15-0.03 Mg)	Tier 0	
norgestimate-ethinyl estradiol (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	Tier 0	
levonorgestrel/ethinyl estradiol (Falmina (28) Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Femynor Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Gemmily Oral Capsule 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol (Hailey Oral Tablet 1.5-30 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Iclevia Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (91))	Tier 0	
desogestrel-ethinyl estradiol (Isibloom Oral Tablet 0.15-0.03 Mg)	Tier 0	
ethinyl estradiol/drospirenone (Jasmiel (28) Oral Tablet 3-0.02 Mg)	Tier 0	
JOLESSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91) (levonorgestrel/ethinyl estradiol)	Tier 0	
desogestrel-ethinyl estradiol (Juleber Oral Tablet 0.15-0.03 Mg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Junel 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Junel 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 24 Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone-ethinyl estradiol/ferrous fumarate (Kaitlib Fe Oral Tablet,Chewable 0.8Mg-25Mcg(24) And 75 Mg (4))	Tier 0	
desogestrel-ethinyl estradiol (Kalliga Oral Tablet 0.15-0.03 Mg)	Tier 0	
ethynodiol diacetate-ethinyl estradiol (Kelnor 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
ethynodiol diacetate-ethinyl estradiol (Kelnor 1-50 (28) Oral Tablet 1-50 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Kurvelo (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Larin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Larin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
levonorgestrel/ethinyl estradiol (Larissia Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
LAYOLIS FE ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4) (norethindrone-ethinyl estradiol/ferrous fumarate)	Tier 0	
levonorgestrel/ethinyl estradiol (Lessina Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)</i>	Tier 0	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)</i>	Tier 0	
levonorgestrel/ethinyl estradiol (Levora-28 Oral Tablet 0.15-0.03 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Lillow (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
ethinyl estradiol/drospirenone (Loryna (28) Oral Tablet 3-0.02 Mg)	Tier 0	
norgestrel-ethinyl estradiol (Low-Ogestrel (28) Oral Tablet 0.3-30 Mg-Mcg)	Tier 0	
ethinyl estradiol/drospirenone (Lo-Zumandimine (28) Oral Tablet 3-0.02 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Lutera (28) Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Marlissa (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Merzee Oral Capsule 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Mibelas 24 Fe Oral Tablet,Chewable 1 Mg-20 Mcg(24) /75 Mg (4))	Tier 0	
norethindrone acetate-ethinyl estradiol (Microgestin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol (Microgestin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Microgestin 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Microgestin Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Microgestin Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
norgestimate-ethinyl estradiol (Mili Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Tier 0	
NEXTSTELLIS ORAL TABLET 3 MG- 14.2 MG (28) (drospirenone/estetrol)	Tier 0	ST: Must meet the following requirement: Two generic contraceptives in 365 days; QL (1 EA per 1 day)
ethinyl estradiol/drospirenone (Nikki (28) Oral Tablet 3-0.02 Mg)	Tier 0	
<i>noreth-ethinyl estradiol-iron oral tablet, chewable 0.4mg-35mcg(21) and 75 mg (7), 0.8mg-25mcg(24) and 75 mg (4)</i>	Tier 0	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Tier 0	
<i>norethindrone-e.estradiol-iron oral capsule 1 mg-20 mcg (24)/75 mg (4)</i>	Tier 0	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)</i>	Tier 0	
<i>norethindrone-e.estradiol-iron oral tablet, chewable 1 mg-20 mcg(24) /75 mg (4)</i>	Tier 0	
<i>norgestimate-ethinyl estradiol oral tablet 0.25-35 mg-mcg</i>	Tier 0	
norethindrone-ethinyl estradiol (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21) (norethindrone-ethinyl estradiol)	Tier 0	
norethindrone-ethinyl estradiol (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Nymyo Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
OCELLA ORAL TABLET 3-0.03 MG (ethinyl estradiol/drospirenone)	Tier 0	
levonorgestrel/ethinyl estradiol (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Philith Oral Tablet 0.4-35 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Pirmella Oral Tablet 1-35 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Portia 28 Oral Tablet 0.15-0.03 Mg)	Tier 0	
norgestimate-ethinyl estradiol (Previfem Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
desogestrel-ethinyl estradiol (Reclipsen (28) Oral Tablet 0.15-0.03 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Setlakin Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (91))	Tier 0	
norgestimate-ethinyl estradiol (Sprintec (28) Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
ethinyl estradiol/drospirenone (Syeda Oral Tablet 3-0.03 Mg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina Fe 1-20 Eq (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Taysofy Oral Capsule 1 Mg-20 Mcg (24)/75 Mg (4))	Tier 0	
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG- 20 MCG (levonorgestrel/ethinyl estradiol)	Tier 0	
drospirenone/ethinyl estradiol/levomefolate calcium (Tydemy Oral Tablet 3-0.03-0.451 Mg (21) (7))	Tier 0	
ethinyl estradiol/drospirenone (Vestura (28) Oral Tablet 3-0.02 Mg)	Tier 0	
levonorgestrel/ethinyl estradiol (Vienva Oral Tablet 0.1-20 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Vyfemla (28) Oral Tablet 0.4-35 Mg-Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Wera (28) Oral Tablet 0.5-35 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol/ferrous fumarate (Wymzya Fe Oral Tablet,Chewable 0.4Mg-35Mcg(21) And 75 Mg (7))	Tier 0	
ethinyl estradiol/drospirenone (Zarah Oral Tablet 3-0.03 Mg)	Tier 0	
ethynodiol diacetate-ethinyl estradiol (Zovia 1/35E (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
ethynodiol diacetate-ethinyl estradiol (Zovia 1-35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 0	
ethinyl estradiol/drospirenone (Zumandimine (28) Oral Tablet 3-0.03 Mg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Contraceptive Oral - Progestin - Birth Control Pills		
norethindrone (Camila Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Deblitane Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Errin Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Heather Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Incassia Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Jencycla Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Lyleq Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Lyza Oral Tablet 0.35 Mg)	Tier 0	
NORA-BE ORAL TABLET 0.35 MG (norethindrone)	Tier 0	
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	Tier 0	
norethindrone (Norlyda Oral Tablet 0.35 Mg)	Tier 0	
norethindrone (Sharobel Oral Tablet 0.35 Mg)	Tier 0	
SLYND ORAL TABLET 4 MG (28) (drospirenone)	Tier 0	
norethindrone (Tulana Oral Tablet 0.35 Mg)	Tier 0	
Contraceptive Oral - Quadruphasic - Birth Control Pills		
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	Tier 0	
NATAZIA ORAL TABLET 3 MG/2 MG-2 MG/ 2 MG-3 MG/1 MG (estradiol valerate/dienogest)	Tier 0	
RIVELSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-20 MCG/ 0.15 MG-25 MCG (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	Tier 0	
Contraceptive Oral - Triphasic - Birth Control Pills		
norethindrone-ethinyl estradiol (Alyacen 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-ethinyl estradiol (Aranelle (28) Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Tier 0	
desogestrel-ethinyl estradiol (Caziant (28) Oral Tablet 0.1/.125/.15-25 Mg-Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Cyclafem 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Dasetta 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	
levonorgestrel/ethinyl estradiol (Enpresse Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	Tier 0	
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG (norethindrone-ethinyl estradiol)	Tier 0	
levonorgestrel/ethinyl estradiol (Levonest (28) Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	Tier 0	
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	Tier 0	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg (28)</i>	Tier 0	
norethindrone-ethinyl estradiol (Nortrel 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Nylia 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	
norethindrone-ethinyl estradiol (Pirmella Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	Tier 0	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tilia Fe Oral Tablet 1-20(5)/1-30(7) /1Mg-35Mcg (9))	Tier 0	
norgestimate-ethinyl estradiol (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tri-Legest Fe Oral Tablet 1-20(5)/1-30(7) /1Mg-35Mcg (9))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Nymyo Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Previfem (28) Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Sprintec (28) Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
levonorgestrel/ethinyl estradiol (Trivora (28) Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	Tier 0	
norgestimate-ethinyl estradiol (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 0	
norgestimate-ethinyl estradiol (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg (28))	Tier 0	
desogestrel-ethinyl estradiol (Velivet Triphasic Regimen (28) Oral Tablet 0.1/.125/.15-25 Mg-Mcg)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Contraceptive Transdermal Combinations - Estrogen And Progestin Comb. - Birth Control Pills		
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24 HR (levonorgestrel/ethinyl estradiol)	Tier 3	QL (3 EA per 28 days)
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24 HR (norelgestromin/ethinyl estradiol)	Tier 0	
norelgestromin/ethinyl estradiol (Zafemy Transdermal Patch Weekly 150-35 Mcg/24 Hr)	Tier 0	
Contraceptives - Intravaginal, Systemic - Estrogen And Progestin Comb. - Birth Control Pills		
ANNOVERA VAGINAL RING 0.15-0.013 MG/24 HOUR (segesterone acetate/ethinyl estradiol)	Tier 0	QL (1 EA per 365 days)
etonogestrel/ethinyl estradiol (Eluryng Vaginal Ring 0.12-0.015 Mg/24 Hr)	Tier 0	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	Tier 0	
Emergency Contraceptives - Birth Control Pills		
AFTER PILL ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
AFTERA ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
ECONTRA EZ ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
ELLA ORAL TABLET 30 MG (ulipristal acetate)	Tier 0	
<i>levonorgestrel oral tablet 1.5 mg</i>	Tier 0	
MY CHOICE ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
MY WAY ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
NEW DAY ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPCICON ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
OPTION-2 ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
TAKE ACTION ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
Emergency Contraceptives - Progestin Type - Birth Control Pills		
AFTER PILL ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
AFTERA ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
MY CHOICE ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
MY WAY ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
NEW DAY ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
OPTION-2 ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
TAKE ACTION ORAL TABLET 1.5 MG (levonorgestrel)	Tier 0	
Spermicides - Birth Control Pills		
GYNOL II VAGINAL GEL 3 % (nonoxynol 9)	Tier 0	
TODAY CONTRACEPTIVE SPONGE VAGINAL CONTRACEPTIVE SPONGE 1,000 MG (nonoxynol 9)	Tier 0	
VAGINAL CONTRACEPTIVE FILM VAGINAL FILM 28 % (nonoxynol 9)	Tier 0	
VCF CONTRACEPTIVE FILM VAGINAL FILM 28 % (nonoxynol 9)	Tier 0	
VCF CONTRACEPTIVE GEL VAGINAL GEL 4 % (nonoxynol 9)	Tier 0	
Dermatological		
Dermatitis - Janus Kinase (Jak) Inhibitors		
OPZELURA TOPICAL CREAM 1.5 % (ruxolitinib phosphate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Drugs For The Skin		
Acne Therapy Systemic - Retinoids And Derivatives - Drugs For The Skin		
ABSORICA LD ORAL CAPSULE 16 MG, 24 MG, 32 MG, 8 MG (isotretinoin, micronized)	Tier 3	ST: Must meet the following requirement: Generic Isotretinoin in 120 days
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG (isotretinoin)	Tier 3	ST: Must meet the following requirement: Generic Isotretinoin in 120 days
isotretinoin (Accutane Oral Capsule 20 Mg, 30 Mg, 40 Mg)	Tier 1	
isotretinoin (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	Tier 1	
isotretinoin (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>isotretinoin oral capsule 25 mg, 35 mg</i>	Tier 1	ST: Must meet the following requirement: Generic Isotretinoin in 120 days
isotretinoin (Myorisan Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
isotretinoin (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Acne Therapy Systemic - Tetracycline Antibiotic - Drugs For The Skin		
minocycline HCl (Coremino Oral Tablet Extended Release 24 Hr 135 Mg, 45 Mg, 90 Mg)	Tier 1	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
<i>minocycline oral capsule, extended release 24hr 135 mg, 45 mg, 90 mg</i>	Tier 1	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	Tier 1	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
MINOLIRA ER ORAL TABLET, IR - ER, BIPHASIC 24HR 105 MG, 135 MG (minocycline HCl)	Tier 3	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
SEYSARA ORAL TABLET 100 MG, 150 MG, 60 MG (sarecycline HCl)	Tier 3	ST: Must meet any of the following requirements: Doryx Mpc, Doxycycline Hyclate, Doxycycline Monohydrate, Minocycline HCL, or Vibramycin in 120 days; QL (1 EA per 1 day); Age (Min 9 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XIMINO ORAL CAPSULE,EXTENDED RELEASE 24HR 135 MG, 45 MG, 90 MG (minocycline HCl)	Tier 3	ST: Must meet the following requirement: Generic immediate-release Minocycline in 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
Acne Therapy Topical - Androgen Receptor Inhibitors - Drugs For The Skin		
WINLEVI TOPICAL CREAM 1 % (clascoterone)	Tier 3	PA
Acne Therapy Topical - Anti-Infective - Drugs For The Skin		
ACIOXIAY TOPICAL CREAM 15-4 % (azelaic acid/niacinamide)	Tier 3	
AMZEEQ TOPICAL FOAM 4 % (minocycline HCl)	Tier 3	ST: Must meet 2 of the following requirements: Adapalene, Adapalene/Benzoyl Peroxide, Clindamycin Phosphate/Benzoyl Peroxide. Clindamycin Phosphate, Erythromycin Base In Ethanol, Erythromycin/Benzoyl Peroxide, Sulfacetamide Sodium/Sulfur/Urea, Sulfacetamide Sodium, Sulfacetamide Sodium/Sulfur, or Tretinoin in 365 days; Age (Min 9 Years)
<i>azelaic acid topical gel 15 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZELEX TOPICAL CREAM 20 % (azelaic acid)	Tier 3	ST: Must meet any of the following requirements: Adapalene, Adapalene/Benzoyl Peroxide, Clindamycin Phosphate/Benzoyl Peroxide, Clindamycin Phosphate, Erythromycin Base In Ethanol, Erythromycin/Benzoyl Peroxide, Sulfacetamide Sodium/Sulfur/Urea, Sulfacetamide Sodium, Sulfacetamide Sodium/Sulfur, or Tretinoin in 120 days
<i>clindamycin phosphate topical foam 1 %</i>	Tier 1	
<i>clindamycin phosphate topical gel 1 %</i>	Tier 1	
<i>clindamycin phosphate topical gel, once daily 1 %</i>	Tier 1	ST: Must meet the following requirement: Clindamycin Phosphate 1% gel in 120 days
<i>clindamycin phosphate topical lotion 1 %</i>	Tier 1	
<i>clindamycin phosphate topical solution 1 %</i>	Tier 1	QL (180 ML per 1 FILL)
<i>clindamycin phosphate topical swab 1 %</i>	Tier 1	
<i>dapsone topical gel 5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dapsone topical gel with pump 7.5 %</i>	Tier 1	ST: Must meet any of the following requirements: Adapalene, Adapalene/Benzoyl Peroxide, Clindamycin Phosphate/Benzoyl Peroxide, Clindamycin Phosphate, Erythromycin Base In Ethanol, Erythromycin/Benzoyl Peroxide, Sulfacetamide Sodium/Sulfur/Urea, Sulfacetamide Sodium, Sulfacetamide Sodium/Sulfur, or Tretinoin in 120 days
DEOXIA TOPICAL GEL 1-4 % (clindamycin/niacinamide)	Tier 3	
ECEOXIA TOPICAL CREAM 10-4 % (sulfacetamide sodium/niacinamide)	Tier 3	
ERY PADS TOPICAL SWAB 2 % (erythromycin base in ethanol)	Tier 1	
<i>erythromycin with ethanol topical gel 2 %</i>	Tier 1	
<i>erythromycin with ethanol topical solution 2 %</i>	Tier 1	QL (180 ML per 1 FILL)
FINACEA TOPICAL FOAM 15 % (azelaic acid)	Tier 2	
NUCARACLINPAK TOPICAL KIT, GEL AND LOTION 1 %-SPF 50 (clindamycin/octinoxate/octyl salicyl/octocryl/oxybenz/titan)	Tier 3	
<i>sulfacetamide sodium (acne) topical suspension 10 %</i>	Tier 1	
Acne Therapy Topical - Anti-Infective Combinations Other - Drugs For The Skin		
CLINDACIN ETZ TOPICAL KIT 1 % (clindamycin phosphate/skin cleanser comb no.19)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLINDACIN PAC TOPICAL KIT 1 % (clindamycin phosphate/skin cleanser comb no.19)	Tier 3	
CLINDAVIX TOPICAL KIT 1-1.8-2 % (clindamycin phosphate/dimethicone/zinc oxide)	Tier 3	
DEOXIA TOPICAL LOTION 1-4 % (clindamycin/niacinamide)	Tier 3	
DIADIMAXIA TOPICAL GEL 6-5-2 % (dapsone/spironolactone/niacinamide)	Tier 3	
DIAOXIA TOPICAL GEL 6-4 % (dapsone/niacinamide)	Tier 3	
DIASDIMAXIA TOPICAL GEL 8.5-5-2 % (dapsone/spironolactone/niacinamide)	Tier 3	
DIASOXIA TOPICAL GEL 8.5-4 % (dapsone/niacinamide)	Tier 3	
Acne Therapy Topical - Anti-Infective-Keratolytic Combinations - Drugs For The Skin		
AVAR LS TOPICAL FOAM 10-2 % (sulfacetamide sodium/sulfur)	Tier 3	
AVAR LS TOPICAL PADS, MEDICATED 10-2 % (sulfacetamide sodium/sulfur)	Tier 3	
AVAR TOPICAL PADS, MEDICATED 9.5-5 % (sulfacetamide sodium/sulfur)	Tier 3	
BP 10-1 TOPICAL CLEANSER 10-1 % (sulfacetamide sodium/sulfur)	Tier 1	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 % (sulfacetamide sodium/sulfur/urea)	Tier 1	
CLENIA PLUS TOPICAL SUSPENSION 9-4.25 % (sulfacetamide sodium/sulfur)	Tier 3	
<i>clindamycin-benzoyl peroxide topical gel 1-5 %, 1.2 % (1 % base) -5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	Tier 1	ST: Must meet the following requirement: Clindamycin Phosphate/Benzoyl Peroxide gel in 120 days
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	Tier 1	
DRAXACE TOPICAL SUSPENSION 2-8 % (salicylic acid/sulfacetamide sodium)	Tier 3	
DRIXECE TOPICAL SUSPENSION 5-10 % (salicylic acid/sulfacetamide sodium)	Tier 3	
<i>erythromycin-benzoyl peroxide topical gel 3-5 %</i>	Tier 1	
NEUAC KIT TOPICAL COMBO PACK, CREAM AND GEL 1.2-5 % (clindamycin phosphate/benzoyl peroxide/emollient comb no.94)	Tier 3	
clindamycin phosphate/benzoyl peroxide (Neuac Topical Gel 1.2 % (1 % Base) -5 %)	Tier 1	
NUCARARXPAK TOPICAL KIT, GEL AND LOTION 1 %-2.5 %- SPF 50 (clindamycin/benzoyl/octinox/octyl/octocryl/oxyben/titanium)	Tier 3	
ONEXTON TOPICAL GEL 1.2 % (1 % BASE) -3.75 % (clindamycin phosphate/benzoyl peroxide)	Tier 3	
ONEXTON TOPICAL GEL WITH PUMP 1.2 % (1 % BASE) -3.75 % (clindamycin phosphate/benzoyl peroxide)	Tier 2	ST: Must meet the following requirement: Clindamycin Phosphate/Benzoyl Peroxide gel in 120 days
ONZDEOXIA TOPICAL GEL 5-1-4 % (benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
PLEXION CLEANSING CLOTHS TOPICAL PADS, MEDICATED 9.8-4.8 % (sulfacetamide sodium/sulfur)	Tier 3	
ROSANIL TOPICAL CLEANSER 10-5 % (W/W) (sulfacetamide sodium/sulfur)	Tier 3	QL (1419 GM per 1 FILL)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSULA CLEANSING CLOTHS TOPICAL PADS, MEDICATED 10-5 % (sulfacetamide sodium/sulfur)	Tier 1	
ROSULA TOPICAL CLEANSER 10-4.5 % (sulfacetamide sodium/sulfur)	Tier 3	
SSS 10-5 TOPICAL CREAM 10-5 % (W/W) (sulfacetamide sodium/sulfur)	Tier 1	
SSS 10-5 TOPICAL FOAM 10-5 % (sulfacetamide sodium/sulfur)	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-2 %, 9-4 %, 9-4.5 %, 9.8-4.8 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	QL (1419 GM per 1 FILL)
<i>sulfacetamide sodium-sulfur topical cream 10-2 %</i>	Tier 3	
<i>sulfacetamide sodium-sulfur topical cream 10-5 % (w/w), 9.8-4.8 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w), 9.8-4.8 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical pads, medicated 10-4 %, 9.8-4.8 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical suspension 10-5 %, 8-4 %</i>	Tier 1	
<i>sulfacetamide sod-sulfur-urea topical cleanser 10-5-10 %</i>	Tier 1	QL (1419 ML per 1 FILL)
<i>sulfacetamide-sulfur-cleansr23 topical kit 9-4.5 %</i>	Tier 1	
SULFACLEANSE 8-4 TOPICAL SUSPENSION 8-4 % (sulfacetamide sodium/sulfur)	Tier 1	
SUMADAN TOPICAL KIT 9-4.5 % (sulfacetamide sodium/sulfur/skin cleanser comb no.23)	Tier 3	
SUMADAN XLT TOPICAL COMBO PACK,CLEANSER AND CREAM 9 %-4.5 % -SPF 25 (sulfacetamide sodium/sulfur/avobenzone/octinoxate/octyl sal)	Tier 3	
SUMAXIN CP TOPICAL KIT 10-4 % (sulfacetamide sodium/sulfur/skin cleanser comb no.23)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Acne Therapy Topical - Anti-Infective-Retinoid Combinations - Drugs For The Skin		
ADAINZDE TOPICAL GEL 0.3-2.5-1 % (adapalene/benzoyl peroxide/clindamycin phosphate)	Tier 3	
<i>clindamycin-tretinoin topical gel 1.2-0.025 %</i>	Tier 1	ST: Must meet the following requirement: Clindamycin gel or Tretinoin gel 0.025% in 120 days
TARDEOXIA TOPICAL CREAM 0.025-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
Acne Therapy Topical - Keratolytic - Drugs For The Skin		
BENZEPRO (MICROSPHERES) TOPICAL CLEANSER 7 % (benzoyl peroxide microspheres)	Tier 1	
BENZEPRO TOPICAL TOWELETTE 6 % (benzoyl peroxide)	Tier 1	
<i>benzoyl peroxide topical cleanser 7 %</i>	Tier 1	
<i>benzoyl peroxide topical foam 9.8 %</i>	Tier 1	
BPO TOPICAL GEL 8 % (benzoyl peroxide)	Tier 1	
INOVA TOPICAL COMBO PACK 4-5 %, 8-5 % (benzoyl peroxide/vitamin E mixed)	Tier 3	
PACNEX HP TOPICAL PADS, MEDICATED 7 % (benzoyl peroxide)	Tier 3	
PACNEX LP TOPICAL PADS, MEDICATED 4.25 % (benzoyl peroxide)	Tier 3	
PR BENZOYL PEROXIDE TOPICAL CLEANSER 7 % (benzoyl peroxide microspheres)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Acne Therapy Topical - Keratolytic Combinations Other - Drugs For The Skin		
INOVA 4-1 TOPICAL COMBO PACK 1-4-5 % (salicylic acid/benzoyl peroxide/vitamin E mixed)	Tier 3	
INOVA 8-2 TOPICAL COMBO PACK 2-8-5 % (salicylic acid/benzoyl peroxide/vitamin E mixed)	Tier 3	
Acne Therapy Topical - Keratolytic-Glucocorticoid Combinations - Drugs For The Skin		
VANOXIDE-HC TOPICAL SUSPENSION 5-0.5 % (benzoyl peroxide/hydrocortisone)	Tier 2	
Acne Therapy Topical - Retinoid Combinations Other - Drugs For The Skin		
ADAINZOXIA TOPICAL GEL 0.3-2.5-4 % (adapalene/benzoyl peroxide/niacinamide)	Tier 3	
<i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %</i>	Tier 1	ST: Must meet the following requirement: Adapalene 0.1% gel in 120 days; Age (Max 25 Years)
EPIDUO FORTE TOPICAL GEL WITH PUMP 0.3-2.5 % (adapalene/benzoyl peroxide)	Tier 2	ST: Must meet the following requirement: Adapalene 0.1% gel in 120 days; Age (Max 25 Years)
OXIATAR TOPICAL CREAM 0.025-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
OXIAVARRY TOPICAL CREAM 0.05-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
OXIAZAR TOPICAL CREAM 0.1-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
TARDIMAXIA TOPICAL GEL 0.025-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAROXIA TOPICAL CREAM 0.025-4 % (tretinoin/niacinamide)	Tier 3	
TAROXIA TOPICAL GEL 0.025-4 % (tretinoin/niacinamide)	Tier 3	
VARDIMAXIA TOPICAL GEL 0.05-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	
VAROXIA TOPICAL CREAM 0.05-4 % (tretinoin/niacinamide)	Tier 3	
VAROXIA TOPICAL GEL 0.05-4 % (tretinoin/niacinamide)	Tier 3	
Acne Therapy Topical - Retinoids And Derivatives - Drugs For The Skin		
<i>adapalene topical cream 0.1 %</i>	Tier 1	Age (Max 25 Years)
<i>adapalene topical gel 0.1 %, 0.3 %</i>	Tier 1	Age (Max 25 Years)
<i>adapalene topical gel with pump 0.3 %</i>	Tier 1	Age (Max 25 Years)
<i>adapalene topical lotion 0.1 %</i>	Tier 1	Age (Max 25 Years)
<i>adapalene topical solution 0.1 %</i>	Tier 3	ST: Must meet the following requirement: Adapalene 0.1% gel in 120 days; Age (Max 25 Years)
<i>adapalene topical swab 0.1 %</i>	Tier 1	ST: Must meet the following requirement: Adapalene 0.1% gel in 120 days; QL (1 EA per 1 day); Age (Max 25 Years)
AKLIEF TOPICAL CREAM 0.005 % (trifarotene)	Tier 3	ST: Must meet any of the following requirements: Adapalene, Differin, Tazarotene, or Tretinoin in 120 days; Age (Max 25 Years)
ALTRENO TOPICAL LOTION 0.05 % (tretinoin)	Tier 3	Age (Max 25 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARAZLO TOPICAL LOTION 0.045 % (tazarotene)	Tier 3	ST: Must meet any of the following requirements: Adapalene, Differin, Tazarotene, or Tretinoin in 120 days; Age (Max 25 Years)
AVITA TOPICAL CREAM 0.025 % (tretinoin)	Tier 1	Age (Max 25 Years)
AVITA TOPICAL GEL 0.025 % (tretinoin)	Tier 1	Age (Max 25 Years)
DIFFERIN TOPICAL LOTION 0.1 % (adapalene)	Tier 2	Age (Max 25 Years)
EFFACLAR ADAPALENE TOPICAL GEL 0.1 % (adapalene)	Tier 1	Age (Max 25 Years)
ETHOXIA TOPICAL CREAM 0.05-4 % (tazarotene/niacinamide)	Tier 3	
FABIOR TOPICAL FOAM 0.1 % (tazarotene)	Tier 3	ST: Must meet any of the following requirements: Adapalene, Differin, Tazarotene, or Tretinoin in 120 days; Age (Min 12 Years)
ITHOXIA TOPICAL CREAM 0.1-4 % (tazarotene/niacinamide)	Tier 3	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 % (tretinoin microspheres)	Tier 3	ST: Must meet the following requirements: Generic Tretinoin Microspheres 0.04% and 0.10% in 365 days; Age (Max 25 Years)
<i>tazarotene topical foam 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Adapalene, Differin, Tazarotene, or Tretinoin in 120 days; Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tretinoin microspheres topical gel 0.04 %, 0.1 %</i>	Tier 1	Age (Max 25 Years)
<i>tretinoin microspheres topical gel with pump 0.04 %, 0.1 %</i>	Tier 1	Age (Max 25 Years)
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	Tier 1	Age (Max 25 Years)
<i>tretinoin topical gel 0.01 %, 0.025 %, 0.05 %</i>	Tier 1	Age (Max 25 Years)
Acne Therapy Topical Combinations Other - Drugs For The Skin		
DIMOXIA TOPICAL GEL 5-4 % (spironolactone/niacinamide)	Tier 3	
Antipsoriatic - Retinoid (Vitamin A Derivative) - Glucocorticoid - Drugs For The Skin		
DUOBRII TOPICAL LOTION 0.01-0.045 % (halobetasol propionate/tazarotene)	Tier 3	ST: Must meet any of the following requirements: Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol, Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) in 120 days; QL (200 GM per 28 days)
Antipsoriatic - Vitamin D Analog - Glucocorticoid Combinations - Drugs For The Skin		
<i>calcipotriene-betamethasone topical ointment 0.005-0.064 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcipotriene-betamethasone topical suspension 0.005-0.064 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
ENSTILAR TOPICAL FOAM 0.005-0.064 % (calcipotriene/betamethasone dipropionate)	Tier 3	ST: Must meet the following requirement: Calcipotriene/Betamethasone ointment in 120 days
WYNZORA TOPICAL CREAM 0.005-0.064 % (calcipotriene/betamethasone dipropionate)	Tier 3	ST: Must meet the following requirement: Calcipotriene/Betamethasone ointment in 120 days
Antipsoriatic Agents - Interleukin 12 And Il-23 Inhibitors, Mc Antibody - Drugs For The Skin		
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab)	Tier 4	PA
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML (ustekinumab)	Tier 4	PA
Antipsoriatic Agents - Interleukin-23 (Il-23) Antagonist, Mc Antibody - Drugs For The Skin		
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML (risankizumab-rzaa)	Tier 4	PA
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.83 ML (risankizumab-rzaa)	Tier 4	PA
SKYRIZI SUBCUTANEOUS SYRINGE KIT 150MG/1.66ML(75 MG/0.83 ML X2) (risankizumab-rzaa)	Tier 4	PA
TREMFYA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML (guselkumab)	Tier 4	PA
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML (guselkumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antipsoriatic Agents-Interleukin-17 (Il-17) Antagonist, Mc Antibody - Drugs For The Skin		
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML (secukinumab)	Tier 2	PA
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML (secukinumab)	Tier 2	PA
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML (secukinumab)	Tier 2	PA
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML (secukinumab)	Tier 2	PA
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML (secukinumab)	Tier 4	PA
SILIQ SUBCUTANEOUS SYRINGE 210 MG/1.5 ML (brodalumab)	Tier 4	PA
TALTZ AUTOINJECTOR (2 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 4	PA
TALTZ AUTOINJECTOR (3 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 4	PA
TALTZ AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 4	PA
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML (ixekizumab)	Tier 4	PA
Dermatitis Or Eczema Agents, Systemic-Interleukin-4 (Il-4Ra) Antag.Mab - Drugs For The Skin		
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 4	PA
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatitis Or Eczema Agents, Topical - Phosphodiesterase-4 Inhibitors - Drugs For The Skin		
EUCRISA TOPICAL OINTMENT 2 % (crisaborole)	Tier 2	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
Dermatological - Antibacterial Aminoglycosides - Drugs For The Skin		
<i>gentamicin topical cream 0.1 %</i>	Tier 1	QL (90 GM per 1 FILL)
<i>gentamicin topical ointment 0.1 %</i>	Tier 1	QL (90 GM per 1 FILL)
Dermatological - Antibacterial And Antifungal Agents - Drugs For The Skin		
QUINJA TOPICAL GEL 1.25-1 % (iodoquinol/aloe polysaccharides no.1)	Tier 3	
Dermatological - Antibacterial Other - Drugs For The Skin		
AZADROX TOPICAL GEL IN PACKET (silver/urea)	Tier 3	
BASADROX TOPICAL GEL IN PACKET (silver)	Tier 3	
CENTANY AT TOPICAL OINTMENT KIT 2 % (mupirocin)	Tier 3	
<i>mupirocin calcium topical cream 2 %</i>	Tier 1	QL (90 GM per 1 FILL)
<i>mupirocin topical ointment 2 %</i>	Tier 1	QL (90 GM per 1 FILL)
NORMLGEL AG TOPICAL GEL 0.11 % (silver carbonate)	Tier 3	
<i>silver nitrate topical solution 0.5 %</i>	Tier 1	
<i>silver nitrate topical solution 10 %, 25 %, 50 %</i>	Tier 1	
SILVRSTAT TOPICAL GEL 32 PPM (silver)	Tier 3	
SOLOX GEL TOPICAL GEL 55 PPM (silver nitrate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antibacterial Pleuromutilin Derivatives - Drugs For The Skin		
ALTABAX TOPICAL OINTMENT 1 % (retapamulin)	Tier 3	ST: Must meet the following requirement: Mupirocin ointment in 120 days
Dermatological - Antibacterial Quinolones - Drugs For The Skin		
XEPI TOPICAL CREAM 1 % (ozenoxacin)	Tier 3	ST: Must meet the following requirement: Mupirocin ointment in 120 days
Dermatological - Antibacterial,Antifungal Agent With Glucocorticoid - Drugs For The Skin		
ALA-QUIN TOPICAL CREAM 3-0.5 % (clioquinol/hydrocortisone)	Tier 3	
ALCORTIN A TOPICAL GEL IN PACKET 2-1-1 % (hydrocortisone acetate/iodoquinol/aloe polysaccharides no.2)	Tier 3	
<i>hydrocortisone-iodoquinol-aloe2 topical gel 2-1-1 %</i>	Tier 1	
<i>hydrocortisone-iodoquinol-aloe topical cream in packet 1.9-1 %</i>	Tier 1	
PHEODOYO TOPICAL CREAM 2-1-2.5 % (ketoconazole/iodoquinol/hydrocortisone)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antibacterial-Glucocorticoid Combinations - Drugs For The Skin		
NEO-SYNALAR KIT TOPICAL CREAM 0.5 % (0.35 % BASE)-0.025 % (neomycin sulfate/fluocinolone acetone/emo/lient comb no.65)	Tier 3	ST: Must meet 2 of the following requirements: Bacitracin Zinc, Bacitracin, Capex Shampoo, Fluocinolone Acetone, Iluvien, Retisert, or Yutiq in 365 days
NEO-SYNALAR TOPICAL CREAM 0.5 % (0.35 % BASE)-0.025 % (neomycin sulfate/fluocinolone acetone)	Tier 3	ST: Must meet 2 of the following requirements: Bacitracin Zinc, Bacitracin, Capex Shampoo, Fluocinolone Acetone, Iluvien, Retisert, or Yutiq in 365 days
Dermatological - Anticholinergic Hyperhidrosis Treatment Agents - Drugs For The Skin		
QBREXZA TOPICAL TOWELETTE 2.4 % (glycopyrronium tosylate)	Tier 2	PA
Dermatological - Antifungal Allylamines - Drugs For The Skin		
<i>naftifine topical cream 1 %</i>	Tier 1	
<i>naftifine topical cream 2 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>naftifine topical gel 1 %</i>	Tier 1	
NAFTIN TOPICAL GEL 2 % (naftifine HCl)	Tier 3	
Dermatological - Antifungal Amphoteric Polyene Macrolides - Drugs For The Skin		
nystatin (Nyamyc Topical Powder 100,000 Unit/Gram)	Tier 1	
<i>nystatin topical cream 100,000 unit/gram</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nystatin topical ointment 100,000 unit/gram</i>	Tier 1	QL (90 GM per 1 FILL)
<i>nystatin topical powder 100,000 unit/gram</i>	Tier 1	
nystatin (Nystop Topical Powder 100,000 Unit/Gram)	Tier 1	
Dermatological - Antifungal Benzylamines - Drugs For The Skin		
MENTAX TOPICAL CREAM 1 % (butenafine HCl)	Tier 3	
Dermatological - Antifungal Combinations Other - Drugs For The Skin		
DIFMETIOXRIME TOPICAL SOLUTION 4-2-1-4 % (fluconazole/ibuprofen/itraconazole/terbinafine HCl)	Tier 3	
EXODERM TOPICAL LOTION 25-1 % (sodium thiosulfate/salicylic acid)	Tier 1	
IMIOXIA TOPICAL CREAM 1-4 % (econazole nitrate/niacinamide)	Tier 3	
Dermatological - Antifungal Hydroxypyridinone - Drugs For The Skin		
CICLODAN KIT TOPICAL COMBO PACK 0.77 % (ciclopirox olamine/skin cleanser combination no.28)	Tier 3	
<i>ciclopirox topical cream 0.77 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>ciclopirox topical gel 0.77 %</i>	Tier 1	
<i>ciclopirox topical shampoo 1 %</i>	Tier 1	
<i>ciclopirox topical solution 8 %</i>	Tier 1	QL (19.8 ML per 1 FILL)
<i>ciclopirox topical suspension 0.77 %</i>	Tier 1	QL (180 ML per 1 FILL)
<i>ciclopirox-ure-camph-menth-euc topical solution 8 %</i>	Tier 1	QL (19.8 ML per 1 FILL)
HIXDEFRIMA TOPICAL SOLUTION 8-1-1 % (ciclopirox olamine/fluconazole/terbinafine HCl)	Tier 3	
LOPROX KIT TOPICAL COMBO PACK 0.77 % (ciclopirox olamine/skin cleanser combination no.40)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOPROX KIT TOPICAL KIT, SUSPENSION AND CLEANSER 0.77 % (ciclopirox olamine/skin cleanser combination no.40)	Tier 3	
Dermatological - Antifungal Imidazole And Related Agents - Drugs For The Skin		
<i>clotrimazole topical cream 1 %</i>	Tier 1	
<i>clotrimazole topical solution 1 %</i>	Tier 1	
<i>econazole topical cream 1 %</i>	Tier 1	QL (170 GM per 1 FILL)
ECOZA TOPICAL FOAM 1 % (econazole nitrate)	Tier 3	
ERTACZO TOPICAL CREAM 2 % (sertaconazole nitrate)	Tier 3	
EXELDERM TOPICAL CREAM 1 % (sulconazole nitrate)	Tier 2	
EXELDERM TOPICAL SOLUTION 1 % (sulconazole nitrate)	Tier 2	
<i>ketoconazole topical cream 2 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>ketoconazole topical foam 2 %</i>	Tier 1	ST: Must meet the following requirement: Ketoconazole 2% cream or shampoo in 120 days
<i>ketoconazole topical shampoo 2 %</i>	Tier 1	QL (360 ML per 1 FILL)
KETODAN KIT TOPICAL COMBO PACK 2 % (ketoconazole/skin cleanser combination no.28)	Tier 3	
ketoconazole (Ketodan Topical Foam 2 %)	Tier 1	ST: Must meet the following requirement: Ketoconazole 2% cream or shampoo in 120 days
<i>luliconazole topical cream 1 %</i>	Tier 1	ST: Must meet the following requirements: Clotrimazole and Ketoconazole in 365 days; QL (60 GM per 28 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>miconazole nitrate-zinc ox-pet topical ointment 0.25-15-81.35 %</i>	Tier 1	
<i>oxiconazole topical cream 1 %</i>	Tier 1	QL (180 GM per 1 FILL)
OXISTAT TOPICAL LOTION 1 % (oxiconazole nitrate)	Tier 3	
PEDIZOL PAK TOPICAL KIT, CREAM AND SOLUTION 2-2 % (ketoconazole/miconazole nitrate)	Tier 3	
<i>sulconazole topical cream 1 %</i>	Tier 1	
<i>sulconazole topical solution 1 %</i>	Tier 1	
XOLEGEL TOPICAL GEL 2 % (ketoconazole)	Tier 3	ST: Must meet the following requirement: Ketoconazole 2% cream or shampoo in 120 days
ZOLPAK TOPICAL KIT 1 %- 6 CM X 7 CM (econazole nitrate/transparent dressing)	Tier 3	
Dermatological - Antifungal Oxaborole - Drugs For The Skin		
<i>tavaborole topical solution with applicator 5 %</i>	Tier 1	PA
Dermatological - Antifungal Triazole - Drugs For The Skin		
JUBLIA TOPICAL SOLUTION WITH APPLICATOR 10 % (efinaconazole)	Tier 3	PA
Dermatological - Antifungal-Glucocorticoid Combinations - Drugs For The Skin		
<i>clotrimazole-betamethasone topical cream 1-0.05 %</i>	Tier 1	
<i>clotrimazole-betamethasone topical lotion 1-0.05 %</i>	Tier 1	
DERMACINRX THERAZOLE PAK TOPICAL COMBO PACK 1-0.05-20 % (clotrimazole/betamethasone dipropionate/zinc oxide)	Tier 3	
DERMAZENE TOPICAL CREAM IN PACKET 1-1 % (hydrocortisone/iodoquinol)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HAXCHLO TOPICAL SHAMPOO 0.77-0.05 % (ciclopirox olamine/clobetasol propionate)	Tier 3	
<i>hydrocortisone-iodoquinol topical cream 1-1 %</i>	Tier 1	
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	Tier 1	
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	Tier 1	QL (180 GM per 1 FILL)
PHEYO TOPICAL CREAM 2-2.5 % (ketoconazole/hydrocortisone)	Tier 3	
TRIAMAZOLE TOPICAL COMBO PACK,OINTMENT AND CREAM 1-0.1 % (econazole nitrate/triamcinolone acetoneide)	Tier 3	
TRILOCICLO TOPICAL KIT,OINTMENT AND LIQUID 8-0.1 % (ciclopirox/triamcinolone acetoneide)	Tier 3	
Dermatological - Antifungals Other - Drugs For The Skin		
<i>triacetin liquid 100 %</i>	Tier 3	
Dermatological - Antineoplastic Alkylating Agents - Drugs For The Skin		
VALCHLOR TOPICAL GEL 0.016 % (mechlorethamine HCl)	Tier 4	PA
Dermatological - Antineoplastic Antimetabolites - Drugs For The Skin		
FLUOROPLEX TOPICAL CREAM 1 % (fluorouracil)	Tier 3	PA
<i>fluorouracil topical cream 0.5 %</i>	Tier 1	PA
<i>fluorouracil topical cream 5 %</i>	Tier 1	
<i>fluorouracil topical solution 2 %, 5 %</i>	Tier 1	
TOLAK TOPICAL CREAM 4 % (fluorouracil)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antineoplastic Or Premalignant Lesions - Antimicrotubule - Drugs For The Skin		
KLISYRI TOPICAL OINTMENT IN PACKET 1 % (tirbanibulin)	Tier 3	PA
Dermatological - Antineoplastic Or Premalignant Lesions -Diterpene Esters - Drugs For The Skin		
PICATO TOPICAL GEL 0.015 %, 0.05 % (ingenol mebutate)	Tier 3	PA
Dermatological - Antineoplastic Or Premalignant Lesions - Nsaid's - Drugs For The Skin		
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	QL (100 GM per 1 FILL)
SOLARAVIX TOPICAL KIT 3 %- 1.59" X 59" (diclofenac sodium/silicone, adhesive)	Tier 3	
Dermatological - Antineoplastic Retinoids - Drugs For The Skin		
PANRETIN TOPICAL GEL 0.1 % (alitretinoin)	Tier 4	QL (60 GM per 28 days)
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist - Drugs For The Skin		
TARGRETIN TOPICAL GEL 1 % (bexarotene)	Tier 4	PA
Dermatological - Antiperspirants - Drugs For The Skin		
DRYSOL DAB-O-MATIC TOPICAL SOLUTION 20 % (aluminum chloride)	Tier 2	
DRYSOL TOPICAL SOLUTION 20 % (aluminum chloride)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antipsoriatic Agents Systemic, Photosensitizing - Drugs For The Skin		
<i>methoxsalen oral capsule, liqd-filled, rapid rel 10 mg</i>	Tier 1	
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives - Drugs For The Skin		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	Tier 4	
Dermatological - Antipsoriatic Agents Topical - Drugs For The Skin		
BRYHALI TOPICAL LOTION 0.01 % (halobetasol propionate)	Tier 3	ST: Must meet any of the following requirements: Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol, Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) in 120 days; QL (400 GM per 1 FILL)
<i>calcipotriene scalp solution 0.005 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>calcipotriene topical cream 0.005 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcipotriene topical foam 0.005 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>calcipotriene topical ointment 0.005 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>calcitriol topical ointment 3 mcg/gram</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
DRITHOCREME HP TOPICAL CREAM 1 % (anthralin)	Tier 2	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>halobetasol propionate topical foam 0.05 %</i>	Tier 1	ST: Must meet any of the following requirements: Clobetasol Propionate, Clobetasol Propionate/emollient, or Halobetasol Propionate in 120 days; QL (100 GM per 1 FILL)
IMPOYZ TOPICAL CREAM 0.025 % (clobetasol propionate)	Tier 3	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days; QL (200 GM per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEXETTE TOPICAL FOAM 0.05 % (halobetasol propionate)	Tier 3	ST: Must meet any of the following requirements: Clobetasol Propionate, Clobetasol Propionate/emollient, or Halobetasol Propionate in 120 days; QL (100 GM per 1 FILL)
NUDERMRXPAK TOPICAL KIT 0.005-5 % (calcipotriene/dimethicone)	Tier 3	
SORILUX TOPICAL FOAM 0.005 % (calcipotriene)	Tier 3	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>tazarotene topical cream 0.1 %</i>	Tier 1	
TAZORAC TOPICAL CREAM 0.05 % (tazarotene)	Tier 2	
TAZORAC TOPICAL GEL 0.05 % (tazarotene)	Tier 3	
TAZORAC TOPICAL GEL 0.1 % (tazarotene)	Tier 3	ST: Must meet any of the following requirements: Adapalene, Differin, Tazarotene, or Tretinoin in 120 days
ULTRAVATE TOPICAL LOTION 0.05 % (halobetasol propionate)	Tier 3	ST: Must meet any of the following requirements: Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, or Halobetasol 0.05% (cream, ointment) in 120 days; QL (120 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZITHRANOL TOPICAL SHAMPOO 1 % (anthralin micronized)	Tier 3	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
Dermatological - Antipsoriatics Systemic, Phosphodiesterase 4 Inhib. - Drugs For The Skin		
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG(19) (apremilast)	Tier 4	PA
Dermatological - Antiseborrheic - Drugs For The Skin		
LOUTREX TOPICAL CREAM (emollient combination no.85)	Tier 1	
OVACE PLUS SHAMPOO TOPICAL SHAMPOO 10 % (sulfacetamide sodium)	Tier 2	
OVACE PLUS TOPICAL CREAM 10 % (sulfacetamide sodium)	Tier 3	
OVACE PLUS TOPICAL FOAM 9.8 % (sulfacetamide sodium)	Tier 3	
OVACE PLUS TOPICAL LOTION 9.8 % (sulfacetamide sodium)	Tier 3	ST: Must meet the following requirement: Ciclopirox or Ketoconazole in 120 days
PROMISEB TOPICAL CREAM (emollient combination no.43)	Tier 3	
<i>selenium sulfide topical lotion 2.5 %</i>	Tier 1	
<i>selenium sulfide topical shampoo 2.25 %, 2.3 %</i>	Tier 1	
<i>sulfacetamide sodium topical cleanser 10 %</i>	Tier 1	
<i>sulfacetamide sodium topical cleanser, gel 10 %</i>	Tier 1	
<i>sulfacetamide sodium topical shampoo 10 %</i>	Tier 3	
TERSI FOAM TOPICAL FOAM 2.25 % (selenium sulfide)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antiviral, Herpes - Drugs For The Skin		
<i>acyclovir topical cream 5 %</i>	Tier 1	ST: Must meet 2 of the following requirements: Acyclovir, Famciclovir, or Valacyclovir HCL in 365 days
<i>acyclovir topical ointment 5 %</i>	Tier 1	
DENAVIR TOPICAL CREAM 1 % (penciclovir)	Tier 3	ST: Must meet 2 of the following requirements: Acyclovir, Famciclovir, or Valacyclovir HCL in 365 days
Dermatological - Antiviral-Glucocorticoid Combinations - Drugs For The Skin		
XERESE TOPICAL CREAM 5-1 % (acyclovir/hydrocortisone)	Tier 3	ST: Must meet any of the following requirements: Acyclovir, Famciclovir, Sitavig, or Valacyclovir HCL in 120 days; QL (10 GM per 365 days)
Dermatological - Burn Products Anti-Infective - Drugs For The Skin		
<i>mafenide acetate topical packet 50 gram</i>	Tier 1	
<i>silver sulfadiazine topical cream 1 %</i>	Tier 1	
SSD TOPICAL CREAM 1 % (silver sulfadiazine)	Tier 1	
SULFAMYLON TOPICAL CREAM 85 MG/G (mafenide acetate)	Tier 3	
SULFAMYLON TOPICAL PACKET 50 GRAM (mafenide acetate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Calcineurin Inhibitors - Drugs For The Skin		
OXIANUJO (WITH HYALURONATE) TOPICAL CREAM 0.1-1-4 % (tacrolimus/hyaluronate sodium/niacinamide)	Tier 3	
OXIANUJO TOPICAL OINTMENT 0.1-4 % (tacrolimus/niacinamide)	Tier 3	
<i>pimecrolimus topical cream 1 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
<i>tacrolimus topical ointment 0.03 %, 0.1 %</i>	Tier 1	
Dermatological - Depigmenting Agents - Drugs For The Skin		
<i>hydroquinone topical cream 4 %</i>	Tier 1	
KAXM TOPICAL EMULSION 4 % (hydroquinone)	Tier 3	
KEXM TOPICAL EMULSION 6 % (hydroquinone)	Tier 3	
KUTEA TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	
KUXM TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	
OBAGI ELASTIDERM TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
OBAGI NU-DERM BLENDER TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
OBAGI NU-DERM CLEAR TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
Dermatological - Depigmenting Combinations - Drugs For The Skin		
KATARYA TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KATARYAXN TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KEIDO TOPICAL EMULSION 6-1 % (hydroquinone/hyaluronate sodium)	Tier 3	
KETARYA TOPICAL EMULSION 6-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KEVARYA TOPICAL EMULSION 6-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KEYA TOPICAL EMULSION 6-0.5 % (hydroquinone/hydrocortisone)	Tier 3	
KUTARYAXM TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUTARYAXMPA TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUVARYA TOPICAL EMULSION 8-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUVARYE TOPICAL EMULSION 8-0.05-1 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
OBAGI NU-DERM SUNFADER TOPICAL CREAM 4 %- SPF 15 (hydroquinone/sunscreens (oxybenzone/octinoxate))	Tier 3	
OBAGI-C CLARIFYING SERUM TOPICAL LIQUID 4-10 % (hydroquinone/ascorbic acid)	Tier 3	
OBAGI-C THERAPY NIGHT TOPICAL CREAM 4 % (hydroquinone/ascorbic acid/vit E acetate (d-alpha tocoph))	Tier 3	
TRI-LUMA TOPICAL CREAM 0.01-4-0.05 % (fluocinolone acetone/tretinoin/hydroquinone)	Tier 3	
Dermatological - Emollient Combinations - Drugs For The Skin		
CERAVE DAILY MOISTURIZING TOPICAL LOTION (ceramides 1,3,6-II)	Tier 3	
CERAVE FOAMING FACIAL TOPICAL CLEANSER (ceramides 1,3,6-II/niacinamide)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CERAVE PM TOPICAL LOTION,EXTENDED RELEASE (ceramides 1,3,6-II/niacinamide/hyaluronic acid)	Tier 3	
CERAVE SA (WITH NIACINAMIDE) TOPICAL CLEANSER (ceramides (1,3,6-II)/salicylic acid/niacinamide)	Tier 3	
CERAVE SA (WITH NIACINAMIDE) TOPICAL CREAM (ceramides (1,3,6-II)/salicylic acid/niacinamide)	Tier 3	
CERAVE SA TOPICAL LOTION (salicylic acid/ceramides 1,3,6-II)	Tier 3	
CERAVE TOPICAL CLEANSER (ceramides 1,3,6-II)	Tier 3	
CERAVE TOPICAL CREAM (ceramides 1,3,6-II)	Tier 3	
Dermatological - Emollient Combinations Other - Drugs For The Skin		
HPR PLUS HYDROGEL TOPICAL KIT,CREAM AND GEL (emol53/sod mag fluorosilicat/cyclomethicone/phos acid/bicarb)	Tier 1	
HPR PLUS-MB HYDROGEL TOPICAL COMBO PACK,GEL AND FOAM 96.53-3-0.4 -0.066 % (emol53/e.water/NaMgFS/NaPhos/NaCl/hypochlorous acid/NahypoCl)	Tier 1	
MB HYDROGEL (CYCLOMETHICONE) TOPICAL KIT,CREAM AND GEL (emol53/sod mag fluorosilicat/cyclomethicone/phos acid/bicarb)	Tier 1	
MB HYDROGEL TOPICAL KIT,CREAM AND GEL 96.53-3-0.4 -0.066 % (emol53/e.water/NaMgFS/NaPhos/NaCl/hypochlorous acid/NahypoCl)	Tier 1	
Dermatological - Emollient Mixtures - Drugs For The Skin		
ATOPADERM TOPICAL CREAM (emollient combination no.53)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ATRAPRO CP TOPICAL COMBO PACK, CREAM AND GEL (emollient combination no.47/emollient combination no.60)	Tier 3	
ATRAPRO HYDROGEL TOPICAL GEL (emollient combination no.60)	Tier 3	
AVO CREAM TOPICAL EMULSION (emollient combination no.10)	Tier 1	
CELACYN TOPICAL GEL WITH PUMP (emollient combination no.60)	Tier 3	
CERACADE TOPICAL EMULSION (emollient combination no.103)	Tier 3	
CERAMAX TOPICAL CREAM (emollient combination no.101)	Tier 3	
CERAMAX TOPICAL LOTION (emollient combination no.101)	Tier 3	
DEXERYL TOPICAL CREAM (emollient combination no.104)	Tier 3	
EMULSION SB TOPICAL EMULSION (emollient combination no.32)	Tier 1	
ENTTY TOPICAL SPRAY, NON-AEROSOL (palm oil/hyaluronate sodium)	Tier 3	
EPICERAM TOPICAL EMULSION, EXTENDED RELEASE (emollient combination no.32)	Tier 3	PA
HALUCORT TOPICAL GEL (emollient combination no.56/hyaluronic acid)	Tier 3	
HAPRODERM TOPICAL GEL (emollient combination no.56/hyaluronic acid)	Tier 3	
HPR PLUS TOPICAL CREAM (emollient combination no.53)	Tier 3	
HPR PLUS TOPICAL FOAM (emollient combination no.53)	Tier 3	
HPR TOPICAL FOAM (emollient combination no.44)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYLAGUARD TOPICAL CREAM (emollient combination no.53)	Tier 3	
HYLATOPIC TOPICAL FOAM (emollient combination no.44)	Tier 3	
HYLATOPICPLUS TOPICAL CREAM (emollient combination no.53)	Tier 3	
HYLATOPICPLUS TOPICAL LOTION (emollient combination no.53)	Tier 3	
LEVICYN ANTIPRURITIC SG TOPICAL SPRAY GEL (emollient combination no.60)	Tier 3	
LOUTREX TOPICAL CREAM (emollient combination no.85)	Tier 1	
LOYON TOPICAL SPRAY, NON-AEROSOL (dicaprylyl carbonate/dimethicone)	Tier 3	
LUXAMEND TOPICAL CREAM (emollient combination no.10)	Tier 3	
MINERIN CREME TOPICAL CREAM (lanolin alcohols/mineral oil/petrolatum, white/ceresin)	Tier 1	
NEOSALUS TOPICAL CREAM (emollient combination no.47)	Tier 3	
NEOSALUS TOPICAL FOAM (emollient combination no.38)	Tier 3	
NEOSALUS TOPICAL LOTION (emollient combination no.47)	Tier 3	
NIVATOPIC PLUS TOPICAL CREAM (emollient combination no.53)	Tier 3	
NUTRASEB TOPICAL CREAM (emollient combination no.107)	Tier 3	
PENLEN TOPICAL SPRAY, NON-AEROSOL (palm oil/hyaluronate sodium)	Tier 3	
PRESERA TOPICAL FOAM (emollient combination no.80)	Tier 3	
PRUCLAIR TOPICAL CREAM (vitamin E acet (dl,tocopheryl)/grape/hyaluronic acid)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRUMYX TOPICAL CREAM (emollient combination no.35)	Tier 1	
SEBUDERM TOPICAL GEL (emollient combination no.60)	Tier 3	
SONAFINE TOPICAL EMULSION (emollient combination no.10)	Tier 1	
THERAPEUTIC MOISTURIZING CREAM TOPICAL CREAM (lanolin alcohols/mineral oil/petrolatum,white/ceresin)	Tier 1	
XCLAIR TOPICAL CREAM (hyaluronate sodium/vit E/emollient no.12/allantoin/shear tree)	Tier 3	
Dermatological - Emollients - Drugs For The Skin		
<i>ammonium lactate topical cream 12 %</i>	Tier 1	
<i>ammonium lactate topical lotion 12 %</i>	Tier 1	
<i>glycerin topical liquid</i>	Tier 3	
<i>glycerin topical solution 99.5 %</i>	Tier 3	
KIVIK TOPICAL EMULSION (palm oil/benzoyl peroxide)	Tier 3	
LANOLIN (HPA) TOPICAL CREAM 100 % (modified lanolin)	Tier 3	
PHLAG SPRAY TOPICAL SPRAY, NON-AEROSOL (palm oil/eucalyptus oil)	Tier 3	
PURELAN TOPICAL CREAM (lanolin)	Tier 3	
RADIAGEL TOPICAL GEL (emollient base)	Tier 3	
SYNERDERM TOPICAL SPRAY, NON-AEROSOL (palm oil)	Tier 3	
Dermatological - Enzymes - Drugs For The Skin		
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM (collagenase Clostridium histolyticum)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Eyelid Cleansers - Drugs For The Skin		
ACUICYN TOPICAL SPRAY, NON-AEROSOL 0.01 % (hypochlorous acid/sodium chloride)	Tier 3	
AVENOVA TOPICAL SPRAY, NON-AEROSOL 0.01 % (hypochlorous acid/sodium chloride)	Tier 3	
CLEANSING EYELID MOIST PADS TOPICAL PADS, MEDICATED (eyelid cleanser combination no.8)	Tier 3	
CLEANSING EYELID WIPES EXT STR TOPICAL PADS, MEDICATED (eyelid cleanser combination no.10)	Tier 3	
HYPOCYN TOPICAL SPRAY, NON-AEROSOL 0.01 % (hypochlorous acid/sodium chloride)	Tier 3	
VISTA MEIBO EYELID CLEANSING TOPICAL FOAM (eyelid cleanser combination no.11)	Tier 3	
VISTA MEIBO EYELID CLEANSING TOPICAL PADS, MEDICATED (eyelid cleanser combination no.12)	Tier 3	
Dermatological - Glucocorticoid - Drugs For The Skin		
ADVANCED ALLERGY COLLECT KIT TOPICAL KIT 2.5 % (hydrocortisone)	Tier 3	
hydrocortisone (Ala-Cort Topical Cream 1 %)	Tier 1	
hydrocortisone (Ala-Scalp Topical Lotion 2 %)	Tier 1	ST: Must meet the following requirement: Generic Hydrocortisone 2.5% lotion in 120 days
<i>alclometasone topical cream 0.05 %</i>	Tier 1	
<i>alclometasone topical ointment 0.05 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amcinonide topical cream 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone 0.1% ointment, Fluticasone 0.005% ointment, Mometasone 0.1% ointment, or Triamcinolone 0.5% (ointment, cream) in 120 days
<i>amcinonide topical lotion 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone 0.1% ointment, Fluticasone 0.005% ointment, Mometasone 0.1% ointment, or Triamcinolone 0.5% (ointment, cream) in 120 days
APEXICON E TOPICAL CREAM 0.05 % (diflorasone diacetate/emollient base)	Tier 3	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days; QL (180 GM per 30 days)
<i>betamethasone dipropionate topical cream 0.05 %</i>	Tier 1	
<i>betamethasone dipropionate topical lotion 0.05 %</i>	Tier 1	
<i>betamethasone dipropionate topical ointment 0.05 %</i>	Tier 1	
<i>betamethasone valerate topical cream 0.1 %</i>	Tier 1	
<i>betamethasone valerate topical foam 0.12 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone valerate topical lotion 0.1 %</i>	Tier 1	
<i>betamethasone valerate topical ointment 0.1 %</i>	Tier 1	
<i>betamethasone, augmented topical cream 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical gel 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical lotion 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical ointment 0.05 %</i>	Tier 1	
CAPEX TOPICAL SHAMPOO 0.01 % (fluocinolone acetonide)	Tier 3	
<i>clobetasol scalp solution 0.05 %</i>	Tier 1	
<i>clobetasol topical cream 0.05 %</i>	Tier 1	
<i>clobetasol topical foam 0.05 %</i>	Tier 1	
<i>clobetasol topical gel 0.05 %</i>	Tier 1	
<i>clobetasol topical lotion 0.05 %</i>	Tier 1	
<i>clobetasol topical ointment 0.05 %</i>	Tier 1	
<i>clobetasol topical shampoo 0.05 %</i>	Tier 1	
<i>clobetasol topical spray, non-aerosol 0.05 %</i>	Tier 1	
<i>clobetasol-emollient topical cream 0.05 %</i>	Tier 1	
<i>clobetasol-emollient topical foam 0.05 %</i>	Tier 1	
CLOBETAVIX TOPICAL KIT 0.05 %- 4" X 4" (clobetasol propionate/hydrocolloid dressing)	Tier 3	
<i>clocortolone pivalate topical cream 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORDRAN TAPE LARGE ROLL TOPICAL TAPE 4 MCG/CM2 (flurandrenolide)	Tier 3	ST: Must meet any of the following requirements: Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, or Halobetasol 0.05% (cream, ointment) in 120 days; QL (2 EA per 30 days)
CORDRAN TOPICAL CREAM 0.025 % (flurandrenolide)	Tier 3	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days
DESONATE TOPICAL GEL 0.05 % (desonide)	Tier 3	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days
<i>desonide topical cream 0.05 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desonide topical gel 0.05 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days
<i>desonide topical lotion 0.05 %</i>	Tier 1	
<i>desonide topical ointment 0.05 %</i>	Tier 1	
<i>desoximetasone topical cream 0.05 %, 0.25 %</i>	Tier 1	
<i>desoximetasone topical gel 0.05 %</i>	Tier 1	
<i>desoximetasone topical ointment 0.05 %, 0.25 %</i>	Tier 1	
<i>desoximetasone topical spray,non-aerosol 0.25 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol, Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desonide (Desrx Topical Gel 0.05 %)	Tier 3	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days
<i>diflorasone topical cream 0.05 %</i>	Tier 1	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days; QL (180 GM per 30 days)
<i>diflorasone topical ointment 0.05 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol, Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) in 120 days; QL (180 GM per 30 days)
<i>fluocinolone and shower cap scalp oil 0.01 %</i>	Tier 1	
<i>fluocinolone topical cream 0.01 %, 0.025 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinolone topical oil 0.01 %</i>	Tier 1	
<i>fluocinolone topical ointment 0.025 %</i>	Tier 1	
<i>fluocinolone topical solution 0.01 %</i>	Tier 1	
<i>fluocinonide topical cream 0.05 %, 0.1 %</i>	Tier 1	
<i>fluocinonide topical gel 0.05 %</i>	Tier 1	
<i>fluocinonide topical ointment 0.05 %</i>	Tier 1	
<i>fluocinonide topical solution 0.05 %</i>	Tier 1	
fluocinonide/emollient base (Fluocinonide-E Topical Cream 0.05 %)	Tier 1	
<i>fluocinonide-emollient topical cream 0.05 %</i>	Tier 1	
FLUOVIX PLUS TOPICAL KIT 0.1 % (fluocinonide/silicone, adhesive)	Tier 3	
FLUOVIX TOPICAL KIT 0.1 % (fluocinonide/silicone, adhesive)	Tier 3	
<i>flurandrenolide topical cream 0.05 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days
<i>flurandrenolide topical lotion 0.05 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>flurandrenolide topical ointment 0.05 %</i>	Tier 1	ST: Must meet any of the following requirements: Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment in 120 days; QL (180 GM per 30 days)
<i>fluticasone propionate topical cream 0.05 %</i>	Tier 1	
<i>fluticasone propionate topical lotion 0.05 %</i>	Tier 1	
<i>fluticasone propionate topical ointment 0.005 %</i>	Tier 1	
<i>halcinonide topical cream 0.1 %</i>	Tier 1	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days
<i>halobetasol propionate topical cream 0.05 %</i>	Tier 1	
<i>halobetasol propionate topical ointment 0.05 %</i>	Tier 1	
HALOG TOPICAL OINTMENT 0.1 % (halcinonide)	Tier 3	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HALOG TOPICAL SOLUTION 0.1 % (halcinonide)	Tier 3	ST: Must meet the following requirement: Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) in 120 days
<i>hydrocortisone butyrate topical cream 0.1 %</i>	Tier 1	
<i>hydrocortisone butyrate topical lotion 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days; QL (236 ML per 30 days)
<i>hydrocortisone butyrate topical ointment 0.1 %</i>	Tier 1	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days
<i>hydrocortisone butyrate topical solution 0.1 %</i>	Tier 1	
<i>hydrocortisone butyr-emollient topical cream 0.1 %</i>	Tier 3	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone topical cream with perineal applicator 1 %</i>	Tier 3	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	Tier 1	
<i>hydrocortisone topical lotion 2.5 %</i>	Tier 1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	Tier 1	
<i>hydrocortisone valerate topical cream 0.2 %</i>	Tier 1	
<i>hydrocortisone valerate topical ointment 0.2 %</i>	Tier 1	ST: Must meet any of the following requirements: Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment in 120 days
IMPEKLO TOPICAL LOTION IN METERED-DOSE PUMP 0.05 % (clobetasol propionate)	Tier 3	ST: Must meet any of the following requirements: Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, or Halobetasol 0.05% (cream, ointment) in 120 days
<i>mometasone topical cream 0.1 %</i>	Tier 1	
<i>mometasone topical ointment 0.1 %</i>	Tier 1	
<i>mometasone topical solution 0.1 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PANDEL TOPICAL CREAM 0.1 % (hydrocortisone probutate)	Tier 3	ST: Must meet any of the following requirements: Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) in 120 days; QL (160 GM per 30 days)
<i>prednicarbate topical cream 0.1 %</i>	Tier 1	
<i>prednicarbate topical ointment 0.1 %</i>	Tier 1	
hydrocortisone (Procto-Med Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Procto-Pak Topical Cream With Perineal Applicator 1 %)	Tier 3	
hydrocortisone (Proctosol Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
SCALACORT DK TOPICAL COMBO PACK 2-2-2 % (hydrocortisone/salicylic acid/sulfur/shampoo no. 1)	Tier 2	
SERNIVO TOPICAL SPRAY WITH PUMP 0.05 % (betamethasone dipropionate)	Tier 3	ST: Must meet any of the following requirements: Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment in 120 days
SILA III TOPICAL KIT 0.1 %- 4" X 4" (triamcinolone acetonide/gauze bandage/silicone, adhesive)	Tier 3	
SILALITE PAK TOPICAL KIT, OINTMENT AND SHEET 0.1 % (triamcinolone acetonide/silicones)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TASOPROL TOPICAL KIT 0.05 %- 4" X 4" (clobetasol propionate/gauze bandage/silicone, adhesive)	Tier 3	
TEXACORT TOPICAL SOLUTION 2.5 % (hydrocortisone)	Tier 2	ST: Must meet the following requirement: Generic Hydrocortisone 2.5% lotion in 120 days
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Tier 1	
<i>triamcinolone acetonide topical cream 0.025 %, 0.1 %</i>	Tier 1	
<i>triamcinolone acetonide topical cream 0.5 %</i>	Tier 1	QL (454 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	Tier 1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	Tier 1	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Tier 1	QL (430 GM per 30 days)
triamcinolone acetonide (Trianex Topical Ointment 0.05 %)	Tier 1	QL (430 GM per 30 days)
triamcinolone acetonide (Triderm Topical Cream 0.1 %)	Tier 1	
triamcinolone acetonide (Triderm Topical Cream 0.5 %)	Tier 1	QL (454 GM per 30 days)
VERDESO TOPICAL FOAM 0.05 % (desonide)	Tier 3	ST: Must meet the following requirement: Fluocinolone Acetonide 0.01% body oil in 120 days
Dermatological - Glucocorticoid Combinations Other - Drugs For The Skin		
CHLOOXIA TOPICAL CREAM 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
CHLOOXIA TOPICAL OINTMENT 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
CHLOOXIA TOPICAL SOLUTION 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
CLOBETEX KIT 0.05 %- 5 MG (clobetasol propionate/desloratadine)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIOCHLOY TOPICAL SOLUTION 0.05-0.005 % (clobetasol propionate/calcipotriene)	Tier 3	
Dermatological - Glucocorticoid-Emollient Combinations - Drugs For The Skin		
BESER KIT TOPICAL KIT, LOTION AND CREAM, EMOLLIENT 0.05 % (fluticasone propionate/emollient combination no.65)	Tier 3	
ELLZIA PAK TOPICAL KIT, OINTMENT AND CREAM 0.1-5 % (triamcinolone acetonide/dimethicone)	Tier 1	
FLUOPAR TOPICAL KIT 0.1-5 % (fluocinonide/dimethicone)	Tier 3	
NOXIPAK TOPICAL KIT 0.01-20 % (fluocinolone acetonide/urea/silicone, adhesive)	Tier 3	
NUCORT TOPICAL LOTION 2 % (hydrocortisone acetate/aloe vera)	Tier 3	
QUINIXIL TOPICAL CREAM 0.1-5 % (mometasone furoate/dimethicone)	Tier 3	
SANADERMRX TOPICAL KIT 0.1-5 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 1	ST: Must meet 3 of the following requirements: Dimethicone, Silicone Disc, Silicone Roll, Silicone Scar, Silicone Sheet, Silicone Tape, or Triamcinolone Acetonide in 365 days; QL (1 EA per 30 days)
SYNALAR CREAM KIT TOPICAL CREAM 0.025 % (fluocinolone acetonide/emollient combination no.65)	Tier 3	QL (375 GM per 30 days)
SYNALAR OINTMENT KIT TOPICAL COMBO PACK, OINTMENT AND CREAM 0.025 % (fluocinolone acetonide/emollient combination no.65)	Tier 3	QL (375 GM per 30 days)
TOVET KIT TOPICAL COMBO PACK 0.05 % (clobetasol propionate/emollient combination no.65)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WHYTEDERM TDKIT TOPICAL KIT 0.1-2 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 3	
WHYTEDERM TRILASIL PAK TOPICAL KIT 0.1-2 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 3	
Dermatological - Glucocorticoid-Local Anesthetic Combinations - Drugs For The Skin		
ANALPRAM-HC TOPICAL LOTION 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
EPIFOAM TOPICAL FOAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	ST: Must meet the following requirement: Hydrocortisone/Pramoxine 2.5%-1% cream in 120 days
<i>hydrocortisone-pramoxine topical cream 2.35-1 %</i>	Tier 1	
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac topical cream 3-0.5 %</i>	Tier 1	
NOVACORT TOPICAL GEL WITH PERINEAL APPLICATOR 2-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	
PRAMOSONE TOPICAL CREAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	ST: Must meet the following requirement: Hydrocortisone/Pramoxine 2.5%-1% cream in 120 days
PRAMOSONE TOPICAL LOTION 1-1 %, 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
PRAMOSONE TOPICAL OINTMENT 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	ST: Must meet the following requirement: Hydrocortisone/Pramoxine 2.5%-1% cream in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRAMOSONE TOPICAL OINTMENT 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
Dermatological - Glucocorticoid-Skin Cleanser Combinations - Drugs For The Skin		
AQUA GLYCOLIC HC TOPICAL COMBO PACK 2 % (hydrocortisone/skin cleanser combination no.25)	Tier 3	
CLODAN KIT TOPICAL KIT,SHAMPOO AND CLEANSER 0.05 % (clobetasol propionate/skin cleanser combination no.28)	Tier 3	
SYNALAR TS TOPICAL KIT 0.01 % (fluocinolone acetonide/skin cleanser comb no.28)	Tier 3	
XILAPAK TOPICAL KIT 0.01 % (fluocinolone acetonide/skin cleanser no.10/silicone, tape)	Tier 3	
Dermatological - Immunomodulator - Catechins - Genital Wart/Hpv Tx - Drugs For The Skin		
VEREGEN TOPICAL OINTMENT 15 % (sinecatechins)	Tier 3	ST: Must meet the following requirements: Imiquimod and Podofilox in 120 days
Dermatological - Immunomodulator - Imidazoquinolinamines - Drugs For The Skin		
<i>imiquimod topical cream in metered-dose pump 3.75 %</i>	Tier 1	PA
<i>imiquimod topical cream in packet 3.75 %</i>	Tier 1	PA
<i>imiquimod topical cream in packet 5 %</i>	Tier 1	QL (24 EA per 30 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 % (imiquimod)	Tier 3	PA
ZYCLARA TOPICAL CREAM IN PACKET 3.75 % (imiquimod)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Immunomodulator - Interferons - Drugs For The Skin		
ALFERON N INJECTION SOLUTION 5 MILLION UNIT/ML (interferon alfa-n3)	Tier 4	
Dermatological - Immunomodulator Combinations - Drugs For The Skin		
QUIHOXVAR TOPICAL GEL 5-0.05-1 % (imiquimod/tretinoin/levocetirizine dihydrochloride)	Tier 3	
Dermatological - Insect Repellents - Drugs For The Skin		
RANGER READY REPELLENT TOPICAL SPRAY WITH PUMP 20 % (icaridin)	Tier 3	
Dermatological - Keratolytic Combinations Other - Drugs For The Skin		
GEAMETDRAY TOPICAL GEL 17 %-2 %- 5 % (salicylic acid/ibuprofen/cimetidine)	Tier 3	
GUANENDRUX TOPICAL CREAM 40-10-5 % (salicylic acid/cimetidine/lidocaine)	Tier 3	
URAMAXIN GT TOPICAL KIT, CREAM AND GEL 45 % (urea/emollient combination no.65)	Tier 3	
Dermatological - Keratolytic-Antimitotic Combinations - Drugs For The Skin		
SALVAX DUO PLUS TOPICAL FOAM 6-35 % (salicylic acid/urea)	Tier 3	
<i>silver nitrate applicators topical stick 75-25 %</i>	Tier 1	
Dermatological - Keratolytic-Antimitotic Single Agents - Drugs For The Skin		
BENSAL HP TOPICAL OINTMENT 3 % (salicylic acid)	Tier 3	
<i>cantharidin in acetone topical solution 0.7 %</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEM-UREA TOPICAL GEL 45 % (urea)	Tier 1	
CONDYLOX TOPICAL GEL 0.5 % (podofilox)	Tier 3	ST: Must meet the following requirement: Podofilox in 120 days
HYDRO 35 TOPICAL FOAM 35 % (urea)	Tier 3	
KERALYT SCALP COMPLETE TOPICAL KIT, SHAMPOO AND GEL 6-6 % (salicylic acid)	Tier 3	
PODOCON TOPICAL LIQUID 25 % (podophyllum resin)	Tier 1	
<i>podofilox topical solution 0.5 %</i>	Tier 1	
RYNODERM TOPICAL CREAM 37.5 % (urea)	Tier 3	
<i>salicylic acid topical cream 6 %</i>	Tier 1	
<i>salicylic acid topical cream, extended release 6 %</i>	Tier 1	
<i>salicylic acid topical film forming liquid w/appl 27.5 %</i>	Tier 1	
<i>salicylic acid topical film-forming soln er w/ appl 28.5 %</i>	Tier 3	
<i>salicylic acid topical foam 6 %</i>	Tier 1	
<i>salicylic acid topical gel 6 %</i>	Tier 1	
<i>salicylic acid topical liquid 26 %</i>	Tier 1	
<i>salicylic acid topical lotion 6 %</i>	Tier 1	
<i>salicylic acid topical lotion, extended release 6 %</i>	Tier 1	
<i>salicylic acid topical shampoo 6 %</i>	Tier 1	
<i>salicylic acid-ceramides no.1 topical kit, cleanser and cream er 6 %</i>	Tier 1	
SALIMEZ FORTE TOPICAL CREAM 10 % (salicylic acid)	Tier 3	
SALVAX TOPICAL FOAM 6 % (salicylic acid)	Tier 1	
TRI-CHLOR TOPICAL SOLUTION 80 % (trichloroacetic acid)	Tier 3	
<i>trichloroacetic acid topical recon soln 100 %, 20 %, 25 %, 30 %, 35 %, 40 %, 50 %, 75 %, 80 %, 90 %</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRASAL-ER TOPICAL FILM-FORMING SOLN ER W/ APPL 28.5 % (salicylic acid)	Tier 3	
UMECTA TOPICAL FOAM 40 % (urea)	Tier 1	
URAMAXIN TOPICAL FOAM 20 % (urea)	Tier 3	
URAMAXIN TOPICAL LOTION 45 % (urea)	Tier 3	
UREA NAIL STICK TOPICAL SOLUTION 50 % (urea)	Tier 1	
<i>urea topical cream 39 %, 40 %, 41 %, 45 %, 47 %, 50 %</i>	Tier 1	
<i>urea topical foam 35 %</i>	Tier 1	
<i>urea topical gel 45 %</i>	Tier 1	
<i>urea topical lotion 40 %</i>	Tier 1	
UREVAZ TOPICAL CREAM 44 % (urea)	Tier 3	
XALIX TOPICAL FILM-FORMING SOLN ER W/ APPL 28 % (salicylic acid)	Tier 3	
Dermatological - Keratoplastic Tar Products - Drugs For The Skin		
<i>coal tar topical solution 20 %</i>	Tier 3	
Dermatological - Liver Derivative Complex - Drugs For The Skin		
NEXAVIR INJECTION SOLUTION 25.5 MG/ML (liver extract (beef-pork))	Tier 3	
Dermatological - Local Anesthetic Combinations - Drugs For The Skin		
ADAZIN TOPICAL CREAM 2-2-10-0.035 % (lidocaine HCl/benzocaine/methyl salicylate/capsaicin)	Tier 3	
ANODYNE LPT TOPICAL KIT 2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
CETACAINE ANESTHETIC TOPICAL LIQUID 2-2-14 % (tetracaine/benzocaine/butamben)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CETACINE TOPICAL AEROSOL, SPRAY 2 %-2 %-14 % (200 MG/SEC) (tetracaine/benzocaine/butamben)	Tier 3	
DOLOTRANZ TOPICAL KIT, CREAM AND GEL 4-2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
ENZNONUTY TOPICAL OINTMENT 10-10-20 % (lidocaine/tetracaine/benzocaine)	Tier 3	
ILIDERM TOPICAL SPRAY, NON-AEROSOL (lidocaine HCl/palm oil)	Tier 3	
KAMDOY TOPICAL SPRAY, NON-AEROSOL (lidocaine HCl/palm oil)	Tier 3	
<i>lidocaine-prilocaine topical cream 2.5-2.5 %</i>	Tier 1	
<i>lidocaine-prilocaine topical kit 2.5-2.5 %</i>	Tier 3	
LIDORXKIT TOPICAL COMBO PACK, OINTMENT AND CREAM 5 % (lidocaine/skin cleanser combination no.37)	Tier 3	
LMR PLUS TOPICAL KIT 5-6 % (lidocaine/menthol)	Tier 3	
MENTHO-CAINE TOPICAL KIT, OINTMENT AND SPRAY 5-8 % (lidocaine/menthol)	Tier 3	
PAINGO KFT TOPICAL CREAM 2.5-2.5-30-10 % (lidocaine/prilocaine/methyl salicylate/menthol)	Tier 3	
PRIZOTRAL-II TOPICAL CREAM 2.5-2.5-3.88 % (lidocaine/prilocaine/lidocaine HCl)	Tier 3	
SOLUPAK TOPICAL KIT, OINTMENT AND SPRAY 5-10-3 % (lidocaine/methyl salicylate/menthol)	Tier 3	
WPR PLUS TOPICAL KIT, CREAM AND GEL 4-30-10 % (lidocaine HCl/methyl salicylate/menthol)	Tier 3	
Dermatological - Local Anesthetic Gas Combinations - Drugs For The Skin		
ACCUCAINE KIT KIT 10 MG/ML (1 %) (lidocaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAIN EASE MEDIUM STREAM SPRAY TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
PAIN EASE MIST SPRAY TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
SPRAY AND STRETCH TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
Dermatological - Local Anesthetic Gas Single Agents - Drugs For The Skin		
<i>ethyl chloride topical aerosol,spray 100 %</i>	Tier 1	
Dermatological - Miscellaneous Single Agents - Drugs For The Skin		
NEURAPTINE TOPICAL CREAM IN PACKET 10 % (gabapentin)	Tier 3	
NEURAPTINE TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (gabapentin)	Tier 3	
<i>sodium chloride topical solution 0.9 %</i>	Tier 1	
Dermatological - Nsaid And Local Anesthetic Combination - Drugs For The Skin		
DICLOVIX TOPICAL KIT, PATCH, SOLUTION DROPS 1.5-2.5-4-2 % (diclofenac sodium/lidocaine/methyl salicylate/camphor)	Tier 3	
TRIXYLITRAL TOPICAL KIT, CREAM AND SOLUTION 1.5-3.88 % (diclofenac sodium/lidocaine HCl/kinesiology tape)	Tier 3	
Dermatological - Nsaid Combinations - Drugs For The Skin		
diclofenac sodium/capsaicin (Capsfenac Pak Topical Kit, Cream And Solution 1.5-0.025 %)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAPSINAC TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DERMACINRX LEXITRAL TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOFEX DC TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
diclofenac sodium/capsaicin (Dicloheal-60 Topical Kit, Cream And Solution 1.5-0.025 %)	Tier 3	
DICLOPAK TOPICAL KIT, CREAM AND SOLUTION 1.5-0.025 % (diclofenac sodium/capsaicin)	Tier 3	
DICLOPR TOPICAL COMBO PACK,CREAM AND GEL 1-30-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	
DICLOTAL TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOTREX TOPICAL KIT 1.5-10-4 % (diclofenac sodium/menthol/camphor)	Tier 3	
DICLOVIX M TOPICAL KIT 1.5-8 % (diclofenac sodium/menthol/kinesiology tape)	Tier 3	
DIMENTHO TOPICAL KIT 1.5-10 % (diclofenac sodium/menthol/kinesiology tape)	Tier 3	
DITHOL TOPICAL COMBO PACK 1.5-10 % (diclofenac sodium/menthol)	Tier 3	
INFLAMMA-K TOPICAL KIT, PATCH, SOLUTION DROPS 1.5-10-6-3.1 % (diclofenac sodium/methyl salicylate/menthol/camphor)	Tier 3	
KAPZIN DC TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUDICLO SOLUPAK TOPICAL KIT, CREAM AND SOLUTION 1.5-0.025 % (diclofenac sodium/capsaicin)	Tier 3	
PENNSAICIN TOPICAL KIT, CREAM AND SOLUTION 1.5-0.025 % (diclofenac sodium/capsaicin)	Tier 3	
ROAOXIA TOPICAL GEL 3-2-4 % (diclofenac sodium/hyaluronate sodium/niacinamide)	Tier 3	
SURE RESULT DSS PREMIUM PACK TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
VAROPHEN (DICLOFENAC) TOPICAL KIT, CREAM AND SOLUTION 1.5-15-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	
XELITRAL TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
ZICLOPRO TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
Dermatological - Nsaid Single Agents - Drugs For The Skin		
CLOFENAX TOPICAL KIT 1.5 % (diclofenac sodium/kinesiology tape)	Tier 3	
DICLO GEL TOPICAL KIT 1 % (diclofenac sodium)	Tier 3	
DICLO GEL-XRYLIX SHEET TOPICAL KIT 1 % (diclofenac sodium/kinesiology tape)	Tier 3	
<i>diclofenac epolamine transdermal patch 12 hour 1.3 %</i>	Tier 1	
<i>diclofenac sodium topical drops 1.5 %</i>	Tier 1	
<i>diclofenac sodium topical gel 1 %</i>	Tier 1	
DICLOFONO TOPICAL GEL IN PACKET 1.6 % (diclofenac sodium)	Tier 3	
DICLOZOR TOPICAL KIT 1 % (diclofenac sodium)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FROTEK TOPICAL CREAM IN PACKET 10 % (ketoprofen)	Tier 3	
FROTEK TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (ketoprofen, micronized)	Tier 3	
LEXIXRYL TOPICAL KIT 1.5 % (diclofenac sodium/kinesiology tape)	Tier 3	
LICART TRANSDERMAL PATCH 24 HOUR 1.3 % (diclofenac epolamine)	Tier 3	ST: Must meet the following requirement: Diclofenac Epolamine patch in 120 days; QL (1 EA per 1 day)
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %) (diclofenac sodium)	Tier 3	ST: Must meet the following requirement: Diclofenac Sodium in 120 days
PENNSAID TOPICAL SOLUTION IN PACKET 2 % (diclofenac sodium)	Tier 3	ST: Must meet the following requirement: Diclofenac Sodium in 120 days
VENNGEL ONE TOPICAL KIT 1 % (diclofenac sodium)	Tier 1	
XRYLIX (DICLOFENAC-KINES TAPE) TOPICAL KIT 1.5 % (diclofenac sodium/kinesiology tape)	Tier 3	
Dermatological - Photodynamic Therapy Agents Topical - Drugs For The Skin		
AMELUZ TOPICAL GEL 10 % (aminolevulinic acid HCl)	Tier 3	
LEVULAN TOPICAL SOLUTION 20 % (aminolevulinic acid HCl)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Protectant Combinations - Drugs For The Skin		
BEAU RX TOPICAL GEL (dimethyl siloxane/dimethicone/hexamethyldisiloxane)	Tier 3	ST: Must meet the following requirement: Kelo-cote or Recedo in 120 days; QL (30 GM per 30 days)
HYGEL TOPICAL GEL 2.5 % (hyaluronate sodium/hydroxyethylcellulose/polyethylene glycol)	Tier 3	
KELARX TOPICAL GEL (dimethicone/dimethicone crosspolymer/trimethylsiloxysilicate)	Tier 3	
PR CREAM TOPICAL CREAM (protectives combination no.2/ceramides 1,3,6-II)	Tier 1	
PROSILK GEL TOPICAL GEL (protectives combination no.6)	Tier 3	
RADIAPLEXRX TOPICAL GEL (hyaluronate sodium/allantoin/aloe vera extract)	Tier 3	
RECEDO TOPICAL GEL (polydimethylsiloxanes/silicon dioxide)	Tier 3	
SCARCIN GEL TOPICAL GEL (protectives combination no.6)	Tier 3	
SCARCIN ROLL-ON TOPICAL LIQUID ROLL-ON (protectives combination no.5)	Tier 3	
SCARSILK GEL TOPICAL GEL (protectives combination no.6)	Tier 3	
SILIPAC TOPICAL KIT (dimethicone/dimethicone crossp/trimethylsil/silicone gel pad)	Tier 3	
WOUNDGELHA MATRIX TOPICAL GEL 2.5 % (hyaluronate sodium/hydroxyethylcellulose/polyethylene glycol)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Protectants - Drugs For The Skin		
BIONECT TOPICAL CREAM 0.2 % (hyaluronate sodium)	Tier 3	
BIONECT TOPICAL FOAM 0.2 % (hyaluronate sodium)	Tier 3	
BIONECT TOPICAL GEL 0.2 % (hyaluronate sodium)	Tier 3	
DERMELLE TOPICAL GEL (dimethicone)	Tier 3	
DERPIXA TOPICAL GEL (dimethicone)	Tier 3	
NUVAIL TOPICAL NAIL FILM SOLUTION 16 % (poly-ureaurethane)	Tier 3	
PHARMABASE BARRIER TOPICAL OINTMENT 9.38 % (zinc oxide)	Tier 3	
SCARCARE TOPICAL KIT 2 X 5.5 " (gel-matrix pad,silicone-dimethicone-dime-decameoct-oct-vit E)	Tier 3	
STRATAMARK TOPICAL GEL (dimethicone)	Tier 3	
STRATATRIZ TOPICAL GEL (dimethicone)	Tier 3	
TETRIX TOPICAL CREAM (protectives combination no.2)	Tier 3	
VASELINE WHITE PETROLEUM TOPICAL OINTMENT IN PACKET (petrolatum,white)	Tier 3	
<i>zinc oxide topical ointment 20 %</i>	Tier 3	
<i>zinc oxide topical paste 25 %</i>	Tier 3	
Dermatological - Rosacea Therapy, Systemic - Drugs For The Skin		
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg</i>	Tier 1	ST: Must meet the following requirement: generic Doxycycline Monohydrate 50mg capsules in 120 days; QL (1 EA per 1 day); Age (Min 18 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Rosacea Therapy, Topical - Drugs For The Skin		
AVEIDAOXIA TOPICAL GEL 1-1-4 % (ivermectin/metronidazole/niacinamide)	Tier 3	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 % (sulfacetamide sodium/sulfur/urea)	Tier 1	
FINACEA TOPICAL FOAM 15 % (azelaic acid)	Tier 2	
<i>metronidazole topical cream 0.75 %</i>	Tier 1	
<i>metronidazole topical gel 0.75 %, 1 %</i>	Tier 1	
<i>metronidazole topical gel with pump 1 %</i>	Tier 1	
<i>metronidazole topical lotion 0.75 %</i>	Tier 1	
MIRVASO TOPICAL GEL WITH PUMP 0.33 % (brimonidine tartrate)	Tier 3	
NORITATE TOPICAL CREAM 1 % (metronidazole)	Tier 3	ST: Must meet the following requirement: Generic Metronidazole 0.75% (gel, lotion, cream) in 120 days
RHOFADE TOPICAL CREAM 1 % (oxymetazoline HCl)	Tier 3	
<i>metronidazole (Rosadan Topical Cream 0.75 %)</i>	Tier 1	
ROSDAN TOPICAL KIT, CLEANSER AND GEL 0.75 % (metronidazole/skin cleanser combination no.23)	Tier 3	
ROSDAN TOPICAL KIT, CLEANSER AND CREAM 0.75 % (metronidazole/skin cleanser combination no.23)	Tier 3	
SOOLANTRA TOPICAL CREAM 1 % (ivermectin)	Tier 1	ST: Must meet the following requirement: Finacea gel or foam in 120 days
<i>sulfacetamide sod-sulfur-urea topical cleanser 10-5-10 %</i>	Tier 1	QL (1419 ML per 1 FILL)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUMADAN XLT TOPICAL COMBO PACK,CLEANSER AND CREAM 9 %-4.5 % -SPF 25 (sulfacetamide sodium/sulfur/avobenzone/octinoxate/octyl sal)	Tier 3	
ZILXI TOPICAL FOAM 1.5 % (minocycline HCl)	Tier 3	ST: Must meet the following requirement: Generic Metronidazole 0.75% (gel, lotion, cream) in 120 days; QL (30 GM per 30 days)
Dermatological - Soap And/Or Cleanser Combinations - Drugs For The Skin		
SAF-CLENS AF DERMAL WOUND TOPICAL CLEANSER (skin cleanser)	Tier 3	
Dermatological - Sunscreens - Drugs For The Skin		
CERAVE AM TOPICAL LOTION 30 SPF (homosalate/meradimate/octinoxate/octocrylene/zinc oxide)	Tier 3	
Dermatological - Tissue/Wound Adhesives - Fibrin Sealants - Drugs For The Skin		
ARTISS TOPICAL SYRINGE 2.5 TO 6.5 UNIT/ML (10ML), 2.5 TO 6.5 UNIT/ML (2 ML), 2.5 TO 6.5 UNIT/ML (4 ML) (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	
TISSEEL VHSD (APROTININ, SYN) TOPICAL KIT 10 ML, 2 ML, 4 ML (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	
TISSEEL VHSD (APROTININ, SYN) TOPICAL SYRINGE 10 ML, 2 ML, 4 ML (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Topical Local Anesthetic Amides - Drugs For The Skin		
ANASTIA TOPICAL LOTION 2.75 % (lidocaine HCl)	Tier 3	
ASTERO TOPICAL GEL WITH PUMP 4 % (lidocaine HCl)	Tier 3	
DERMACINRX LIDOGEL TOPICAL GEL 2.8 % (lidocaine HCl)	Tier 3	
DERMALID TOPICAL COMBO PACK 5 % (lidocaine/elastic bandage)	Tier 1	
FORAXA TOPICAL GEL 2 %-1 % -1.2 % (lidocaine HCl/aloe vera/collagen,bovine)	Tier 3	
lidocaine HCl (Glydo Mucous Membrane Jelly In Applicator 2 %)	Tier 1	
L.E.T. (LIDO-EPINEPH-TETRA) TOPICAL GEL 4-0.05-0.5 % (lidocaine HCl/racepinephrine HCl/tetracaine HCl)	Tier 3	
L.E.T. (LIDO-EPINEPH-TETRA) TOPICAL SOLUTION 4-0.05-0.5 % (lidocaine HCl/racepinephrine HCl/tetracaine HCl)	Tier 3	
L.E.T.(LIDO-EPINEPH BIT-TETRA) TOPICAL GEL 4-0.18-0.5 % (lidocaine HCl/epinephrine bitartrate/tetracaine HCl)	Tier 3	
LDO PLUS TOPICAL GEL WITH PUMP 4 % (lidocaine HCl)	Tier 3	
<i>lidocaine hcl mucous membrane jelly 2 %</i>	Tier 1	
<i>lidocaine hcl mucous membrane jelly in applicator 2 %</i>	Tier 1	
<i>lidocaine hcl topical cream 3 %, 3.88 %</i>	Tier 1	
<i>lidocaine hcl topical lotion 3 %</i>	Tier 1	
<i>lidocaine topical adhesive patch,medicated 5 %</i>	Tier 1	QL (90 EA per 30 days)
<i>lidocaine-racepinep-tetracaine topical solution 4-0.05-0.5 %</i>	Tier 3	
<i>lidocaine-tetracaine topical cream 7-7 %</i>	Tier 1	
LIDOPAC TOPICAL KIT 5 % (lidocaine)	Tier 3	
LIDOPIN TOPICAL CREAM 3.25 % (lidocaine HCl)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIDOPURE PATCH TOPICAL COMBO PACK 5 % (lidocaine/kinesiology tape)	Tier 1	
LIDORX TOPICAL GEL WITH PUMP 3 % (lidocaine HCl)	Tier 3	
LIDOTRANS 5 PAK TOPICAL KIT 5 %- 6 CM X 7 CM (lidocaine/transparent dressing)	Tier 3	
LIDOTREX (WITH VITAMIN E) TOPICAL GEL 2 % (vitamin E/lidocaine/aloe vera/collagen)	Tier 3	
LIDOTREX TOPICAL GEL 2 %-1 % -1.2 % (lidocaine HCl/aloe vera/collagen,bovine)	Tier 3	
LIDOVEX TOPICAL CREAM 3.75 % (lidocaine)	Tier 3	
LIDTOPIC MAX TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (lidocaine HCl)	Tier 3	
NUMBONEX TOPICAL LOTION 2.75 % (lidocaine HCl)	Tier 3	
REGENECARE TOPICAL GEL 2 % (lidocaine HCl/collagen)	Tier 3	
REGENECARE WITH ALOE TOPICAL GEL 2 % (vitamin E/lidocaine/aloe vera/collagen)	Tier 3	
SUVICORT TOPICAL GEL 2 %-1 % -1 % (lidocaine HCl/aloe vera/collagen,bovine)	Tier 3	
SYNERA TOPICAL PATCH, MEDICATED SELF-HEATING 70-70 MG (lidocaine/tetracaine)	Tier 3	
TRANZAREL TOPICAL GEL 4 % (lidocaine)	Tier 3	
VEXASYN TOPICAL GEL 2 %-1 % -1.2 % (lidocaine HCl/aloe vera/collagen,bovine)	Tier 3	
XRYLIDERM TOPICAL KIT 5 % (lidocaine/kinesiology tape)	Tier 3	
ZEYOCAINE TOPICAL KIT, OINTMENT AND TAPE 5 % (lidocaine/kinesiology tape)	Tier 3	
ZILACAINE PATCH TOPICAL COMBO PACK 5 % (lidocaine/silicone, adhesive)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED 1.8 % (lidocaine)	Tier 3	ST: Must meet the following requirement: Lidocaine 5% patch in 120 days; QL (90 EA per 30 days)
Dermatological - Topical Local Anesthetic Esters - Drugs For The Skin		
ANACAINE TOPICAL OINTMENT 10 % (benzocaine)	Tier 3	
PONTOCAINE TOPICAL SOLUTION 2 % (tetracaine HCl)	Tier 3	
Dermatological - Topical Local Anesthetics And Combinations - Drugs For The Skin		
DERMACINRX PHN PAK TOPICAL KIT, PATCH, MEDICATED, CREAM 5 % (lidocaine/emollient combination no.102)	Tier 3	
DERMACINRX ZRM PAK TOPICAL KIT, PATCH, MEDICATED, CREAM 5-5 % (lidocaine/dimethicone)	Tier 3	
DERMAZYL KIT TOPICAL KIT, PATCH, MEDICATED, CREAM 5-5 % (lidocaine/dimethicone)	Tier 3	
NEURCAINE TOPICAL KIT, PATCH, MEDICATED, CREAM 5 % (lidocaine/emollient combination no.102)	Tier 3	
PRILO PATCH II TOPICAL KIT, PATCH, MEDICATED, CREAM 5-2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
PRILO PATCH TOPICAL KIT, PATCH, MEDICATED, CREAM 5-2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
Dermatological Antipruritics - Antihistamines - Drugs For The Skin		
<i>doxepin topical cream 5 %</i>	Tier 1	ST: Must meet the following requirement: Topical Anti-inflammatory Steroidal in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological Antipruritics Other - Drugs For The Skin		
LEVICYN ANTIPRURITIC TOPICAL GEL (sod Mg fluo/sodium phos/NaCl/hypochlorous acid/sod hypochlor)	Tier 3	
Dermatological Irritants-Counter-Irritant Combinations - Drugs For The Skin		
CHEST RUB (WITH PINE OIL) TOPICAL OINTMENT (eucalyptus oil/lavender oil/pine needle oil/beeswax)	Tier 3	
Dermatological Irritants-Counter-Irritant Single Agents - Drugs For The Skin		
<i>methyl salicylate oil</i>	Tier 1	
<i>methyl salicylate topical liquid</i>	Tier 1	
QUTENZA TOPICAL KIT 8 % (capsaicin/skin cleanser)	Tier 3	PA
WINTERGREEN OIL OIL (methyl salicylate)	Tier 3	
Human Cellular Regenerative Tissue Matrix - Drugs For The Skin		
EPIFIX AMNIOTIC MEMBRANE TOPICAL SHEET 14 MM, 2 X 3 CM, 4 X 4 CM, 5 X 6 CM, 7 X 7 CM (human regenerative tissue matrix)	Tier 3	
GRAFIX CORE TOPICAL SHEET 1.5 X 2 CM, 14 MM, 16 MM, 2 X 3 CM, 3 X 4 CM, 5 X 5 CM (human regenerative tissue matrix)	Tier 3	
GRAFIX PRIME TOPICAL SHEET 1.5 X 2 CM, 14 MM, 16 MM, 2 X 3 CM, 3 X 4 CM, 5 X 5 CM (human regenerative tissue matrix)	Tier 3	
GRAFIX XC TOPICAL SHEET 7.5 X 15 CM (human regenerative tissue matrix)	Tier 3	
STRAVIX TOPICAL SHEET 2 X 4 CM, 3 X 6 CM (human regenerative tissue matrix)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSKIN TOPICAL SHEET 2 X 4 CM, 4 X 8 CM (human regenerative tissue matrix)	Tier 3	
Nail Protectives - Drugs For The Skin		
GENADUR (WITH LEXINAL) KIT 2,500 MCG (biotin/carbitol/equisetum xt/ethanol/hydroxypropyl chito/msm)	Tier 3	
GENADUR TOPICAL LIQUID (carbitol/equisetum ext/ethanol/hydroxypropyl chitosan/msm)	Tier 3	
Ovine (Sheep) Skin Dressings, Non-Living - Drugs For The Skin		
KERAMATRIX TOPICAL SHEET 2 X 2 ", 4 X 4 " (tissue matrix, keratin-based, ovine derived)	Tier 3	
Porcine Skin Dressings, Non-Living - Drugs For The Skin		
MATRISTEM MICROMATRIX TOPICAL POWDER 100 MG, 20 MG, 200 MG, 30 MG, 60 MG (extracellular matrix (ecm), porcine derived)	Tier 3	
MATRISTEM TOPICAL SHEET 10 X 15 CM, 3 X 3 1/2 CM, 3 X 7 CM, 7 X 10 CM (extracellular matrix (ECM),porcine derived, fenestrated)	Tier 3	
Scabicide And Pediculicide Single Agents - Drugs For The Skin		
crotamiton (Crotan Topical Lotion 10 %)	Tier 3	
EURAX TOPICAL CREAM 10 % (crotamiton)	Tier 3	
EURAX TOPICAL LOTION 10 % (crotamiton)	Tier 3	
LICE-BEDBUG-MITE BEDDING AEROSOL, SPRAY 0.5 % (permethrin)	Tier 3	
<i>lindane topical shampoo 1 %</i>	Tier 1	
<i>malathion topical lotion 0.5 %</i>	Tier 1	
<i>permethrin topical cream 5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>spinosad topical suspension 0.9 %</i>	Tier 1	
ULESFIA TOPICAL LOTION 5 % (benzyl alcohol)	Tier 3	
Skin Replacement, Live Tissue Dressings - Drugs For The Skin		
APLIGRAF TOPICAL DISK (cultured skin substitute,human and bovine)	Tier 3	
DERMAGRAFT TOPICAL SHEET 2 X 3 " (cultured skin substitute,human and bovine)	Tier 3	
OASIS ULTRA FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX MESHED TOPICAL SHEET 5 X 7 CM, 7 X 10 CM, 7 X 20 CM (porcine acell submucosa,meshed)	Tier 3	
Wound Care - Cleanser Combinations - Drugs For The Skin		
ATRAPRO DERMAL SPRAY TOPICAL SPRAY, NON-AEROSOL 0.003-0.004 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
DELUO TOPICAL SPRAY, NON-AEROSOL 0.018 %-0.004 % -0.06 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
EPICYN TOPICAL SPRAY, NON-AEROSOL (hypochlorous acid/sodium chloride/sodium phosphate)	Tier 3	
LEVICYN DERMAL TOPICAL SPRAY, NON-AEROSOL 0.009 % (hypochlorous acid/sod chlor/sod sulfate/sod phosphate,mono)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICROCYN TOPICAL SPRAY, NON-AEROSOL 0.003 %-0.004 % -0.023 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
Wound Care - Cleansers - Drugs For The Skin		
VASHE WOUND THERAPY IRRIGATION IRRIGATION SOLUTION 0.033 % (sodium chloride irrigating solution/hypochlorous acid)	Tier 3	
Wound Care - Dressings - Drugs For The Skin		
ACESO AG TOPICAL BANDAGE 4 X 4 " (silver/silicone/foam bandage)	Tier 3	
ACTICOAT 7 DRESSING TOPICAL BANDAGE 2 X 2 ", 4 X 5 ", 6 X 6 " (silver)	Tier 3	
ACTICOAT DRESSING TOPICAL BANDAGE 16 X 16 ", 2 X 2 ", 4 X 4 ", 4 X 48 ", 4 X 8 ", 5 X 5 ", 8 X 16 " (silver)	Tier 3	
ACTICOAT FLEX 3 DRESSING TOPICAL BANDAGE 16 X 16 ", 2 X 2 ", 4 X 4 ", 4 X 48 ", 4 X 8 ", 8 X 16 " (silver)	Tier 3	
ACTICOAT FLEX 7 DRESSING TOPICAL BANDAGE 1 X 24 ", 16 X 16 ", 2 X 2 ", 4 X 5 ", 6 X 6 ", 8 X 16 " (silver)	Tier 3	
ACTICOAT SURGICAL DRESSING TOPICAL BANDAGE 4 X 10 ", 4 X 13 3/4 ", 4 X 4 3/4 ", 4 X 8 " (silver/foam bandage)	Tier 3	
ALLEVYN ADHESIVE DRESSING TOPICAL BANDAGE 3 X 3 ", 5 X 5 ", 7 X 7 ", 9 X 9 " (foam bandage)	Tier 3	
ALLEVYN AG ADHESIVE TOPICAL BANDAGE 5 %- 3" X 3", 5 %- 5" X 5", 5 %- 7" X 7" (silver sulfadiazine/foam bandage)	Tier 3	
ALLEVYN AG GENTLE DRESSING TOPICAL BANDAGE 5 %- 2" X 2", 5 %- 4" X 4", 5 %- 6" X 6", 5 %- 8" X 8" (silver sulfadiazine/foam bandage)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLEVYN AG TOPICAL BANDAGE 5 %- 2" X 2", 5 %- 4" X 4", 5 %- 6" X 6", 5 %- 8" X 8" (silver sulfadiazine/foam bandage)	Tier 3	
ALLEVYN HEEL TOPICAL BANDAGE 4 1/2 X 5 1/2 " (foam bandage)	Tier 3	
ALLEVYN LIFE DRESSING TOPICAL BANDAGE 4 X 4 ", 5 1/16 X 5 1/16 ", 6 1/16 X 6 1/16 ", 8 1/4 X 8 1/4 " (foam bandage)	Tier 3	
ALLEVYN TOPICAL BANDAGE 2 X 2 ", 4 X 4 ", 6 X 6 ", 8 X 8 " (foam bandage)	Tier 3	
BIOSTEP AG TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/silver/sodium alginate/carboxymethylcellulose)	Tier 3	
BIOSTEP TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/sodium alginate/carboxymethylcellulose)	Tier 3	
CARRASYN HYDROGEL WOUND DRESS TOPICAL GEL (gel dressing)	Tier 3	
COLLATYL TOPICAL GEL 1 % (collagen, hydrolyzed (bovine), type 1/silver oxide)	Tier 3	
CURAFIL GEL WOUND TOPICAL GEL (gel dressing)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL SPONGE 0.2 %- 2" X 2" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL STRIP 0.2 %- 1/2" X 3 FEET (polyhexamethylene biguanide/gauze bandage)	Tier 3	
KERAGEL TOPICAL GEL (gel dressing)	Tier 3	
KERAGELT TOPICAL GEL (gel dressing)	Tier 3	
KERLIX AMD TOPICAL BANDAGE 0.2 %- 4.5" X 4.1 YARD (polyhexamethylene biguanide/gauze bandage)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERLIX AMD TOPICAL SPONGE 0.2 %- 6" X 6.75" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
MEDIHONEY (CAL ALGINATE-HONEY) TOPICAL BANDAGE 2 X 2 ", 3/4 X 12 ", 4 X 5 " (calcium alginate/honey)	Tier 3	
MEDIHONEY (HONEY) TOPICAL GEL 80 % (honey)	Tier 3	
MEDIHONEY (HONEY) TOPICAL PASTE 100 % (honey)	Tier 3	
MEDIHONEY (HYDROCOLLOID-HONEY) TOPICAL BANDAGE 2 X 2 ", 4 X 5 " (honey/hydrocolloid dressing)	Tier 3	
PROTYL AG TOPICAL GEL 1 % (collagen, hydrolyzed (bovine), type 1/silver oxide)	Tier 3	
REPLICARE DRESSING TOPICAL BANDAGE 1 1/2 X 2 1/2 ", 4 X 4 ", 6 X 6 ", 8 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE THIN TOPICAL BANDAGE 2 X 2 3/4 ", 3 1/2 X 5 1/2 ", 6 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE ULTRA DRESSING TOPICAL BANDAGE 4 X 4 ", 6 X 6 ", 7 X 8 " (hydrocolloid dressing)	Tier 3	
RESTORE CALCIUM ALGINATE TOPICAL BANDAGE 4 X 4 3/4 " (silver/calcium alginate)	Tier 3	
RESTORE TOPICAL BANDAGE 1 X 12 ", 2 X 2 " (silver/calcium alginate)	Tier 3	
SPECTRAGEL TOPICAL GEL (gel dressing)	Tier 3	
STRATACTX TOPICAL GEL (gel dressing)	Tier 3	
STRATAGRT TOPICAL GEL (gel dressing)	Tier 3	
STRATAXRT TOPICAL GEL (gel dressing)	Tier 3	
Wound Care - Growth Factor Agents - Drugs For The Skin		
REGRANEX TOPICAL GEL 0.01 % (becaplermin)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Wound Care Combinations Other - Drugs For The Skin		
<i>balsam peru-castor oil topical ointment</i>	Tier 1	
BPCO TOPICAL OINTMENT (balsam peru/castor oil)	Tier 1	
DERMACINRX CLORHEXACIN TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMACINRX SURGICAL PHARMAPAK TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMAWERX SURGICAL PLUS PAK TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMULCERA TOPICAL OINTMENT (balsam peru/castor oil)	Tier 3	
LEVICYN ANTIPRURITIC TOPICAL GEL (sod Mg fluo/sodium phos/NaCl/hypochlorous acid/sod hypochlor)	Tier 3	
NUSURGEPAK SURGICAL PREP TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
VENELEX TOPICAL OINTMENT (balsam peru/castor oil)	Tier 3	
VENELEX TOPICAL OINTMENT IN PACKET (balsam peru/castor oil)	Tier 3	
WHYTEDERM SURGIPAK TOPICAL KIT 2-4-2 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
Diagnostic Agents		
Diagnostic Radiopharmaceuticals - Endocrine		
<i>sodium iodide-123 oral capsule 3.7 mbq (100 microci), 7.4 mbq (200 microci)</i>	Tier 1	
<i>sodium iodide-131 oral capsule 3.7 mbq (100 microci)</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Drugs To Treat Erectile Dysfunction - Drugs For The Urinary System		
Erectile Dysfunction (Ed) Drugs-Sel.Cgmp Phosphodiesterase Type5 Inhib - Drugs For Erectile Dysfunction		
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	PA
Eating Disorder Therapy - Drugs For Eating Disorders		
Appetite Stimulants - Cannabinoids - Drugs For Eating Disorders		
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Appetite Stimulants - Progestin Hormone Type - Drugs For Eating Disorders		
<i>megestrol oral suspension 400 mg/10 ml (10 ml)</i>	Tier 1	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	Tier 1	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 1	ST: Must meet the following requirement: Megestrol Acetate 40mg/mL suspension in 120 days
Electrolyte Balance-Nutritional Products - Drugs For Nutrition		
Amino Acid - Carnitine Derivatives - Drugs For Nutrition		
<i>levocarnitine oral tablet 330 mg</i>	Tier 1	
Amino Acids, Single Ingredient, Oral (Non-Injectable) - Drugs For Nutrition		
ENDARI ORAL POWDER IN PACKET 5 GRAM (glutamine)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lysine hcl oral capsule 500 mg</i>	Tier 3	
<i>lysine hcl oral tablet 500 mg</i>	Tier 3	
N.O.MAX ER ORAL TABLET EXTENDED RELEASE 660 MG (arginine oxoglurate)	Tier 3	
B-Complex Vitamin Combinations - Drugs For Nutrition		
<i>b complex-vitamin c-folic acid oral tablet 400 mcg</i>	Tier 1	
BALANCED B-50 COMPLEX (FOLIC) ORAL TABLET 50 MCG (vitamin B complex/folic acid)	Tier 3	
<i>b-complex with vitamin c oral tablet</i>	Tier 1	
FOLIKA-NC ORAL TABLET 1 MG-100 MG- 300 MCG (vitamin B complex/folic acid/ascorbic acid/biotin)	Tier 3	
MULTIVITAMIN-ZINC-STRESS ORAL TABLET 500 MG-400 MCG- 23.9 MG-3 MG (B comp/C/folic acid/zinc sulfate/cupric sulfate/vitamin E ac)	Tier 3	
MYNEPHRON ORAL CAPSULE 1 MG (vitamin B complex and vitamin C no.20/folic acid)	Tier 3	
NEPHRON FA ORAL TABLET 66 MG IRON- 1,000 MCG (vit B complex and vit C no.24/ferrous fumarate/folic acid)	Tier 3	
STRESSTABS ENERGY ORAL TABLET 120 MG-400 MCG- 62.5 MG (vit B comp/vit C/folic ac/arginine/glutamine/taurine/ashwag)	Tier 3	
ULTRA B-100 COMPLEX (FOODBASE) ORAL TABLET 400 MCG-100MCG- 100 MCG (vit B complex/folic acid/choline bitartrate/inositol/herbs)	Tier 3	
B-Complex Vitamins - Drugs For Nutrition		
B COMPLEX 100 INJECTION SOLUTION 100-2-100-2-2 MG/ML (thiamine HCl/riboflavin/niacinamide/dexpanthenol/pyridoxine)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
B-COMPLEX INJECTION INJECTION SOLUTION 100-2-100-2-2 MG/ML (thiamine HCl/riboflavin/niacinamide/dexpanthenol/pyridoxine)	Tier 1	
Bioflavonoid Combinations - Drugs For Nutrition		
BIO C 1:1 ORAL CAPSULE 500-500 MG (ascorbic acid/bioflavonoids)	Tier 3	
Dietary Product - Infant Formulas - Drugs For Nutrition		
PHENEX-1 ORAL POWDER 15 GRAM-480 KCAL/100 GRAM (infant formula for PKU, iron, no.2)	Tier 3	
Dietary Product - Sweeteners - Drugs For Nutrition		
DANDLELION KISSES ORAL DROPS 24 % (sucrose)	Tier 3	
saccharin powder	Tier 3	
Diluents - Insulin Diluting Solutions - Drugs For Nutrition		
DILUTING MEDIUM FOR NOVOLOG INJECTION SOLUTION (diluent,insulin aspart combination no.1)	Tier 3	
Diluents - Others - Drugs For Nutrition		
STERILE HYDROGEL FOR JELMYTO INTRA-PYELOCALYCEAL SOLUTION (diluent for mitomycin (hydroxypropyl,poloxam,polyethyl))	Tier 3	
Diluents - Sodium Chloride - Drugs For Nutrition		
sodium chlor 0.9% bacteriostat injection solution 0.9 %	Tier 1	
sodium chloride 0.9 % injection solution	Tier 1	
sodium chloride injection syringe 0.9 %	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diluents - Vaccine Diluents - Drugs For Nutrition		
DILUENT FOR ROTARIX ORAL SYRINGE (diluent for oral live rotavirus vaccine (calcium carbonate))	Tier 3	
Electrolyte Depleters - Ion Exchange Resin - Drugs For Nutrition		
LOKELMA ORAL POWDER IN PACKET 10 GRAM, 5 GRAM (sodium zirconium cyclosilicate)	Tier 2	
<i>sodium polystyrene sulfonate oral powder</i>	Tier 1	
sodium polystyrene sulfonate/sorbitol solution (Sps (With Sorbitol) Oral Suspension 15-20 Gram/60 ML)	Tier 1	
SPS (WITH SORBITOL) RECTAL ENEMA 30-40 GRAM/120 ML (sodium polystyrene sulfonate/sorbitol solution)	Tier 3	
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 25.2 GRAM, 8.4 GRAM (patiromer calcium sorbitex)	Tier 3	PA
Geriatric Vitamins - Drugs For Nutrition		
ELDERTONIC ORAL LIQUID 3.6 MG-0.75 MG /15 ML (vitamin B complex/zinc sulfate/manganese sulfate)	Tier 3	
Irrigation Solutions - Drugs For Nutrition		
AQUA CARE SODIUM CHLORIDE IRRIGATION SOLUTION 0.9 % (sodium chloride irrigating solution)	Tier 1	
AQUA CARE STERILE WATER IRRIGATION SOLUTION (water for irrigation,sterile)	Tier 1	
<i>lactated ringers irrigation solution</i>	Tier 3	
PHYSIOLYTE IRRIGATION SOLUTION 140-5-3-98 MEQ/L (physiological irrigating solution no.1)	Tier 3	
PHYSIOSOL IRRIGATION IRRIGATION SOLUTION 140-5-3-98 MEQ/L (physiological irrigating solution no.1)	Tier 3	
<i>ringer's irrigation solution</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium chloride irrigation solution 0.9 %</i>	Tier 1	
TIS-U-SOL PENTALYTE IRRIGATION IRRIGATION SOLUTION 800-40-20-8.75- 6.25 MG/100 ML (sodium chloride/pot chloride/mag sul/sod phos,db/pot phos,mb)	Tier 3	
<i>water for irrigation, sterile irrigation solution</i>	Tier 1	
Minerals And Electrolytes - Calcium Replacement - Drugs For Nutrition		
<i>calcium acetate oral tablet 667 mg</i>	Tier 3	
<i>calcium carbonate oral tablet 500 mg calcium (1,250 mg), 600 mg calcium (1,500 mg)</i>	Tier 3	
<i>calcium citrate oral tablet 200 mg (950 mg)</i>	Tier 3	
OSSOPAN-1100 ORAL CAPSULE 275 MG CALCIUM (1,100 MG) (hydroxyapatite)	Tier 3	
OYSTER SHELL CALCIUM 500 ORAL TABLET 500 MG CALCIUM (1,250 MG) (calcium carbonate)	Tier 3	
Minerals And Electrolytes - Calcium Replacement Combinations - Drugs For Nutrition		
ALGAE BASED CALCIUM ORAL TABLET 333.33 MG-6.67 MCG-32 MG (calcium/vitamin D3/magnesium/vitamin K2/minerals/herb 326)	Tier 3	
<i>calc-d3-magnes-b6-zn-cu-mangan oral tablet 250 mg-400 unit -40 mg-5 mg</i>	Tier 3	
<i>calcium carb-mag ox-zinc sulf oral tablet 334-134-5 mg</i>	Tier 3	
<i>calcium-magnesium-vit d3-boron oral capsule 400 mg-133 mg- 6.67 mcg-1 mg</i>	Tier 3	
<i>calcium-vitamin d3-vitamin k oral tablet,chewable 650 mg-12.5 mcg-40 mcg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Minerals And Electrolytes - Calcium Replacement/Vitamin D Combinations - Drugs For Nutrition		
<i>calcium carbonate-vitamin d3 oral capsule 600 mg(1,500mg) -400 unit</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet 250-125 mg-unit, 500 mg(1,250mg) -125 unit, 500 mg(1,250mg) -200 unit, 500 mg(1,250mg) -400 unit, 500mg (1,250mg) -600 unit, 600 mg(1,500mg) -200 unit, 600 mg(1,500mg) -400 unit, 600 mg(1,500mg) -800 unit</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500 mg(1,250mg) -400 unit</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500-100 mg-unit</i>	Tier 3	
<i>calcium citrate-vitamin d3 oral tablet 200 mg-6.25 mcg (250 unit), 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 3	
<i>calcium phos,dibas-vitamin d3 oral tablet 100 mg calcium- 3 mcg</i>	Tier 3	
<i>calcium phosphate-vitamin d3 oral tablet,chewable 250 mg-10 mcg (400 unit)</i>	Tier 3	
UPCAL D ORAL POWDER IN PACKET 500 MG-12.5 MCG /5 GRAM (calcium citrate/cholecalciferol (vitamin D3))	Tier 3	
YOGURT PLUS CALCIUM GUMMIES ORAL TABLET,CHEWABLE 250 MG-2.5 MCG (100 UNIT) (calcium phosphate, tribasic/cholecalciferol (vitamin D3))	Tier 3	
Minerals And Electrolytes - Drugs For Nutrition		
MOVE FREE ULTRA FASTER COMFORT ORAL TABLET 216 MG (calcium fructoborate)	Tier 3	
Minerals And Electrolytes - Iodine - Drugs For Nutrition		
LUGOLS ORAL SOLUTION 5 % (potassium iodide/iodine)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SSKI ORAL SOLUTION 1 GRAM/ML (potassium iodide)	Tier 1	
STRONG IODINE ORAL SOLUTION 5 % (potassium iodide/iodine)	Tier 1	
Minerals And Electrolytes - Iron - Drugs For Nutrition		
ACCRUFER ORAL CAPSULE 30 MG (ferric maltol)	Tier 3	PA
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	QL (12 EA per 1 day)
CHILDREN'S IRON ORAL DROPS 15 MG IRON (75 MG)/ML (ferrous sulfate)	Tier 0	Age (Max 1 Years)
FERGON ORAL TABLET 225 MG (27 MG IRON) (ferrous gluconate)	Tier 3	
<i>ferrous gluconate oral tablet 324 mg (37.5 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral drops 15 mg iron (75 mg)/ml</i>	Tier 0	Age (Max 1 Years)
<i>ferrous sulfate oral liquid 300 mg (60 mg iron)/5 ml</i>	Tier 3	
<i>ferrous sulfate oral solution 220 mg (44 mg iron)/5 ml</i>	Tier 3	
<i>ferrous sulfate oral tablet 325 mg (65 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral tablet, delayed release (dr/ec) 324 mg (65 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral tablet, delayed release (dr/ec) 325 mg (65 mg iron)</i>	Tier 3	
HEMATEX ORAL LIQUID 100 MG IRON/5 ML (iron polysaccharide complex)	Tier 3	
HEMATEX ORAL TABLET 150 MG IRON (iron polysaccharide complex)	Tier 3	
<i>iron bisglycinate chelate oral capsule 28 mg iron, 29 mg iron</i>	Tier 3	
NEONATAL FE ORAL TABLET 90 MG-120 MG-12 MCG-1,000 MCG (iron, carbonyl/ascorbic acid/cyanocobalamin/folic acid)	Tier 3	
NU-IRON ORAL CAPSULE 150 MG IRON (iron polysaccharide complex)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIA IRON ORAL DROPS 15 MG IRON (75 MG)/ML (ferrous sulfate)	Tier 0	Age (Max 1 Years)
PEDIATRIC FE-VITE ORAL DROPS 15 MG IRON (75 MG)/ML (ferrous sulfate)	Tier 0	Age (Max 1 Years)
<i>polysaccharide iron complex oral capsule 150 mg iron</i>	Tier 3	
SLOW RELEASE IRON ORAL TABLET EXTENDED RELEASE 143 MG (45 MG IRON) (ferrous sulfate)	Tier 3	
Minerals And Electrolytes - Iron Combinations - Drugs For Nutrition		
FERIVA 21-7 ORAL TABLET 75 MG IRON-175 MG-1 MG-12 MCG (iron asp gly/ascorbic acid/folate no.1/vit B12/zinc/succinic)	Tier 3	
FERIVA FA (WITH SUMALATE) ORAL CAPSULE 110 MG-175 MG- 1 MG-12 MCG (iron bisgly,aspart,fumarate/vit C/folate/B12/biotin/cupric)	Tier 3	
HEMATOGEN FORTE ORAL CAPSULE 460-60-0.01-1 MG (ferrous fumarate/ascorbic acid/cyanocobalamin/folic acid)	Tier 3	
HEMATOGEN ORAL CAPSULE 66 MG IRON- 250 MG-10 MCG (ferrous fumarate/ascorbic acid/cyanocobalamin)	Tier 3	
VIRT-FEFA PLUS ORAL CAPSULE 125 MG IRON- 1 MG (iron fumarate,polysac cplex/folic acid/vitB comp with C no.9)	Tier 3	
VITABEX IRON ORAL CAPSULE 65 MG IRON- 50 MG-1 MG DFE (iron bisglycinate/C/methylfolate/B12/L. acidoph,plant/inulin)	Tier 3	
Minerals And Electrolytes - Magnesium - Drugs For Nutrition		
<i>magnesium chloride oral tablet 64 mg magnesium</i>	Tier 3	
<i>magnesium citrate oral capsule 100 mg</i>	Tier 3	
MAGNESIUM COMPLEX ORAL TABLET 300 MG MAGNESIUM (magnesium carb,citrate,oxide)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>magnesium glycinate-mag oxide oral capsule 120 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral capsule 400 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral tablet 250 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral tablet 420 mg, 500 mg</i>	Tier 3	
Minerals And Electrolytes - Oral Electrolytes - Drugs For Nutrition		
CERASPORT ENDURANCE ORAL POWDER IN PACKET 400 MG-160 MG/42 GRAM (sodium chloride/potassium chloride/sodium citrate/rice/whey)	Tier 3	
CERASPORT PLUS ORAL POWDER IN PACKET 230 MG-85 MG- 120 KCAL/31GRAM (sodium chloride/potassium chloride/sodium citrate/rice syrup)	Tier 3	
ENSURE RAPID HYDRATION ORAL POWDER IN PACKET 30 MEQ-10 MEQ- 25 MEQ-11 GRAM (sodium/potassium/chloride/dextrose)	Tier 3	
HYDRALYTE ORAL SOLUTION (electrolytes/dextrose)	Tier 3	
ORALYTE ORAL SOLUTION (electrolytes/dextrose)	Tier 3	
PEDIALYTE SPARKLING RUSH ORAL POWDER EFFERVESCENT IN PACKET 28.3 MEQ-18.2 MEQ-16.6 MEQ (sodium/potassium/chloride/dextrose)	Tier 3	
Minerals And Electrolytes - Phosphate - Drugs For Nutrition		
<i>potassium, sodium phosphates oral powder in packet 280-160-250 mg</i>	Tier 3	
Minerals And Electrolytes - Potassium Combinations - Drugs For Nutrition		
<i>mag citrate-potassium citrate oral capsule 70-99 mg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Minerals And Electrolytes - Potassium, Oral - Drugs For Nutrition		
EFFER-K ORAL TABLET, EFFERVESCENT 10 MEQ, 20 MEQ (potassium bicarbonate/citric acid)	Tier 3	
EFFER-K ORAL TABLET, EFFERVESCENT 25 MEQ (potassium bicarbonate/citric acid)	Tier 1	
potassium chloride (Klor-Con M10 Oral Tablet,Er Particles/Crystals 10 Meq)	Tier 1	
potassium chloride (Klor-Con M15 Oral Tablet,Er Particles/Crystals 15 Meq)	Tier 1	
potassium chloride (Klor-Con M20 Oral Tablet,Er Particles/Crystals 20 Meq)	Tier 1	
<i>potassium chloride oral capsule, extended release 10 meq, 8 meq</i>	Tier 1	
<i>potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml</i>	Tier 1	
<i>potassium chloride oral packet 20 meq</i>	Tier 1	
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	Tier 1	
<i>potassium chloride oral tablet,er particles/crystals 10 meq, 15 meq, 20 meq</i>	Tier 1	
<i>potassium gluconate oral tablet 595 mg (99 mg)</i>	Tier 3	
Minerals And Electrolytes - Trace Minerals - Drugs For Nutrition		
<i>chromium picolinate oral tablet 200 mcg</i>	Tier 3	
Minerals And Electrolytes - Zinc - Drugs For Nutrition		
IS-ZC 50 ORAL TABLET 50 MG (zinc oxide-zinc citrate)	Tier 3	
PEPCIX ORAL TABLET,CHEWABLE 16 MG (polaprezinc (zinc carnosine))	Tier 3	
<i>zinc citrate oral tablet,chewable 16.7 mg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zinc gluconate oral tablet 50 mg</i>	Tier 3	
<i>zinc sulfate oral capsule 50 mg zinc (220 mg)</i>	Tier 3	
<i>zinc sulfate oral tablet 50 mg zinc (220 mg)</i>	Tier 1	
Minerals And Electrolytes - Zinc Combinations - Drugs For Nutrition		
<i>ascorbic acid-zinc oxide oral capsule 90-50 mg</i>	Tier 3	
Multivitamin And Mineral Combinations - Drugs For Nutrition		
ABC COMPLETE SENIOR WOMEN'S ORAL TABLET 8 MG IRON- 400 MCG-50 MCG (multivit-calc-min/ferrous fumarate/folic acid/vit K1/lutein)	Tier 3	
ADULT 50 PLUS EYE HEALTH ORAL CAPSULE 250-5-1 MG (vit C,E,zinc,copper 11/omega-3/dha/epa/fish/lutein/zeaxanth)	Tier 3	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
ADULTS 50 PLUS ORAL TABLET 0.4-300-250 MG-MCG-MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
ADULTS MULTIVITAMIN ORAL TABLET 18 MG IRON-400 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
ALIVE WOMEN'S 50 PLUS (BLEND) ORAL TABLET 240-120-300 MCG (multivit with minerals/folic/vit K/lutein/herbal complex 293)	Tier 3	
ALIVE WOMEN'S 50 PLUS ORAL TABLET,CHEWABLE 120 MCG-150 MCG -37.5 MG (multivit with minerals/folic/lutein/herbal complex no. 293)	Tier 3	
ANTIOXIDANT FORMULA (SELENIUM) ORAL TABLET 8,333-167-133 UNIT-MG-UNIT (beta-carotene/ascorbic acid/vitE ac/selenium yeast)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CENTRUM ADULT 50 FRESH-FRUIT ORAL TABLET,CHEWABLE 120 MCG (multivitamin with minerals/folic acid)	Tier 3	
CENTRUM SILVER ORAL TABLET 0.4-300-250 MG-MCG-MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CERTAVITE SENIOR ORAL TABLET 0.4-300-250 MG-MCG-MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
COMPLETE MV ADULT 50 PLUS ORAL TABLET 0.4-300-250 MG-MCG-MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CULTURELLE PROBIOTIC-MULTIVIT ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM (multivitamin with minerals/B. coagulans/B. subtilis/inulin)	Tier 3	
DAILY GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
DAYAVITE ORAL TABLET 1-75-10 MG (multivitamin with minerals no.90/folic acid/ALA/coQ10)	Tier 3	
DEKAS PLUS (FOLIC ACID) ORAL CAPSULE 200 MCG-1,000 MCG-10 MG (multivit with minerals no.53/folic acid/vit K1/ubidecarenone)	Tier 3	
DERMACINRX FOLITIN-Z ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX RIBOTIN-E ORAL TABLET 9 MG IRON-500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENEXA FE ORAL TABLET 27 MG IRON-1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENEXA ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMACINRX VENTRIXYL FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENTRIXYL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX VITRANOL FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VITRANOL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX VITREXATE FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VITREXATE ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX ZINTREXYL-C ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
ELITE-OB ORAL TABLET 50 MG IRON- 1.25 MG (multivitamin with minerals no.69/iron,carbonyl/folic acid)	Tier 3	
ESTROVEN MENOPAUSE ORAL TABLET 400 MCG-40 MG- 40 MG-100 MG (multivitamin, min/folic acid/black cohosh/isoflavones/jujube)	Tier 3	
EYE HEALTH PLUS LUTEIN ORAL TABLET 1,000 UNIT- 200 MG-60 UNIT-2 MG (beta-carotene(A) w-C and E/lutein/minerals)	Tier 3	
EYE MULTIVITAMIN ORAL TABLET 7,160 UNIT- 113 MG- 100 UNIT (beta-carotene/ascorbic acid/vitE ac/zinc oxide/cupric oxide)	Tier 3	
EYE MULTIVITAMIN WITH LUTEIN ORAL TABLET 300 MCG-200 MG- 27 MG (vit A, C, E/zinc oxide/sodium selenate/cupric oxide/lutein)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIKA-CI ORAL TABLET 13 MG IRON- 1 MG (multivitamin with mineral no.84/ferrous gluconate/folic acid)	Tier 3	
FOLIKA-MG ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with min no.83/iron bis-glycinate/folate no.10)	Tier 3	
FOLIVANE-OB ORAL CAPSULE 85-1 MG (mv-mins no.74/ferrous fumarate/iron ps cplx/folic acid)	Tier 3	
GENADEK STEP 1 ORAL CAPSULE 200 MCG-1,000 MCG-10 MG (multivit with minerals no.81/folic acid/vit K1/ubidecarenone)	Tier 3	
GENADEK STEP 2 ORAL CAPSULE 200 MCG-1,000 MCG-10 MG (multivit with minerals no.82/folic acid/vit K1/ubidecarenone)	Tier 3	
GERBER GS PRENATAL NOURISH PLS ORAL TABLET,CHEWABLE 120 MCG- 33.3 MG (multivitamin with minerals no.92/folic acid/dha)	Tier 3	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL CAPSULE 133.3 MCG- 1,666.7 MCG (multivitamin with minerals/folic acid/biotin)	Tier 3	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 66.7- 1,666.7 MCG (multivitamin with minerals/folic acid/biotin)	Tier 3	
HIGH POTENCY MULTIVIT (W-IRON) ORAL TABLET 9 MG IRON-400 MCG (multivits with calcium and minerals/iron fumarate/folic acid)	Tier 3	
IMMUNERX ORAL CAPSULE 250 MCG (multivitamin with minerals no.88/folic acid)	Tier 3	
MEN 50 PLUS MULTIVITAMIN ORAL TABLET 300-600-300 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
MEN'S 50 PLUS MULTIVITAMIN ORAL TABLET 400-20-370 MCG (multivitamin with minerals/folic acid/vitamin K1/lycopene)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
MEN'S ONE DAILY ORAL TABLET 400-20-300 MCG (multivitamin with minerals/folic acid/vitamin K1/lycopene)	Tier 3	
MULTI FOR HIM (NO IRON) ORAL CAPSULE 400-40 MCG (multivitamin with minerals/folic acid/phytonadione)	Tier 3	
MULTI PRO ORAL CAPSULE 32 MG IRON-1 MG -315 MG (multivit-mins no.85/iron/folic acid/dha/Lactobacillus casei)	Tier 3	
MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
MULTIVITAMIN WOMEN 50 PLUS ORAL TABLET 8 MG IRON-400 MCG-300 MCG (multivitamin-minerals/ferrous fumarate/folic acid/lutein)	Tier 3	
<i>multivit-min-ferrous fumarate oral tablet 15 mg iron</i>	Tier 3	
NEOVITE ORAL TABLET 1-100-1 MG (multivit-minerals no.67/folic acid/alpha lipoic acid/lutein)	Tier 3	
NICOTINAMIDE (WITH CHROMIUM) ORAL TABLET 500 MCG- 750 MG (levomefolate calc/niacinamide/copper/zinc/selenium/chromium)	Tier 3	
NUMAQUA VITAMIN ORAL TABLET 333 MCG-3 MG-0.67 MG (multivitamin with minerals/folic acid/lutein/zeaxanthin)	Tier 3	
OB COMPLETE ORAL TABLET 50 MG IRON- 1.25 MG (multivitamin with minerals no.69/iron,carbonyl/folic acid)	Tier 3	
ONE DAILY ESSENTIAL ORAL TABLET 0.5 MG (multivitamin with minerals/folic acid)	Tier 3	
ONE DAILY MEN'S HEALTH ORAL TABLET 240 MCG-30 MCG- 300 MCG (multivitamin,calcium,minerals/folic acid/vitamin K1/lycopene)	Tier 3	
ONE DAILY MULTIVITAMIN-IRON ORAL TABLET 18 MG IRON (multivitamin/ferrous sulfate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE DAILY WOMEN 50 PLUS(VIT K) ORAL TABLET 400 MCG-500 MG CALCIUM-20 MCG (multivit with minerals/folic acid/calcium carbonate/vit K1)	Tier 3	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
ONE-A-DAY MEN'S COMPLETE ORAL TABLET 240 MCG-30 MCG- 300 MCG (multivitamin,calcium,minerals/folic acid/vitamin K1/lycopene)	Tier 3	
ONE-A-DAY WOMEN'S COMPLETE ORAL TABLET 18 MG-400 MCG- 25 MCG (multivit with calcium-mins/iron fumarate/folic acid/vit K)	Tier 3	
ONE-DAILY MULTI ORAL CAPSULE 800 MCG-1 MG- 500 MCG-500 MCG (multivitamin-minerals/folic acid/co Q10/lycopene/lutein)	Tier 3	
OPTIFAST ORAL TABLET,CHEWABLE 120-30 MCG (multivitamin,calcium,minerals/folic acid/phytonadione(vit K))	Tier 3	
PNV-OMEGA ORAL CAPSULE 28-1-300 MG (multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)	Tier 3	
PUREFE OB PLUS ORAL CAPSULE 106 MG IRON- 1 MG (multivit-mins no.73/iron fumarate,polysacc comp/folic acid)	Tier 3	
REMEDIENT ORAL CAPSULE 3.6 MG- 1,000 MCG (multivitamin with minerals/iron succinyl-protein/folic acid)	Tier 3	
SPECTRAVITE ADULT 50 PLUS ORAL TABLET 0.4-300-250 MG-MCG-MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
SPECTRAVITE MEN 50 PLUS ORAL TABLET 300-600-300 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPECTRAVITE MEN'S ORAL TABLET 8 MG IRON- 200 MCG-600 MCG (multivits with calcium and minerals/iron/folic acid/lycopene)	Tier 3	
SPECTRAVITE WOMEN 50 PLUS ORAL TABLET 8 MG IRON-400 MCG-300 MCG (multivitamin-minerals/ferrous fumarate/folic acid/lutein)	Tier 3	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG (multivitamin/ferrous sulfate/folic acid)	Tier 3	
TARON-C DHA ORAL CAPSULE 35-1-200 MG (mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)	Tier 3	
VIRT-C DHA ORAL CAPSULE 35-1-200 MG (mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)	Tier 3	
VIRT-PN PLUS ORAL CAPSULE 28-1-300 MG (multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)	Tier 3	
VISTA ADVANCED AREDS2 ORAL CAPSULE 250-137.5-12.5 MG (vit C/vit E/zinc/copper/selen/lutein/zeaxanthin/glutathione)	Tier 3	
VITAJoy ADULT MULTI ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
VITREXYL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
VITREXYL PLUS IRON ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
WOMEN'S 50 PLUS MULTIVITAMIN ORAL TABLET 400 MCG-500 MG CALCIUM-20 MCG (multivit with minerals/folic acid/calcium carbonate/vit K1)	Tier 3	
WOMEN'S MULTIVITAMIN COLLAGEN ORAL TABLET,CHEWABLE 200 MCG- 25 MG (multivitamin with minerals/folic acid/collagen, hydrolyzed)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZATEAN-PN PLUS ORAL CAPSULE 28-1-300 MG (multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)	Tier 3	
ZYVANA ORAL CAPSULE 6 MG-263.5 MG- 20.5 MCG- 11.5MG (pyridoxine/ascorbic acid/vitamin D3/zinc/selenium yeast)	Tier 3	
Multivitamins - Drugs For Nutrition		
CALCIUM PNV ORAL CAPSULE 28-1-250 MG (multivitamin comb no.48/ferrous fumarate/folic acid/dha)	Tier 1	
CENTRUM WOMEN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
CERTAVITE-ANTIOXIDANT ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
DAILY-VITE (WITH FOLIC ACID) ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
ENBRACE HR ORAL CAPSULE,IR - DELAY REL,BIPHASE 1.5 MG IRON- 8.73 MG-6.4 MG (multivit no.41/iron cysteine glycinate/folate no.8/phosph-dha)	Tier 3	
FOLET ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG- 225 MG (multivitamin no.39/iron carb,bisgl/methylfolate/docusate/dha)	Tier 3	
HIGH POTENCY MULTIVIT (W-IRON) ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
HIGH POTENCY MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
<i>multivitamin oral tablet</i>	Tier 3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (multivit 42/iron carbonyl,b-g che/methyltetrahydrofolate/dha)	Tier 3	
OBSTETRIX ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG-225 MG (multivitamin no.39/iron carb,bisgl/methylfolate/docusate/dha)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE DAILY MULTIVITAMIN ORAL TABLET (multivitamin)	Tier 3	
ONE DAILY MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
PNV-DHA ORAL CAPSULE 27 MG IRON-1 MG -300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
PRENATAL-U ORAL CAPSULE 106.5-1 MG (multivitamin combination no.51/ferrous fumarate/folic acid)	Tier 3	
PRENATE AM ORAL TABLET 1-500 MG (multivit no.38/methyltetrahydrofolate glucos,folic acid/ginger)	Tier 3	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE 1 MG (multivitamin no.36/methyltetrahydrofolate gluc,folic acid)	Tier 3	
PRENATE DHA ORAL CAPSULE 28 MG IRON-1 MG -300 MG (multivitamin no.45/iron fumarate/folate comb no.6/dha)	Tier 3	
PRENATE ESSENTIAL ORAL CAPSULE 29 MG IRON-1 MG -300 MG (multivitamin no.46/iron fumarate/folate comb. no.6/dha)	Tier 3	
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE 18 MG IRON- 1 MG-300 MG (multivitamin no.40/iron asparto glycinate/folate no.1/dha)	Tier 3	
SPECTRAVITE ADULT ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
SPECTRAVITE WOMEN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
TAB-A-VITE ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
TARON-PREX PRENATAL-DHA ORAL CAPSULE 30 MG IRON-1.2 MG-55 MG-265 MG (multivitamin no.53/ferrous fum/folic acid/docusate/dha)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THEREMS MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
VIRT-PN DHA ORAL CAPSULE 27 MG IRON-1 MG -300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
ZATEAN-PN DHA ORAL CAPSULE 27 MG IRON-1 MG -300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
Nutritional Product - Glutaric Aciduria Type 1 Specific Formulation - Drugs For Nutrition		
GLUTAREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, glutaric aciduria type 1)	Tier 3	
Nutritional Product - Isovaleric Acidemia Specific Formulation - Drugs For Nutrition		
I-VALEX-2 ORAL POWDER 30-410 GRAM-KCAL (nutritional therapy for isovaleric acidemia with iron)	Tier 3	
Nutritional Product - Lipid Others - Drugs For Nutrition		
DOJOLVI ORAL LIQUID 8.3 KCAL/ML (triheptanoin)	Tier 4	PA
MCT OIL ORAL OIL 14 GRAM-120 KCAL/15 ML (medium chain triglycerides)	Tier 3	
Nutritional Product - Methionine-Free Specific Formulation - Drugs For Nutrition		
HOMINEX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, metabolic disorder, methionine-free)	Tier 3	
Nutritional Product - Msud Specific Formulation - Drugs For Nutrition		
KETONEX-2 ORAL POWDER 30-410 GRAM-KCAL (nutritional therapy for MSUD with iron)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nutritional Product - Nutritional Therapy - Drugs For Nutrition		
ALFAMINO JUNIOR ORAL POWDER 14 GRAM-480 KCAL/100 GRAM (nutritional therapy for impaired digestive function)	Tier 3	
BOOST GLUCOSE CONTROL ORAL LIQUID 0.07-0.8 GRAM-KCAL/ML (nutritional tx. glucose intolerance,lactose-free,soy/fiber)	Tier 3	
ENSURE CLEAR THERAPEUTIC ORAL LIQUID 0.035-1 GRAM-KCAL/ML (nutritional therapy for impaired digestive function)	Tier 3	
GLUCERNA HUNGER SMART ORAL LIQUID (nutritional therapy, glucose intolerance,lactose-free,soy)	Tier 3	
GLUCERNA SNACK BAR ORAL BAR 11 GRAM-160 KCAL/40 GRAM (nutritional therapy, glucose intolerance,soy)	Tier 3	
GLUTAREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, glutaric aciduria type 1)	Tier 3	
IMPACT ADVANCED RECOVERY ORAL LIQUID 0.1 GRAM-1.12 KCAL/ML (nutritional therapy, compromised immune system, regular)	Tier 3	
PROVIMIN ORAL POWDER 73 GRAM-313 KCAL/100 GRAM (nutritional supplement)	Tier 3	
RENAMENT ORAL POWDER IN PACKET 10 GRAM- 210 KCAL (nutritional therapy, impaired renal function)	Tier 3	
SUPLENA CARB STEADY ORAL LIQUID 0.04 GRAM-1.8 KCAL/ML (nutritional therapy, impaired renal function,lactose-reduced)	Tier 3	
VITAL AF 1.2 CAL ORAL LIQUID 0.08 GRAM- 1.2 KCAL/ML (nut.tx.impaired digest fxn/fiber)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nutritional Product - Phenylketonuria (Pku)		
Specific Formulation - Drugs For Nutrition		
PHENEX-1 ORAL POWDER 15 GRAM-480 KCAL/100 GRAM (infant formula for PKU, iron, no.2)	Tier 3	
PHENEX-2 ORAL POWDER 30-410 GRAM-KCAL/100 G (nutritional therapy for phenylketonuria (PKU) with iron no.1)	Tier 3	
Nutritional Product - Propionic Acidemia		
Specific Formulation - Drugs For Nutrition		
PROIMEX-2 ORAL POWDER 30-410 GRAM-KCAL (nutritional therapy for propionic acidemia with iron)	Tier 3	
Nutritional Product - Protein Replacements - Drugs For Nutrition		
PROCEL SINGLES ORAL POWDER IN PACKET 5 GRAM-26 KCAL (whey protein concentrate/amino acids)	Tier 3	
Nutritional Product - Tyrosinemia Specific Formulation - Drugs For Nutrition		
TYREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy for tyrosinemia with iron)	Tier 3	
Nutritional Product - Urea Cycle Disorder Specific Formulation - Drugs For Nutrition		
CYCLINEX-2 ORAL POWDER 15 GRAM-440 KCAL/100 GRAM (nutritional therapy, urea cycle disorder)	Tier 3	
Pediatric Vitamins - Drugs For Nutrition		
CHILDREN'S MULTIVITAMIN ORAL TABLET,CHEWABLE (pediatric multivitamin no.42)	Tier 3	
GERBER LIL BRAINIES ORAL TABLET,CHEWABLE 6.67 MG-1.87MCG -0.77 MG (vit C/vit D3/vit E acet/choline bit/omega 3,6,9 combo no.7)	Tier 3	
GUMMY DINOS ORAL TABLET,CHEWABLE (pediatric multivitamin no.76)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pediatric multivitamin no.171 oral drops 750 unit-35 mg- 400 unit/ml</i>	Tier 3	
PEDIATRIC POLY-VITE ORAL DROPS 250 MCG-50 MG-10-MCG-5 MG/ML (pediatric multivitamin no.197)	Tier 3	
PEDIATRIC TRI-VITE ORAL DROPS 750 UNIT-35 MG - 400 UNIT/ML (vitamin A palmitate/ascorbic acid/cholecalciferol (vit D3))	Tier 3	
POLY-VITA DROPS ORAL DROPS 750 UNIT-35 MG- 400 UNIT/ML (pediatric multivitamin no.171)	Tier 3	
<i>vit a palmitate-vit c-vit d3 oral drops 750 unit-35 mg -400 unit/ml</i>	Tier 3	
Pediatric Vitamins And Mineral Combinations - Drugs For Nutrition		
CULTURELLE KIDS PROBIOTIC-MV ORAL TABLET,CHEWABLE 5 BILLION CELL (pediatric multivitamin no.193/Lactobacillus rhamnosus GG)	Tier 3	
GENADEK ORAL DROPS 19 MCG-500 MCG /ML (pediatric multivitamin no.196/vitamin D3/vit K1)	Tier 3	
GERBER GROW MIGHTY ORAL TABLET,CHEWABLE (pediatric multivitamin no.191)	Tier 3	
JUST 4 KIDZ MULTIVIT-PROBIOTIC ORAL TABLET,CHEWABLE 1.25 MG (pediatric multivitamin no.200/Bacillus coagulans)	Tier 3	
<i>pedi multivit no.194-iron sulf oral drops 10 mg iron/ml</i>	Tier 3	
PEDIATRIC POLY-VITE WITH IRON ORAL DROPS 11 MG IRON/ML (pediatric multivitamin no.197/ferrous sulfate)	Tier 3	
POLY-VITA WITH IRON ORAL DROPS 10 MG/ML (pediatric multivitamin no.160/ferrous sulfate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pediatric Vitamins With Fluoride Combinations - Drugs For Nutrition		
POLY-VI-FLOR ORAL TABLET,CHEWABLE 0.25 MG FLUORIDE, 0.5 MG FLUORIDE, 1 MG FLUORIDE (pediatric multivitamin no.33 with sodium fluoride)	Tier 3	
Prenatal Vitamins And Minerals - Drugs For Nutrition		
BAL-CARE DHA ESSENTIAL ORAL COMBO PACK, TABLET AND CAP, DR 27 MG IRON-1 MG -374 MG (prenatal vit no.100/iron sod EDTA, ps cplex/folic acid/omega3)	Tier 3	
BAL-CARE DHA ORAL COMBO PACK, TABLET AND CAP, DR 27-1-430 MG (prenatal vit no.81/sod.feredetate-iron ps/folic acid/omega-3)	Tier 3	
CADEAU DHA ORAL CAPSULE 29 MG IRON- 1 MG-150 MG (prenatal vitamins no.83/iron fumarate/folate combo no.6/dha)	Tier 3	
CITRANATAL (DUAL-IRON) ORAL TABLET 27 MG IRON-1 MG -50 MG (prenatal vits no.81/iron carbonyl, gluc/folic acid/docusate)	Tier 3	
CITRANATAL 90 DHA (ALGAL OIL) ORAL COMBO PACK 90 MG IRON-1 MG -50 MG-300 MG (prenatal vit no.72/iron carbony, gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL ASSURE ORAL COMBO PACK 35 MG IRON-1 MG -50 MG-300 MG (prenatal vit no.73/iron carbony, gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL DHA (ALGAL OIL) ORAL COMBO PACK 27 MG IRON-1 MG -50 MG-250 MG (prenatal vit no.76/iron carbony, gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL HARMONY (IRON FUM) ORAL CAPSULE 27 MG IRON-1 MG -50 MG-260 MG (prenatal vitamin no.59/iron carb, fum/folic acid/docusate/dha)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
C-NATE DHA ORAL CAPSULE 28 MG IRON-1 MG -200 MG (prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)	Tier 3	
COMPLETE NATAL DHA ORAL COMBO PACK 29-1-250-200 MG (prenatal vitamin no.52/iron/folic acid/omega-3/dha)	Tier 3	
COMPLETENATE ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vitamins no.14/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRENATRIX ORAL TABLET 27 MG IRON-1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRENATRYL ORAL TABLET 27 MG IRON-1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRETRATE ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
DUET DHA BALANCED ORAL COMBO PACK 25 MG IRON-1 MG -267 MG-233 MG (prenatal vits no.117/sod feredet.-iron ps/folic/om3/dha/epa)	Tier 3	
DUET DHA WITH OMEGA-3 ORAL COMBO PACK 25 MG IRON-1 MG -400 MG (prenatal vits 106/sod feredetate-iron ps/folic acid/omega-3s)	Tier 3	
EXTRA-VIRT PLUS DHA ORAL CAPSULE 29 MG IRON-1.25 MG-55 MG (prenatal vits no.57/iron fum/folic acid/docusate calcium/dha)	Tier 1	
FOLET ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG-225 MG (multivitamin no.39/iron carb,bisgl/methylfolate/docusate/dha)	Tier 3	
KOSHER PRENATAL PLUS IRON ORAL TABLET 30 MG IRON- 1 MG (prenatal vitamins no.108/iron,carbonyl/folic acid)	Tier 3	
MARNATAL-F ORAL CAPSULE 60 MG IRON-1 MG (prenatal vits with calcium no.65/iron polysacchar/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
M-NATAL PLUS ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
MYNATAL ADVANCE ORAL TABLET 90-1-50 MG (prenatal vit with calcium 15/iron/folic acid/docusate sodium)	Tier 1	
MYNATAL ORAL CAPSULE 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 3	
MYNATAL ORAL TABLET 90-1-50 MG (prenatal vitamins with calcium/iron,carb/docusate/folic acid)	Tier 1	
MYNATAL PLUS ORAL TABLET 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 1	
MYNATAL-Z ORAL TABLET 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 1	
MYNATE 90 PLUS ORAL TABLET EXTENDED RELEASE 90 MG IRON-1 MG (prenatal vitamins with calcium/ferrous fum/docusate/folic ac)	Tier 1	
NATACHEW (FE BIS-GLYCINATE) ORAL TABLET,CHEWABLE 28 MG IRON -1 MG (prenatal vitamin no.55/iron fumarate,bisglycinate/folic acid)	Tier 3	
NEONATAL COMPLETE ORAL TABLET 29-1 MG (prenatal vitamins no.175/ferrous fumarate/folic acid)	Tier 3	
NEONATAL PLUS VITAMIN ORAL TABLET 27 MG IRON-1 MG (prenatal vitamins no.154/ferrous fumarate/folic acid)	Tier 3	
NEONATAL-DHA ORAL COMBO PACK 29-1-200-500 MG (prenatal vit no.175/iron fum/folic acid/dha/Schiz. algal oil)	Tier 3	
NESTABS ABC ORAL COMBO PACK 32 MG IRON-1 MG - 120 MG-180 MG (prenatal vitamin comb no.86/iron ps cmplx/folic acid/dha/epa)	Tier 3	
NESTABS DHA ORAL COMBO PACK 32 MG IRON- 1,000 MCG-230MG (prenatal vits with calcium no.87/iron bisgly/folic acid/dha)	Tier 3	
NEWGEN ORAL TABLET 32-1,000 MG-MCG (prenatal vitamin no.86/iron bis-glycinate/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEXA PLUS ORAL CAPSULE 29 MG IRON-1.25 MG-55 MG (prenatal vits no.53/iron fum/folic acid/docusate calcium/dha)	Tier 3	
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG (prenatal vit no.85/iron carb,asp.gly/folic acid/dha/fish oil)	Tier 3	
OB COMPLETE PETITE ORAL CAPSULE 35 MG IRON-5 MG IRON-1 MG (prenatal no56/iron carbonyl,asparto glycinate/folic acid/dha)	Tier 3	
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG (prenatal vits no.83/iron,carbonyl,iron aspart.gly/folic acid)	Tier 3	
OB COMPLETE WITH DHA ORAL CAPSULE 30 MG IRON-10 MG IRON-1 MG (prenatal vit no.30/iron carbonyl,asp glyc/folic acid/omega-3)	Tier 3	
OBSTETRIX DHA ORAL COMBO PACK, TABLET AND CAP, DR 29 MG IRON-1 MG -50 MG (prenatal vits no.12/iron,carb/folic acid/docusate/omega-3)	Tier 1	
OBSTETRIX EC ORAL TABLET, DELAYED RELEASE (DR/EC) 29 MG IRON-1 MG -50 MG (prenatal vitamins no.127/iron,carbonyl/folic acid/docusate)	Tier 3	
O-CAL PRENATAL ORAL TABLET 15 MG IRON- 1,000 MCG (prenatal vit with calcium no.127/ferrous fumarate/folic acid)	Tier 3	
ONE-A-DAY PRENATAL-1 ORAL CAPSULE 27 MG IRON-800 MCG-235 MG (prenatal vitamins no.168/iron/folic acid/omega-3/dha/epa)	Tier 3	
PNV 29-1 ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)	Tier 3	
PNV-DHA + DOCUSATE ORAL CAPSULE 27-1.25-55-300 MG (prenatal vits,calcium no.66/iron fum/folic acid/docusate/dha)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PNV-FERROUS FUMARATE-DOCU-FA ORAL TABLET 29 MG IRON- 1 MG-25 MG (prenatal vits no.115/iron fumarate/folic acid/docusate sod.)	Tier 1	
PNV-SELECT ORAL TABLET 27-1 MG (prenatal vit with calcium no.40/iron fumarate/folate no.1)	Tier 3	
PR NATAL 400 EC ORAL COMBO PACK, TABLET AND CAP, DR 29-1-400 MG (prenatal vit no.19/iron bg HCl, suc-prot/folic acid/omega-3)	Tier 3	
PR NATAL 400 ORAL COMBO PACK 29-1-400 MG (prenatal vit with calcium 53/iron bis,s-p/folic acid/omega-3)	Tier 3	
PR NATAL 430 EC ORAL COMBO PACK, TABLET AND CAP, DR 29-1-430 MG (prenatal vit 55/iron bisgly HCl, suc-prot/folic acid/omega-3)	Tier 3	
PR NATAL 430 ORAL COMBO PACK 29 MG IRON-1 MG - 430 MG (prenatal vit with calcium 54/iron bis,s-p/folic acid/omega-3)	Tier 3	
PREGEN DHA ORAL CAPSULE 28 MG-1,000MCG- 35 MG-200 MG (prenatal vit no.174/iron/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
PRENA1 CHEW ORAL TABLET, CHEW, IR - DR, BIPHASE 1.4 MG (prenatal vitamins combination no.42/folic acid)	Tier 3	
PRENA1 PEARL ORAL CAPSULE, IR - DELAY REL, BIPHASE 30-1.4-200 MG (prenatal vit no.71/iron fum-sodium feredetate/folic acid/dha)	Tier 3	
PRENA1 TRUE ORAL COMBO PACK 30 MG IRON- 1.4 MG-300 MG (prenatal vits no.105/iron amino acid chelate/folic acid/dha)	Tier 3	
PRENAISSANCE ORAL CAPSULE 29-1.25-55-325 MG (prenatal vits with calcium no.80/iron fum/folic acid/dss/dha)	Tier 1	
PRENAISSANCE PLUS ORAL CAPSULE 28-1-50-250 MG (prenatal vit with calcium no.69/iron/folic acid/docusate/dha)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATA ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vitamins no.37/ferrous fumarate/folic acid)	Tier 3	
PRENATABS FA ORAL TABLET 29-1 MG (prenatal vits with calcium no.78/ferrous fumarate/folic acid)	Tier 3	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)	Tier 3	
PRENATAL 19 (WITH DOCUSATE) ORAL TABLET 29 MG IRON- 1 MG-25 MG (prenatal vits no.115/iron fumarate/folic acid/docusate sod.)	Tier 1	
PRENATAL 19 ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vits with calcium no.115/iron fumarate/folic acid)	Tier 3	
PRENATAL LOW IRON ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.74/ferrous fumarate/folic acid)	Tier 3	
PRENATAL MULTIVITAMINS ORAL TABLET 28 MG IRON- 800 MCG (prenatal vits with calcium 95/ferrous fumarate/folic acid)	Tier 3	
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
PRENATAL PLUS DHA ORAL COMBO PACK 27 MG IRON-1 MG -312 MG-250 MG (PNV no.72/ferrous fumarate/folic acid/omega-3/dha)	Tier 3	
PRENATAL PLUS ORAL TABLET 29 MG IRON- 1 MG (prenatal vits with calcium no.72/iron,carbonyl/folic acid)	Tier 3	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE 18 MG IRON-1 MG -300 MG (prenatal vitamins no.78/iron asparto glycin/folate no.1/dha)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET 20 MG IRON- 1 MG (prenatal vits no.114/ferrous aspart glycinate/folate no.1)	Tier 3	
PRENATE ELITE ORAL TABLET 26 MG IRON- 1 MG (prenatal vitamins no.36/ferrous fumarate/folate comb. no.6)	Tier 3	
PRENATE ENHANCE ORAL CAPSULE 28 MG IRON- 1 MG-400 MG (prenatal vitamins no.68/iron fumarate/folate no.6/dha)	Tier 3	
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE 18-1-350 MG (prenatal vits no.87/iron carb-asp.glycinate/folate no.1/dha)	Tier 3	
PRENATE PIXIE ORAL CAPSULE 10 MG IRON- 1 MG-200 MG (prenatal vitamins no.85/iron asparto glycin/folate no.1/dha)	Tier 3	
PRENATE RESTORE ORAL CAPSULE 27 MG IRON- 1 MG-400 MG (prenatal vitamins no.69/iron fumarate/folate comb no.6/dha)	Tier 3	
PRENATE STAR ORAL TABLET 20 MG IRON- 1 MG (prenatal vitamins no.77/ferrous asparto glycinate/folic acid)	Tier 3	
PREPLUS ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
PRETAB ORAL TABLET 29-1 MG (prenatal vits with calcium no.78/ferrous fumarate/folic acid)	Tier 3	
PRIMACARE ORAL CAPSULE 30-1-300 MG (prenatal vits no.118/iron asparto glycinate/folate no.6/dha)	Tier 3	
PROVIDA OB ORAL CAPSULE 40 MG IRON- 1.25 MG (prenatal vits no.65/iron fumarate,polysac complex/folic acid)	Tier 3	
R-NATAL OB ORAL CAPSULE 20 MG IRON- 1 MG-320 MG (prenatal vitamins no.66/iron,carbonyl/folic acid/dha)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELECT-OB (FOLIC ACID) ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vit no.128/iron polysaccharide complex/folic acid)	Tier 3	
SELECT-OB + DHA ORAL COMBO PACK 29 MG IRON-1 MG -250 MG (prenatal vitamins no.33/iron polysach complex/folic acid/dha)	Tier 3	
SELECT-OB ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vitamin no.13/iron polysaccharides/folate comb no.1)	Tier 3	
SE-NATAL 19 CHEWABLE ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vits with calcium 118/ferrous fumarate/folic acid)	Tier 3	
SE-NATAL-19 ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamins no.119/iron fumarate/folic acid)	Tier 3	
TARON-PREX PRENATAL-DHA ORAL CAPSULE 30 MG IRON-1.2 MG-55 MG-265 MG (multivitamin no.53/ferrous fum/folic acid/docusate/dha)	Tier 1	
THRIVITE RX ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)	Tier 3	
TRICARE ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium 103/ferrous fumarate/folic acid)	Tier 3	
TRINATE ORAL TABLET 28 MG IRON- 1 MG (prenatal vits with calcium no.73/ferrous fumarate/folic acid)	Tier 3	
TRISTART DHA ORAL CAPSULE 31 MG IRON- 1 MG-200 MG (prenatal vitamins no.93/iron carbonyl/folate comb no.9/dha)	Tier 3	
TRIVEEN-DUO DHA ORAL COMBO PACK 29-1-400 MG (prenatal vit with calcium 53/iron bis,s-p/folic acid/omega-3)	Tier 3	
TRIVEEN-PRX RNF ORAL CAPSULE 26-1.2-55-300 MG (prenatal vits,calcium no.66/iron fum/folic acid/docusate/dha)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA PRENATAL PLUS DHA ORAL CAPSULE 27 MG-800 MCG- 250 MG-200 MG (prenatal vit no.166/iron/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
VENA-BAL DHA ORAL COMBO PACK, TABLET AND CAP, DR 27-1-430 MG (prenatal vit no.81/sod.feredetate-iron ps/folic acid/omega-3)	Tier 1	
VINATE GT ORAL TABLET 90-1-50 MG (prenatal vit with calcium 16/iron/folic acid/docusate sodium)	Tier 1	
VINATE II ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamins with calcium/iron fum,b-g/folic acid)	Tier 1	
VINATE ULTRA ORAL TABLET 90-1-50 MG (prenatal vit with calcium 18/iron/folic acid/docusate sodium)	Tier 1	
VIRT-NATE DHA ORAL CAPSULE 28 MG IRON-1 MG - 200 MG (prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)	Tier 3	
VITAFOL FE PLUS ORAL CAPSULE 90 MG IRON- 1 MG- 200 MG (prenatal vits no.102/iron polysacch/folate no.1/dha)	Tier 3	
VITAFOL FE+ (WITH DOCUSATE) ORAL CAPSULE 90 MG IRON-1 MG -50 MG-200 MG (prenatal vits no.102/iron polysacch/folate no.1/docusate/dha)	Tier 3	
VITAFOL GUMMIES ORAL TABLET, CHEWABLE 3.33 MG IRON- 0.33 MG (prenatal vit no.112/iron phosph/folic acid/omega-3s/dha/epa)	Tier 3	
VITAFOL NANO ORAL TABLET 18 MG IRON- 1 MG (prenatal vitamins no.75/ferrous fumarate/folate comb. no.1)	Tier 3	
VITAFOL ULTRA ORAL CAPSULE 29 MG IRON- 1 MG- 200 MG (prenatal vit no.67/iron polysaccharides/folate comb.no.1/dha)	Tier 3	
VITAFOL-OB ORAL TABLET 65-1 MG (prenatal vits with calcium no.10/ferrous fumarate/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAFOL-OB+DHA ORAL COMBO PACK 65-1-250 MG (prenatal vits with calcium no.10/ferrous fum/folic acid/dha)	Tier 3	
VITAFOL-ONE ORAL CAPSULE 29 MG IRON- 1 MG-200 MG (prenatal vits no.26/iron polysaccharide cplex/folic acid/dha)	Tier 3	
VITAMED MD ONE RX ORAL CAPSULE 30 MG IRON-1MG -200 MG (prenatal vits no.25/ferrous fumarate/folate comb. no.6/dha)	Tier 3	
VIVA DHA ORAL CAPSULE 28 MG IRON-1 MG -200 MG (prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)	Tier 1	
VP-CH PLUS ORAL CAPSULE 29 MG IRON-1 MG -50 MG-265 MG (prenatal vits no.59/iron,carb/folic acid/docuate sodium/dha)	Tier 1	
VP-CH-PNV ORAL CAPSULE 30 MG IRON-1 MG -50 MG-260 MG (prenatal vits no.34/iron,carb/folic acid/docusate sodium/dha)	Tier 1	
VP-PNV-DHA ORAL CAPSULE 28 MG IRON- 1 MG-200 MG (prenatal vitamins no.52/ferrous fumarate/folic acid/dha)	Tier 3	
WESTAB PLUS ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
WESTGEL DHA ORAL CAPSULE 31 MG IRON- 1 MG-200 MG (prenatal vitamins no.93/iron carbonyl/folate comb no.9/dha)	Tier 3	
Prenatal Vitamins With Low Or No Iron (Less Than 27 Mg) - Drugs For Nutrition		
AZESCO ORAL TABLET 13 MG IRON- 1 MG (prenatal vitamins no.147/ferrous gluconate/folic acid)	Tier 3	
PNV TABS 20-1 ORAL TABLET 20 MG IRON- 1 MG (prenatal vitamins no.163/iron bis-glycinate/folate no.10)	Tier 3	
ZALVIT ORAL TABLET 13 MG IRON- 1 MG (prenatal vitamins no.147/ferrous gluconate/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sodium Chloride Flushes - Drugs For Nutrition		
BD POSIFLUSH NORMAL SALINE 0.9 INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	
BD PRE-FILLED NORMAL SALINE INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	
BD PRE-FILLED SALINE BLUNT CAN INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	
CLEARSHIELD SODIUM CHLOR FLUSH INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	
NORMAL SALINE FLUSH INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	
<i>sodium chloride 0.9 % (flush) injection syringe</i>	Tier 1	
Sodium Chloride, Parenteral - Drugs For Nutrition		
<i>sodium chloride 0.45 % intravenous parenteral solution 0.45 %</i>	Tier 1	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	Tier 1	
<i>sodium chloride 0.9 % intravenous piggyback</i>	Tier 1	
Vitamin C Combinations - Drugs For Nutrition		
VITAMIN C FIZZY DRINK ORAL POWDER EFFERVESCENT IN PACKET 1,000 MG (ascorbic acid/multivit with minerals)	Tier 3	
Vitamin D And Folic Acid Combinations - Drugs For Nutrition		
CHOLECAL DF ORAL TABLET 95 MCG (3,800 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLIXAPURE ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLTREXYL ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMACINRX PUREFOLTIN ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
FOLIC D3 ORAL CAPSULE 94.38 MCG(3,775 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
Vitamins - A - Drugs For Nutrition		
A-25 (VIT A PALMITATE) ORAL CAPSULE 7,500 MCG (25,000 UNIT) (vitamin A palmitate)	Tier 3	
<i>beta carotene oral capsule 25,000 unit</i>	Tier 3	
<i>vitamin a oral capsule 10,000 unit</i>	Tier 3	
Vitamins - B Preparation Combinations - Drugs For Nutrition		
NUFOLA ORAL CAPSULE 25 MG-3,500 MCG DFE-1 MG-300 MG (pyridoxal phosphate/levomefolate calcium/mecobalamin/ALA)	Tier 3	
WESTAB MAX ORAL TABLET 2.5-25-2 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB MINI ORAL TABLET 2.2-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB ONE ORAL TABLET 2.5-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
ZINGIBER ORAL TABLET 1.2 MG-40 MG- 124.1 MG-100 MG (folic acid/pyridoxine HCl/Ca phos dibasic & tribasic/ginger)	Tier 3	
Vitamins - B-1, Thiamine And Derivatives - Drugs For Nutrition		
<i>benfotiamine oral capsule 150 mg</i>	Tier 3	
<i>thiamine hcl (vitamin b1) injection solution 100 mg/ml</i>	Tier 1	
<i>thiamine hcl (vitamin b1) oral tablet 100 mg, 50 mg</i>	Tier 3	
<i>thiamine mononitrate (vit b1) oral tablet 100 mg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - B-12 And Folic Acid Combinations - Drugs For Nutrition		
LORMATE ORAL CAPSULE 1 MG-1 MG(1,670 MCG DFE)-500 MG (mecobalamin/levomefolate calcium/turmeric root extract)	Tier 3	
<i>me-thfolate glucos-mecobalamin oral tablet,disintegrating 1,000 mcg dfe- 2,500 mcg</i>	Tier 3	
<i>vitamin b12-folic acid oral tablet,disintegrating 2,500-400 mcg</i>	Tier 3	
Vitamins - B-12, Cyanocobalamin And Derivatives - Drugs For Nutrition		
B12 ACTIVE ORAL TABLET,CHEWABLE 1,000 MCG (mecobalamin)	Tier 3	
<i>cyanocobalamin (vitamin b-12) injection solution 1,000 mcg/ml</i>	Tier 1	
<i>cyanocobalamin (vitamin b-12) oral lozenge 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral tablet 1,000 mcg, 100 mcg, 250 mcg, 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral tablet extended release 1,000 mcg, 2,000 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral tablet,chewable 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) sublingual lozenge 3,000 mcg</i>	Tier 3	
<i>hydroxocobalamin intramuscular solution 1,000 mcg/ml</i>	Tier 1	
<i>mecobalamin (vitamin b12) injection recon soln 10,000 mcg</i>	Tier 3	
<i>mecobalamin (vitamin b12) oral lozenge 5,000 mcg</i>	Tier 3	
<i>mecobalamin (vitamin b12) oral tablet,disintegrating 5,000 mcg</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NASCOBAL NASAL SPRAY, NON-AEROSOL 500 MCG/SPRAY (cyanocobalamin (vitamin B-12))	Tier 3	
VITAMIN B-12 ORAL TABLET 1,000 MCG (cyanocobalamin (vitamin B-12))	Tier 3	
Vitamins - B-3, Niacin And Derivatives - Drugs For Nutrition		
<i>niacin (inositol niacinate) oral capsule 400 mg niacin (500 mg)</i>	Tier 3	
<i>niacin oral tablet 100 mg, 500 mg</i>	Tier 3	
<i>niacin oral tablet extended release 500 mg</i>	Tier 3	
<i>niacinamide oral tablet 500 mg</i>	Tier 3	
Vitamins - B-6, Pyridoxine And Derivatives - Drugs For Nutrition		
<i>pyridoxine (vitamin b6) injection solution 100 mg/ml</i>	Tier 1	
<i>pyridoxine (vitamin b6) oral liquid 100 mg/2.5 ml</i>	Tier 3	
<i>pyridoxine (vitamin b6) oral tablet 100 mg</i>	Tier 3	
Vitamins - C, Ascorbic Acid And Derivatives - Drugs For Nutrition		
ASCOR INTRAVENOUS SOLUTION 500 MG/ML (ascorbic acid)	Tier 3	
<i>ascorbic acid (vitamin c) injection solution 500 mg/ml</i>	Tier 1	
<i>ascorbic acid (vitamin c) oral tablet 1,000 mg, 250 mg</i>	Tier 3	
<i>ascorbic acid (vitamin c) oral tablet, chewable 250 mg</i>	Tier 3	
<i>ascorbic acid (vitamin c) (bulk) granules 100 %</i>	Tier 3	
LIQUID C ORAL LIQUID 500 MG/5 ML (ascorbic acid)	Tier 3	
VITAMIN C WITH ROSE HIPS ORAL TABLET 1,000 MG, 500 MG (ascorbic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - D And K Combinations - Drugs For Nutrition		
OSTEOBLOX CF ORAL CAPSULE 25 MCG-20 MCG- 250 MG (cholecalciferol (vit D3)/vitamin K2/olive leaf extract)	Tier 3	
<i>vitamin d3-vitamin k2 oral capsule 250 mcg (10,000 unit)-45 mcg</i>	Tier 3	
Vitamins - D Derivatives - Drugs For Nutrition		
AQUA-D CONCENTRATE ORAL DROPS 10 MCG-4 MG/ 0.2 ML (cholecalciferol (vit D3)/tocophersolan)	Tier 3	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Tier 1	
<i>calcitriol oral solution 1 mcg/ml</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral capsule 1,250 mcg (50,000 unit), 10 mcg (400 unit), 125 mcg (5,000 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral drops 10 mcg/drop (400 unit/drop), 10 mcg/ml (400 unit/ml)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral drops 125 mcg/0.5 ml (5k unit/0.5ml)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet 125 mcg (5,000 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet 250 mcg (10,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet, chewable 25 mcg (1,000 unit)</i>	Tier 3	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	Tier 1	
<i>ergocalciferol (vitamin d2) oral drops 200 mcg/ml (8,000 unit/ml)</i>	Tier 3	
PEDIATRIC D-VITE ORAL DROPS 10 MCG/ML (400 UNIT/ML) (cholecalciferol (vitamin D3))	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ergocalciferol (vitamin D2) (Vitamin D2 Oral Capsule 1,250 Mcg (50,000 Unit))	Tier 1	
WEEKLY-D ORAL CAPSULE 1,250 MCG (50,000 UNIT) (cholecalciferol (vitamin D3))	Tier 3	
Vitamins - E - Drugs For Nutrition		
vitamin e (dl, acetate) oral capsule 180 mg (400 unit), 45 mg (100 unit), 450 mg (1,000 unit)	Tier 3	
vitamin e (dl, acetate) oral capsule 90 mg (200 unit)	Tier 3	
vitamin e (dl, acetate) oral drops 45 mg/0.25ml 100 unit/0.25ml	Tier 3	
vitamin e acetate (bulk) liquid 125 unit/ml	Tier 3	
vitamin e mixed oral capsule 400 unit	Tier 3	
Vitamins - Folic Acid And Derivatives - Drugs For Nutrition		
folic acid injection solution 5 mg/ml	Tier 1	
folic acid oral tablet 1 mg	Tier 1	
folic acid oral tablet 400 mcg, 800 mcg	Tier 0	
HYLAZINC ORAL TABLET 1 MG-1.5 MG- 1.7 MG-50 MG (folic acid/thiamine/riboflavin/niacin/pyridoxine/B12/C/zinc)	Tier 3	
methylnetetrahydrofolate glucosa oral capsule 1,000 mcg dfe, 5,000 mcg dfe	Tier 3	
Vitamins - Folic Acid Combinations - Drugs For Nutrition		
WESTAB MAX ORAL TABLET 2.5-25-2 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB MINI ORAL TABLET 2.2-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB ONE ORAL TABLET 2.5-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - K, Phytonadione And Derivatives - Drugs For Nutrition		
AQUA-K CONCENTRATE ORAL DROPS 200 MCG-2 MG /0.2 ML (phytonadione (vitamin K1)/vitamin E TPGS)	Tier 3	
K1-1000 ORAL CAPSULE 1,000 MCG (phytonadione (vit K1))	Tier 3	
<i>phytonadione (vitamin k1) injection solution 10 mg/ml</i>	Tier 1	
<i>phytonadione (vitamin k1) injection syringe 1 mg/0.5 ml</i>	Tier 1	
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	
phytonadione (vit K1) (Vitamin K Injection Solution 1 Mg/0.5 MI)	Tier 1	
phytonadione (vit K1) (Vitamin K1 Injection Solution 10 Mg/MI)	Tier 1	
<i>vitamin k2 oral capsule 100 mcg, 45 mcg</i>	Tier 3	
Vitamins - Paba - Drugs For Nutrition		
POTABA ORAL CAPSULE 500 MG (potassium aminobenzoate)	Tier 3	
Endocrine - Hormones		
Abortifacients Or Cervical Ripening Agents - Prostaglandin Analogs - Drugs For Women		
CERVIDIL VAGINAL INSERT, EXTENDED RELEASE 10 MG (dinoprostone)	Tier 3	
PREPIDIL VAGINAL GEL 0.5 MG/3 G (dinoprostone)	Tier 3	
Abortifacients- Progesterone Receptor Antagonist - Drugs For Women		
MIFEPREX ORAL TABLET 200 MG (mifepristone)	Tier 3	
<i>mifepristone oral tablet 200 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Adrenal Steroid Inhibitors - Hormones		
ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG (osilodrostat phosphate)	Tier 4	PA
Adrenocorticotrophic Hormones - Hormones		
ACTHAR INJECTION GEL 80 UNIT/ML (corticotropin)	Tier 4	PA
Agents To Treat Hypoglycemia (Hyperglycemics) - Drugs For Diabetes		
BAQSIMI NASAL SPRAY, NON-AEROSOL 3 MG/ACTUATION (glucagon)	Tier 2	
<i>diazoxide oral suspension 50 mg/ml</i>	Tier 1	
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN 1 MG (glucagon HCl)	Tier 1	
glucagon (Glucagon Emergency Kit (Human) Injection Recon Soln 1 Mg)	Tier 2	
<i>glucose oral tablet, chewable 4 gram</i>	Tier 3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	
SWEET CHEEKS ORAL GEL IN SYRINGE 1.2 GRAM /3 ML (40 %) (dextrose)	Tier 3	
ZEGALOGUE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 0.6 MG/0.6 ML (dasiglucagon HCl)	Tier 2	
ZEGALOGUE SYRINGE SUBCUTANEOUS SYRINGE 0.6 MG/0.6 ML (dasiglucagon HCl)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Amyloidosis Agents- Transthyretin (Ttr) Stabilizer - Hormones		
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	Tier 4	PA
VYNDAQEL ORAL CAPSULE 20 MG (tafamidis meglumine)	Tier 4	PA
Amyloidosis Agents-Ttr Suppression, Antisense Oligonucleotide-Based - Hormones		
TEGSEDI SUBCUTANEOUS SYRINGE 284 MG/1.5 ML (inotersen sodium)	Tier 4	PA
Anabolic Steroid - Single Agents - Drugs For Men		
<i>oxandrolone oral tablet 10 mg, 2.5 mg</i>	Tier 1	PA
Androgen - Single Agents - Drugs For Men		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR (testosterone)	Tier 3	PA
JATENZO ORAL CAPSULE 158 MG, 198 MG, 237 MG (testosterone undecanoate)	Tier 3	PA
METHITEST ORAL TABLET 10 MG (methyltestosterone)	Tier 3	PA
<i>methyltestosterone oral capsule 10 mg</i>	Tier 1	PA
NATESTO NASAL GEL IN METERED-DOSE PUMP 5.5 MG/0.122 GRAM/ACTUATION (testosterone)	Tier 3	PA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	Tier 1	PA
<i>testosterone enanthate intramuscular oil 200 mg/ml</i>	Tier 1	PA
<i>testosterone transdermal gel 50 mg/5 gram (1 %)</i>	Tier 1	PA
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)</i>	Tier 1	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	Tier 1	PA
<i>testosterone transdermal solution in metered pump w/app 30 mg/actuation (1.5 ml)</i>	Tier 1	PA
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML (testosterone enanthate)	Tier 3	PA
Antidiuretic And Vasopressor Hormones - Hormones		
DDAVP NASAL SOLUTION 0.1 MG/ML (REFRIGERATE) (desmopressin acetate)	Tier 2	
<i>desmopressin injection solution 4 mcg/ml</i>	Tier 1	
<i>desmopressin nasal spray with pump 10 mcg/spray (0.1 ml)</i>	Tier 1	
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	
<i>desmopressin nasal spray,non-aerosol 150 mcg/spray (0.1 ml)</i>	Tier 3	
<i>desmopressin oral tablet 0.1 mg, 0.2 mg</i>	Tier 1	
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTEGRATING 55.3 MCG (desmopressin acetate)	Tier 3	QL (1 EA per 1 day)
NOCDURNA (WOMEN) SUBLINGUAL TABLET,DISINTEGRATING 27.7 MCG (desmopressin acetate)	Tier 3	QL (1 EA per 1 day)
NOCTIVA NASAL SPRAY,NON-AEROSOL 0.83 MCG/SPRAY (0.1 ML), 1.66 MCG/SPRAY (0.1 ML) (desmopressin acetate)	Tier 3	QL (3.8 GM per 30 days)
Antihyperglycemic - Alpha-Glucosidase Inhibitors - Drugs For Diabetes		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antihyperglycemic - Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors - Drugs For Diabetes		
<i>alogliptin oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	Tier 1	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (sitagliptin phosphate)	Tier 2	
ONGLYZA ORAL TABLET 2.5 MG, 5 MG (saxagliptin HCl)	Tier 2	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
TRADJENTA ORAL TABLET 5 MG (linagliptin)	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
Antihyperglycemic - Dopamine Receptor Agonists - Drugs For Diabetes		
CYCLOSET ORAL TABLET 0.8 MG (bromocriptine mesylate)	Tier 3	ST: Must meet any of the following requirements: Glipizide/Metformin HCL, Glyburide/Metformin HCL, Metformin HCL, or Riomet ER in 180 days
Antihyperglycemic - Glucocorticoid (Cortisol) Receptor Blocker (Gr-Ii) - Drugs For Diabetes		
KORLYM ORAL TABLET 300 MG (mifepristone)	Tier 4	PA
Antihyperglycemic - Meglitinide Analog And Biguanide Combinations - Drugs For Diabetes		
<i>repaglinide-metformin oral tablet 1-500 mg, 2-500 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic - Meglitinide Analogs - Drugs For Diabetes		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	Tier 1	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
Antihyperglycemic - Sglt-2 Inhibitor And Biguanide Combinations - Drugs For Diabetes		
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG (canagliflozin/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Farxiga, Jardiance, Synjardy, Synjardy XR, or Xigduo XR in 120 days
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG (canagliflozin/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Farxiga, Jardiance, Synjardy, Synjardy XR, or Xigduo XR in 120 days
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 7.5-1,000 MG, 7.5-500 MG (ertugliflozin pidolate/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Farxiga, Jardiance, Synjardy, Synjardy XR, or Xigduo XR in 120 days
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG (empagliflozin/metformin HCl)	Tier 2	
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 25-1,000 MG, 5-1,000 MG (empagliflozin/metformin HCl)	Tier 2	
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 2.5-1,000 MG, 5-1,000 MG, 5-500 MG (dapagliflozin propanediol/metformin HCl)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic - Sglt-2 Inhibitor And Dpp-4 Inhibitor Combinations - Drugs For Diabetes		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (empagliflozin/linagliptin)	Tier 3	
QTERN ORAL TABLET 10-5 MG, 5-5 MG (dapagliflozin propanediol/saxagliptin HCl)	Tier 3	
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (ertugliflozin pidolate/sitagliptin phosphate)	Tier 3	
Antihyperglycemic - Sodium Glucose Cotransporter-2 (Sglt2) Inhibitors - Drugs For Diabetes		
FARXIGA ORAL TABLET 10 MG, 5 MG (dapagliflozin propanediol)	Tier 2	
INVOKANA ORAL TABLET 100 MG, 300 MG (canagliflozin)	Tier 2	
JARDIANCE ORAL TABLET 10 MG, 25 MG (empagliflozin)	Tier 2	
STEGLATRO ORAL TABLET 15 MG, 5 MG (ertugliflozin pidolate)	Tier 2	
Antihyperglycemic - Sulfonylurea And Biguanide Combinations - Drugs For Diabetes		
<i>glipizide-metformin oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	Tier 1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	Tier 1	
Antihyperglycemic - Sulfonylurea Derivatives - Drugs For Diabetes		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>glipizide oral tablet extended release 24hr 10 mg, 2.5 mg, 5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	Tier 1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	Tier 1	
Antihyperglycemic - Thiazolidinedione And Biguanide Combinations - Drugs For Diabetes		
<i>pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg</i>	Tier 1	ST: Must meet any of the following requirements: Metformin, preferred Sulfonylurea or preferred Metformin/Sulfonylurea combination in 120 days
Antihyperglycemic - Thiazolidinedione And Sulfonylurea Combinations - Drugs For Diabetes		
<i>pioglitazone-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	Tier 1	ST: Must meet any of the following requirements: Metformin, preferred Sulfonylurea or preferred Metformin/Sulfonylurea combination in 120 days
Antihyperglycemic, Amylin Analog-Type - Drugs For Diabetes		
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR 2,700 MCG/2.7 ML (pramlintide acetate)	Tier 2	
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR 1,500 MCG/1.5 ML (pramlintide acetate)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic, Incretin Mimetic, Glp-1 Receptor Agonist Analog-Type - Drugs For Diabetes		
ADLYXIN SUBCUTANEOUS PEN INJECTOR 10 MCG/0.2 ML- 20 MCG/0.2 ML, 20 MCG/0.2 ML (lixisenatide)	Tier 3	ST: Must meet any of the following requirements: Bydureon Bcise, Bydureon Pen, Bydureon, Byetta, Ozempic, Rybelsus, Trulicity, Victoza, or Wegovy in 120 days
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85 ML (exenatide microspheres)	Tier 2	
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML (exenatide)	Tier 2	
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML), 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML) (semaglutide)	Tier 2	
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (semaglutide)	Tier 2	
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML (dulaglutide)	Tier 2	
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML) (liraglutide)	Tier 2	
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML) (liraglutide)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibitor And Thiazolidinedione - Drugs For Diabetes		
<i>alogliptin-pioglitazone oral tablet 12.5-15 mg, 12.5-30 mg, 12.5-45 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
Antihyperglycemic-Dipeptidyl Peptidase-4(Dpp-4)Inhibitor And Biguanide - Drugs For Diabetes		
<i>alogliptin-metformin oral tablet 12.5-1,000 mg, 12.5-500 mg</i>	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG (sitagliptin phosphate/metformin HCl)	Tier 2	
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG (sitagliptin phosphate/metformin HCl)	Tier 2	
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG (linagliptin/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG (linagliptin/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG (saxagliptin HCl/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Janumet, Janumet XR, or Januvia in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic-Insulin, Long Acting And Glp-1 Receptor Agonist Comb - Drugs For Diabetes		
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML (insulin glargine,human recombinant analog/lixisenatide)	Tier 2	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Bydureon Bcise, Bydureon Pen, Bydureon, Byetta, Levemir Flextouch, Levemir, Ozempic, Rybelsus, Tresiba Flextouch U-100, Tresiba Flextouch U-200, Tresiba, Trulicity, Victoza, or Wegovy in 120 days
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML) (insulin degludec/liraglutide)	Tier 2	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Bydureon Bcise, Bydureon Pen, Bydureon, Byetta, Levemir Flextouch, Levemir, Ozempic, Rybelsus, Tresiba Flextouch U-100, Tresiba Flextouch U-200, Tresiba, Trulicity, Victoza, or Wegovy in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic-Sglt-2 Inhibitor, Dpp-4 Inhibitor And Biguanide Comb - Drugs For Diabetes		
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 12.5-2.5-1,000 MG, 25-5-1,000 MG, 5-2.5-1,000 MG (empagliflozin/linagliptin/metformin HCl)	Tier 3	ST: Must meet any of the following requirements: Farxiga, Janumet XR, Janumet, Januvia, Jardiance, Synjardy, Synjardy XR, or Xigduo XR in 120 days
Antithyroid Agents, Thionamides - Imidazole Derivatives - Drugs For Thyroid		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier 1	
Antithyroid Agents, Thionamides - Thiouracil Derivatives - Drugs For Thyroid		
<i>propylthiouracil oral tablet 50 mg</i>	Tier 1	
Bone Formation Stimulating Agents - Parathyroid Hormone Rel Peptides - Drugs For Menopause And Bone Loss		
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML) (abaloparatide)	Tier 4	PA
Bone Formation Stimulating Agents - Parathyroid Hormone-Type - Drugs For Menopause And Bone Loss		
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML) (teriparatide)	Tier 4	PA; QL (2.4 ML per 28 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	Tier 4	PA; QL (2.4 ML per 28 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bone Resorption Inhibitors - Bisphosphonate And Vitamin D Combinations - Drugs For Menopause And Bone Loss		
FOSAMAX PLUS D ORAL TABLET 70 MG- 2,800 UNIT, 70 MG- 5,600 UNIT (alendronate sodium/cholecalciferol (vitamin D3))	Tier 2	
Bone Resorption Inhibitors - Bisphosphonates - Drugs For Menopause And Bone Loss		
<i>alendronate oral solution 70 mg/75 ml</i>	Tier 1	QL (75 ML per 7 days)
<i>alendronate oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	Tier 1	
BINOSTO ORAL TABLET, EFFERVESCENT 70 MG (alendronate sodium)	Tier 3	ST: Must meet 2 of the following requirements: Alendronate Sodium, Fosamax Plus D, or Ibandronate Sodium in 365 days; QL (4 EA per 28 days)
<i>etidronate disodium oral tablet 200 mg</i>	Tier 1	
<i>ibandronate oral tablet 150 mg</i>	Tier 1	
<i>risedronate oral tablet 150 mg</i>	Tier 1	ST: Must meet the following requirements: Alendronate Sodium and Ibandronate Sodium in 365 days; QL (1 EA per 30 days)
<i>risedronate oral tablet 30 mg, 5 mg</i>	Tier 1	ST: Must meet the following requirements: Alendronate Sodium and Ibandronate Sodium in 365 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risedronate oral tablet 35 mg</i>	Tier 1	ST: Must meet the following requirements: Alendronate Sodium and Ibandronate Sodium in 365 days; QL (1 EA per 7 days)
<i>risedronate oral tablet, delayed release (dr/ec) 35 mg</i>	Tier 1	ST: Must meet the following requirements: Alendronate Sodium and Ibandronate Sodium in 365 days; QL (1 EA per 7 days)
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer - Drugs For Menopause And Bone Loss		
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	Tier 4	QL (2 EA per 1 day)
<i>cinacalcet oral tablet 90 mg</i>	Tier 4	QL (4 EA per 1 day)
Calcitonins - Drugs For Menopause And Bone Loss		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	Tier 1	
<i>calcitonin (salmon) nasal spray, non-aerosol 200 unit/actuation</i>	Tier 1	
Estrogen And Progestin With Antimineralocorticoid Activity, Combination - Drugs For Women		
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (drospirenone/estradiol)	Tier 3	
Estrogen And Selective Estrogen Receptor Modulator (Serm) Combinations - Drugs For Women		
DUAVEE ORAL TABLET 0.45-20 MG (estrogens, conjugated/bazedoxifene acetate)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Estrogen-Androgen - Drugs For Women		
COVARYX H.S. ORAL TABLET 0.625-1.25 MG (estrogens,esterified/methyltestosterone)	Tier 1	
COVARYX ORAL TABLET 1.25-2.5 MG (estrogens,esterified/methyltestosterone)	Tier 1	
EEMT HS ORAL TABLET 0.625-1.25 MG (estrogens,esterified/methyltestosterone)	Tier 1	
EEMT ORAL TABLET 1.25-2.5 MG (estrogens,esterified/methyltestosterone)	Tier 1	
<i>estrogens-methyltestosterone oral tablet 0.625-1.25 mg, 1.25-2.5 mg</i>	Tier 1	
Estrogen-Progestin - Drugs For Women		
estradiol/norethindrone acetate (Amabelz Oral Tablet 0.5-0.1 Mg, 1-0.5 Mg)	Tier 1	
BIJUVA ORAL CAPSULE 1-100 MG (estradiol/progesterone)	Tier 3	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/24 HR (estradiol/levonorgestrel)	Tier 3	QL (1 EA per 7 days)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR (estradiol/norethindrone acetate)	Tier 2	QL (2 EA per 7 days)
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	Tier 1	
norethindrone acetate-ethinyl estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg)	Tier 1	
norethindrone acetate-ethinyl estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)	Tier 1	
estradiol/norethindrone acetate (Mimvey Oral Tablet 1-0.5 Mg)	Tier 1	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREFEST ORAL TABLET 1 MG (15)/1 MG- 0.09 MG (15) (estradiol/norgestimate)	Tier 3	
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14) (estrogens, conjugated/medroxyprogesterone acetate)	Tier 2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (estrogens, conjugated/medroxyprogesterone acetate)	Tier 2	
Estrogens - Drugs For Women		
ALORA TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR (estradiol)	Tier 2	QL (2 EA per 7 days)
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML (estradiol valerate)	Tier 3	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	Tier 3	
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %), 1.25 MG/1.25 GRAM (0.1 %) (estradiol)	Tier 2	
estradiol (Dotti Transdermal Patch Semiweekly 0.025 Mg/24 Hr, 0.0375 Mg/24 Hr, 0.05 Mg/24 Hr, 0.075 Mg/24 Hr, 0.1 Mg/24 Hr)	Tier 1	QL (2 EA per 7 days)
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP 0.87 GRAM/ACTUATION (estradiol)	Tier 3	
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	Tier 1	QL (2 EA per 7 days)
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	Tier 1	QL (1 EA per 7 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	Tier 3	
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ACTUATION (estradiol)	Tier 3	
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL 1.53 MG/SPRAY (1.7%) (estradiol)	Tier 3	ST: Must meet the following requirement: Alora or Estradiol in 120 days
estradiol (Lyllana Transdermal Patch Semiweekly 0.025 Mg/24 Hr, 0.0375 Mg/24 Hr, 0.05 Mg/24 Hr, 0.075 Mg/24 Hr, 0.1 Mg/24 Hr)	Tier 1	QL (2 EA per 7 days)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (estrogens, esterified)	Tier 2	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24 HR (estradiol)	Tier 3	QL (1 EA per 7 days)
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens, conjugated)	Tier 2	
Fertility Enhancer - Luteal Phase Supporting, Progesterone-Type - Drugs For Women		
CRINONE VAGINAL GEL 8 % (progesterone, micronized)	Tier 3	ST: Must meet the following requirement: Endometrin in 120 days
ENDOMETRIN VAGINAL INSERT 100 MG (progesterone, micronized)	Tier 2	
Fertility Enhancer - Ovulation Stimulant - Synthetic (Non-Fsh) - Drugs For Women		
<i>clomiphene citrate oral tablet 50 mg</i>	Tier 1	
Follicle-Stimulating And Luteinizing Hormones - Drugs For Women		
MENOPUR SUBCUTANEOUS RECON SOLN 75 UNIT (menotropins)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Follicle-Stimulating Hormone (Fsh) - Drugs For Women		
BRAVELLE INJECTION RECON SOLN 75 UNIT (urofollitropin)	Tier 4	
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML (follitropin beta, recombinant)	Tier 4	ST: Must meet any of the following requirements: Gonal-F RFF, Gonal-F RFF Redi-ject, or Gonal-F in 120 days
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR 300/0.5 UNIT/ML, 450/0.75 UNIT/ML, 900/1.5 UNIT/ML (follitropin alfa, recombinant)	Tier 4	
GONAL-F RFF SUBCUTANEOUS RECON SOLN 75 UNIT (follitropin alfa, recombinant)	Tier 4	
GONAL-F SUBCUTANEOUS RECON SOLN 1,050 UNIT, 450 UNIT (follitropin alfa, recombinant)	Tier 4	
Glucocorticoid Salt Combinations - Drugs For Inflammation		
BETALOAN SUIK KIT 6 MG/ML (betamethasone acetate and sodium phosph/norflurane/HFC 245fa)	Tier 3	
Glucocorticoids - Drugs For Inflammation		
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (hydrocortisone)	Tier 4	PA
dexamethasone (Decadron Oral Tablet 0.5 Mg, 0.75 Mg, 4 Mg, 6 Mg)	Tier 1	
dexamethasone (Dexabliss Oral Tablets, Dose Pack 1.5 Mg (39 Tabs))	Tier 1	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
DEXAMETHASONE INTENSOL ORAL DROPS 1 MG/ML (dexamethasone)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dexamethasone oral elixir 0.5 mg/5 ml</i>	Tier 1	
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	Tier 1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1.5 mg, 4 mg, 6 mg</i>	Tier 1	
<i>dexamethasone oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>dexamethasone oral tablets, dose pack 1.5 mg (21 tabs), 1.5 mg (35 tabs), 1.5 mg (51 tabs)</i>	Tier 1	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
DEXONTO IONTOPHORETIC SOLUTION 0.4 % (dexamethasone sodium phosphate)	Tier 3	
DMT SUIK KIT 10 MG/ML (dexamethasone/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
dexamethasone (Dxevo Oral Tablets, Dose Pack 1.5 Mg (39 Tabs))	Tier 3	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (deflazacort)	Tier 4	PA
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (deflazacort)	Tier 4	PA
HEMADY ORAL TABLET 20 MG (dexamethasone)	Tier 3	
dexamethasone (Hidex Oral Tablets, Dose Pack 1.5 Mg (21 Tabs))	Tier 1	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
MEDROL ORAL TABLET 2 MG (methylprednisolone)	Tier 2	
MEDROLOAN II SUIK KIT 40 MG/ML (methylprednisolone acetate/norflurane/HFC 245fa)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDROLOAN SUIK KIT 40 MG/ML (methylprednisolone acetate/norflurane/HFC 245fa)	Tier 3	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
<i>methylprednisolone oral tablets,dose pack 4 mg</i>	Tier 1	
MILLIPRED DP ORAL TABLETS,DOSE PACK 5 MG (21 TABS), 5 MG (48 TABS) (prednisolone)	Tier 2	
MILLIPRED ORAL TABLET 5 MG (prednisolone)	Tier 2	
<i>prednisolone oral solution 15 mg/5 ml</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/ml), 20 mg/5 ml (4 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (5 ml)</i>	Tier 3	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml)</i>	Tier 1	
<i>prednisolone sodium phosphate oral tablet,disintegrating 10 mg, 15 mg, 30 mg</i>	Tier 1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (prednisone)	Tier 2	
<i>prednisone oral solution 5 mg/5 ml</i>	Tier 1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	Tier 1	
<i>prednisone oral tablets,dose pack 10 mg, 5 mg</i>	Tier 1	
RAYOS ORAL TABLET,DELAYED RELEASE (DR/EC) 1 MG, 2 MG, 5 MG (prednisone)	Tier 3	PA
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 100 MG/2 ML (hydrocortisone sodium succinate/PF)	Tier 3	
SOLU-CORTEF INJECTION RECON SOLN 100 MG (hydrocortisone sod succinate)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dexamethasone (Taperdex Oral Tablets,Dose Pack 1.5 Mg (21 Tabs), 1.5 Mg (49 Tabs))	Tier 1	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS) (dexamethasone)	Tier 1	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
TRILOAN II SUIK KIT 40 MG/ML (triamcinolone/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
TRILOAN SUIK KIT 40 MG/ML (triamcinolone/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
ZCORT ORAL TABLETS,DOSE PACK 1.5 MG (25 TABS) (dexamethasone)	Tier 3	ST: Must meet the following requirement: generic Dexamethasone 1.5mg tablets in 120 days
Gonadotropin Inhibitor Pituitary Suppressants - Drugs For Women		
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	Tier 1	
Growth Hormone Receptor Antagonists - Drugs For Growth		
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (pegvisomant)	Tier 4	
Growth Hormone Releasing Hormones (Ghrh) - Drugs For Growth		
EGRIFTA SV SUBCUTANEOUS RECON SOLN 2 MG (tesamorelin acetate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Growth Hormones - Drugs For Growth		
GENOTROPIN MINIQUEL SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML, 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML (somatropin)	Tier 4	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML), 5 MG/ML (15 UNIT/ML) (somatropin)	Tier 4	PA
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT), 6 MG (18 UNIT) (somatropin)	Tier 4	PA
HUMATROPE INJECTION RECON SOLN 5 (15 UNIT) MG (somatropin)	Tier 4	PA
NORDITROPIN FLEXPEN SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) (somatropin)	Tier 4	PA
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML), 5 MG/2 ML (2.5 MG/ML) (somatropin)	Tier 4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) (somatropin)	Tier 4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG (somatropin)	Tier 4	PA
SAIZEN SAIZENPREP SUBCUTANEOUS CARTRIDGE 8.8 MG/1.51 ML (FINAL CONC.) (somatropin)	Tier 4	PA
SAIZEN SUBCUTANEOUS RECON SOLN 5 MG, 8.8 MG (somatropin)	Tier 4	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG (somatropin)	Tier 4	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG, 5 MG (somatropin)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Human Chorionic Gonadotropin (Hcg) - Drugs For Women		
<i>chorionic gonadotropin, human intramuscular recon soln 10,000 unit</i>	Tier 3	ST: Must meet the following requirement: Novarel or Ovidrel in 120 days
NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT, 5,000 UNIT (chorionic gonadotropin, human)	Tier 2	
OVIDREL SUBCUTANEOUS SYRINGE 250 MCG/0.5 ML (choriogonadotropin alfa)	Tier 2	
PREGNYL INTRAMUSCULAR RECON SOLN 10,000 UNIT (chorionic gonadotropin, human)	Tier 3	ST: Must meet the following requirement: Novarel or Ovidrel in 120 days
Human Insulins - Fixed Combinations - Drugs For Diabetes		
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 3	ST: Must meet the following requirement: Humulin 70-30 or Humulin 70/30 Kwikpen in 120 days
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 3	ST: Must meet the following requirement: Humulin 70-30 or Humulin 70/30 Kwikpen in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Human Insulins - Intermediate Acting - Drugs For Diabetes		
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin NPH human isophane)	Tier 3	
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (insulin NPH human isophane)	Tier 2	
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin NPH human isophane)	Tier 3	ST: Must meet the following requirement: Humulin N in 120 days
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (insulin NPH human isophane)	Tier 3	ST: Must meet the following requirement: Humulin N in 120 days
Human Insulins - Rapid Acting - Drugs For Diabetes		
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (90)/ 12 UNIT (90) (insulin regular, human)	Tier 3	PA
Human Insulins - Short Acting - Drugs For Diabetes		
HUMULIN R REGULAR U-100 INSULIN INJECTION SOLUTION 100 UNIT/ML (insulin regular, human)	Tier 2	
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML (insulin regular, human)	Tier 2	
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML) (insulin regular, human)	Tier 2	
MYXREDLIN INTRAVENOUS SOLUTION 100 UNIT/100 ML (1 UNIT/ML) (insulin regular, human in 0.9 % sodium chloride)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin regular, human)	Tier 3	ST: Must meet the following requirement: Humulin R or Humulin R U-500 in 120 days
NOVOLIN R REGULAR U-100 INSULN INJECTION SOLUTION 100 UNIT/ML (insulin regular, human)	Tier 3	ST: Must meet the following requirement: Humulin R or Humulin R U-500 in 120 days
Insulin Analogs - Fixed Combinations - Drugs For Diabetes		
HUMALOG MIX 50-50 INSULN U-100 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (50-50) (insulin lispro protamine and insulin lispro)	Tier 2	
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50) (insulin lispro protamine and insulin lispro)	Tier 2	
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25) (insulin lispro protamine and insulin lispro)	Tier 2	
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25) (insulin lispro protamine and insulin lispro)	Tier 2	
<i>insulin asp prt-insulin aspart subcutaneous insulin pen 100 unit/ml (70-30)</i>	Tier 3	ST: Must meet any of the following requirements: Humalog Mix 75-25 in 120 days
<i>insulin asp prt-insulin aspart subcutaneous solution 100 unit/ml (70-30)</i>	Tier 3	ST: Must meet any of the following requirements: Humalog Mix 75-25 in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30) (insulin aspart protamine human/insulin aspart)	Tier 3	ST: Must meet any of the following requirements: Humalog Mix 75-25 in 120 days
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin aspart protamine human/insulin aspart)	Tier 3	ST: Must meet any of the following requirements: Humalog Mix 75-25 in 120 days
Insulin Analogs - Long Acting - Drugs For Diabetes		
BASAGLAR KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 2	
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
LEVEMIR FLEXTOUCH U-100 INSULN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin detemir)	Tier 2	
LEVEMIR U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin detemir)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEMGLEE PEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
SEMGLEE U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
SEMGLEE(INSULIN GLARGINE-YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine-yfgn)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
SEMGLEE(INSULIN GLARG-YFGN)PEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine-yfgn)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: Must meet any of the following requirements: Basaglar Kwikpen U-100, Levemir Flextouch, Levemir, Tresiba Flextouch U-100, Tresiba Flextouch U-200, or Tresiba in 120 days
TRESIBA FLEXTOUCH U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin degludec)	Tier 2	
TRESIBA FLEXTOUCH U-200 SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin degludec)	Tier 2	
TRESIBA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin degludec)	Tier 2	
Insulin Analogs - Rapid Acting - Drugs For Diabetes		
ADMELOG SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro)	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADMELOG U-100 INSULIN LISPRO SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro)	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin glulisine)	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glulisine)	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart (niacinamide))	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML) (insulin aspart (niacinamide))	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin aspart (niacinamide))	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT 100 UNIT/ML (insulin lispro)	Tier 2	
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro)	Tier 1	
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin lispro)	Tier 2	
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (insulin lispro)	Tier 2	
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro)	Tier 1	
<i>insulin aspart u-100 subcutaneous cartridge 100 unit/ml</i>	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
<i>insulin aspart u-100 subcutaneous insulin pen 100 unit/ml (3 ml)</i>	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin aspart u-100 subcutaneous solution 100 unit/ml</i>	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
LYUMJEV KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro-aabc)	Tier 2	
LYUMJEV KWIKPEN U-200 INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin lispro-aabc)	Tier 2	
LYUMJEV U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro-aabc)	Tier 2	
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart)	Tier 3	ST: Must meet any of the following requirements: Humalog Kwikpen U-200, Humalog, Lyumjev Kwikpen U-100, Lyumjev Kwikpen U-200, or Lyumjev in 120 days
Insulin Response Enhancers - Biguanides - Drugs For Diabetes		
DM2 COMBO PACK, TABLET AND STRIP 500 MG (metformin HCl/blood sugar diagnostic)	Tier 3	
<i>metformin oral solution 500 mg/5 ml</i>	Tier 1	
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	Tier 1	
<i>metformin oral tablet extended release 24 hr 500 mg, 750 mg</i>	Tier 1	
<i>metformin oral tablet extended release 24hr 1,000 mg, 500 mg</i>	Tier 1	ST: Must meet the following requirement: Metformin HCL in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg, 500 mg</i>	Tier 1	ST: Must meet the following requirement: Metformin HCL in 120 days
RIOMET ER ORAL SUSPENSION,EXTENDED REL RECON 500 MG/5 ML (metformin HCl)	Tier 3	ST: Must meet the following requirement: Metformin HCL in 120 days
Insulin Response Enhancers - Thiazolidinediones (Ppar-Gamma Agonists) - Drugs For Diabetes		
<i>pioglitazone oral tablet 15 mg, 30 mg, 45 mg</i>	Tier 1	
Insulin-Like Growth Factor-1 (Igf-1) - Hormones		
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML (mecasermin)	Tier 4	PA
Leptin Hormone Analogs - Hormones		
MYALEPT SUBCUTANEOUS RECON SOLN 5 MG/ML (FINAL CONC.) (metreleptin)	Tier 4	QL (1 EA per 1 day)
Lhrh (Gnrh) Agonist Analog Pituitary Supp. And Progestin Comb. - Drugs For Women		
LUPANETA PACK (1 MONTH) KIT. SYRINGE AND TABLET 3.75 MG -5 MG (30) (leuprolide acetate/norethindrone acetate)	Tier 4	
LUPANETA PACK (3 MONTH) KIT. SYRINGE AND TABLET 11.25 MG -5 MG (90) (leuprolide acetate/norethindrone acetate)	Tier 4	
Lhrh (Gnrh) Agonist Analog Pituitary Suppressants - Drugs For Women		
SYNAREL NASAL SPRAY, NON-AEROSOL 2 MG/ML (nafarelin acetate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lhrh (Gnrh) Antagonist, Estrogen And Progestin Combinations - Drugs For Woman		
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix/estradiol/norethindrone acetate)	Tier 2	
ORIAHNN ORAL CAPSULE, SEQUENTIAL 300-1-0.5MG(AM) /300 MG(PM) (elagolix sodium/estradiol/norethindrone acetate)	Tier 2	
Lhrh (Gnrh) Antagonists - Drugs For Women		
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (cetorelix acetate)	Tier 4	
<i>ganirelix subcutaneous syringe 250 mcg/0.5 ml</i>	Tier 4	ST: Must meet the following requirement: Cetrotide in 120 days
ORILISSA ORAL TABLET 150 MG, 200 MG (elagolix sodium)	Tier 2	
Menopausal Symptoms Suppressant-Ssri Antidepressant Type - Drugs For Women		
<i>paroxetine mesylate(menop.sym) oral capsule 7.5 mg</i>	Tier 1	ST: Must meet the following requirements: Paroxetine HCL or Venlafaxine HCL in 120 days; QL (1 EA per 1 day)
Mineralocorticoids - Drugs For Inflammation		
<i>fludrocortisone oral tablet 0.1 mg</i>	Tier 1	
Oxytocic - Ergot Alkaloids - Drugs For Women		
<i>methylergonovine oral tablet 0.2 mg</i>	Tier 1	QL (28 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Parathyroid Hormones - Drugs For Menopause And Bone Loss		
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG/DOSE, 25 MCG/DOSE, 50 MCG/DOSE, 75 MCG/DOSE (parathyroid hormone)	Tier 4	PA
Progestins - Drugs For Women		
<i>medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>norethindrone acetate oral tablet 5 mg</i>	Tier 1	
<i>progesterone intramuscular oil 50 mg/ml</i>	Tier 1	
<i>progesterone micronized oral capsule 100 mg, 200 mg</i>	Tier 1	
Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists - Drugs For Women		
<i>cabergoline oral tablet 0.5 mg</i>	Tier 1	
Selective Estrogen Receptor Modulators (Serms) - Drugs For Menopause And Bone Loss		
<i>raloxifene oral tablet 60 mg</i>	Tier 1	
Somatostatic Agents - Drugs For Growth		
MYCAPSSA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG (octreotide acetate)	Tier 4	PA
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	Tier 4	
<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)</i>	Tier 4	
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML) (pasireotide diaspertate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Thyroid Hormone Combinations - Synthetic T3 And T4 - Drugs For Thyroid		
THYROLAR-1 ORAL TABLET 12.5-50 MCG (liotrix)	Tier 3	
THYROLAR-1/2 ORAL TABLET 6.25-25 MCG (liotrix)	Tier 3	
THYROLAR-1/4 ORAL TABLET 3.1-12.5 MCG (liotrix)	Tier 3	
THYROLAR-2 ORAL TABLET 25-100 MCG (liotrix)	Tier 3	
THYROLAR-3 ORAL TABLET 37.5-150 MCG (liotrix)	Tier 3	
Thyroid Hormones - Animal Source (Porcine) - Drugs For Thyroid		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (thyroid,pork)	Tier 2	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (thyroid,pork)	Tier 1	
WESTHROID ORAL TABLET 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG (thyroid,pork)	Tier 1	
Thyroid Hormones - Synthetic T3 (Triiodothyronine) - Drugs For Thyroid		
<i>liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg</i>	Tier 1	
Thyroid Hormones - Synthetic T4 (Thyroxine) - Drugs For Thyroid		
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 1	
<i>levothyroxine oral capsule 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier 1	PA
<i>levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THYQUIDITY ORAL SOLUTION 20 MCG/ML (levothyroxine sodium)	Tier 3	
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (levothyroxine sodium)	Tier 3	PA
Enzymes - Vitamins And Minerals		
Enzymes - Vitamins And Minerals		
HYQVIA HY COMPONENT SUBCUTANEOUS SOLUTION 1,600 UNIT/10 ML, 2,400 UNIT/15 ML, 200 UNIT/1.25 ML, 400 UNIT/2.5 ML, 800 UNIT/5 ML (hyaluronidase, human recomb.)	Tier 3	
Fdb Class Obsolete-Not Used		
Alternative Therapy - Homeopathic Products		
AURUMHEEL ORAL DROPS (homeopathic drugs)	Tier 3	
CANTHARIS COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	
CRALONIN ORAL DROPS (homeopathic drugs)	Tier 3	
EYE ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
LAMIOFLUR ORAL DROPS (homeopathic drugs)	Tier 3	
PLANTAGO-HOMACCORD ORAL DROPS (homeopathic drugs)	Tier 3	
POPULUS COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	
PSORINOHEEL ORAL DROPS (homeopathic drugs)	Tier 3	
RENEEL ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
SABAL-HOMACCORD ORAL DROPS (homeopathic drugs)	Tier 3	
SYZYGIUM COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERTIGOHEEL ORAL DROPS (homeopathic drugs)	Tier 3	
VERTIGOHEEL ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
Gastrointestinal Therapy Agents - Drugs For The Stomach		
Antacid - Calcium - Drugs For Ulcers And Stomach Acid		
PRELIEF ORAL TABLET 65 MG (calcium glycerophosphate)	Tier 3	
Antacid - Magnesium - Drugs For Ulcers And Stomach Acid		
<i>magnesium oxide oral tablet 400 mg (241.3 mg magnesium)</i>	Tier 3	
Antacid Combinations Other - Drugs For Ulcers And Stomach Acid		
ALKA-SELTZER PM (MELATONIN) ORAL TABLET,CHEWABLE 250-1.5 MG (calcium phosphate, tribasic/melatonin)	Tier 3	
Antidiarrheal - Antiperistaltic Agents - Drugs For Diarrhea		
<i>loperamide oral capsule 2 mg</i>	Tier 1	
<i>opium tincture oral tincture 10 mg/ml (morphine)</i>	Tier 1	
Antidiarrheal - Gastrointestinal Chloride Channel Inhibitors - Drugs For Diarrhea		
MYTESI ORAL TABLET,DELAYED RELEASE (DR/EC) 125 MG (crofelemer)	Tier 3	ST: Must meet the following requirement: Antiretrovirals in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidiarrheal - Tryptophan Hydroxylase Inhibitor - Drugs For Diarrhea		
XERMELO ORAL TABLET 250 MG (telotristat etiprate)	Tier 4	PA
Antidiarrheal Antiperistaltic-Anticholinergic Combinations - Drugs For Diarrhea		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	Tier 1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Tier 1	
MOTOFEN ORAL TABLET 1-0.025 MG (difenoxin HCl/atropine sulfate)	Tier 3	ST: Must meet the following requirement: Diphenoxylate HCL/Atropine in 120 days; QL (8 EA per 1 day)
Antiemetic - Anticholinergics - Drugs For Vomiting And Nausea		
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	Tier 1	
Antiemetic - Antihistamines - Drugs For Vomiting And Nausea		
ANTIVERT ORAL TABLET 50 MG (meclizine HCl)	Tier 3	QL (2 EA per 1 day)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	
Antiemetic - Antihistamine-Vitamin Combinations - Drugs For Vomiting And Nausea		
BONJESTA ORAL TABLET,IR,DELAYED REL,BIPHASIC 20-20 MG (doxylamine succinate/pyridoxine HCl (vitamin B6))	Tier 3	QL (60 EA per 30 days)
<i>doxylamine-pyridoxine (vit b6) oral tablet, delayed release (dr/ec) 10-10 mg</i>	Tier 1	QL (120 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiemetic - Cannabinoid Type - Drugs For Vomiting And Nausea		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Antiemetic - Dopamine (D2)/5-Ht3 Antagonists - Drugs For Vomiting And Nausea		
<i>trimethobenzamide oral capsule 300 mg</i>	Tier 1	
Antiemetic - Phenothiazines - Drugs For Vomiting And Nausea		
prochlorperazine (Compro Rectal Suppository 25 Mg)	Tier 1	
<i>prochlorperazine rectal suppository 25 mg</i>	Tier 1	
<i>promethazine rectal suppository 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 25 Mg)	Tier 1	
Antiemetic - Selective Serotonin 5-Ht3 Antagonists - Drugs For Vomiting And Nausea		
<i>granisetron hcl oral tablet 1 mg</i>	Tier 1	ST: Must meet the following requirement: Ondansetron or Ondansetron HCL in 120 days; QL (8 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5 ml</i>	Tier 1	QL (50 ML per 15 days)
<i>ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg</i>	Tier 1	
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	Tier 1	
SANCUSO TRANSDERMAL PATCH WEEKLY 3.1 MG/24 HOUR (granisetron)	Tier 3	QL (1 EA per 7 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZUPLENZ ORAL FILM 4 MG (ondansetron)	Tier 3	ST: Must meet the following requirement: Ondansetron or Ondansetron HCL in 120 days; QL (2 EA per 3 days)
ZUPLENZ ORAL FILM 8 MG (ondansetron)	Tier 3	ST: Must meet the following requirement: Ondansetron or Ondansetron HCL in 120 days; QL (1 EA per 3 days)
Antiemetic - Substance P-Neurokinin 1 (Nk1) Receptor Antagonists - Drugs For Vomiting And Nausea		
<i>aprepitant oral capsule 125 mg</i>	Tier 1	QL (1 EA per 21 days)
<i>aprepitant oral capsule 40 mg</i>	Tier 1	QL (1 EA per 28 days)
<i>aprepitant oral capsule 80 mg</i>	Tier 1	QL (2 EA per 21 days)
<i>aprepitant oral capsule, dose pack 125 mg (1)- 80 mg (2)</i>	Tier 1	QL (3 EA per 21 days)
EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ ML FINAL CONC.) (aprepitant)	Tier 2	QL (3 EA per 21 days)
VARUBI ORAL TABLET 90 MG (rolapitant HCl)	Tier 3	QL (2 EA per 14 days)
Antiemetic - Substance P-Neurokinin 1 And 5-Ht3 Recept Antagonist Comb - Drugs For Vomiting And Nausea		
AKYNZEO (NETUPITANT) ORAL CAPSULE 300-0.5 MG (netupitant/palonosetron HCl)	Tier 2	QL (1 EA per 28 days)
Bile Acids - Drugs For The Stomach		
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (cholic acid)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Chronic Idiopathic Const. Agents - Guanylate Cyclase-C (Gc-C) Agonists - Drugs For Constipation		
TRULANCE ORAL TABLET 3 MG (plecanatide)	Tier 3	ST: Must meet the following requirement: Linzess in 120 days; QL (1 EA per 1 day)
Colonic Acidifier (Ammonia Inhibitor) - Drugs For The Stomach		
lactulose (Enulose Oral Solution 10 Gram/15 Ml)	Tier 1	
lactulose (Generlac Oral Solution 10 Gram/15 Ml)	Tier 1	
<i>lactulose oral solution 10 gram/15 ml (15 ml)</i>	Tier 1	
Digestive Enzyme Mixtures - Drugs For The Stomach		
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT (lipase/protease/amylase)	Tier 2	
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT, 4,200-14,200- 24,600 UNIT (lipase/protease/amylase)	Tier 3	
PANXYME PH ORAL CAPSULE 10.2-10-45 MG (lipase/protease/amylase)	Tier 3	
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 24,000-86,250- 90,750 UNIT, 4,000-14,375- 15,125 UNIT, 8,000-28,750- 30,250 UNIT (lipase/protease/amylase)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIOKACE ORAL TABLET 10,440-39,150- 39,150 UNIT, 20,880-78,300- 78,300 UNIT (lipase/protease/amylase)	Tier 3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT (lipase/protease/amylase)	Tier 2	
Digestive Enzymes - Drugs For The Stomach		
DAIRY DIGESTIVE ORAL TABLET 9,000 UNIT (lactase)	Tier 3	
DAIRY RELIEF ORAL TABLET 3,000 UNIT, 9,000 UNIT (lactase)	Tier 3	
SUCRAID ORAL SOLUTION 8,500 UNIT/ML (sacrosidase)	Tier 4	PA
Gallstone Solubilizing (Litholysis) Agents - Drugs For The Stomach		
CHENODAL ORAL TABLET 250 MG (chenodiol)	Tier 4	PA
RELTONE ORAL CAPSULE 200 MG, 400 MG (ursodiol)	Tier 3	PA
<i>ursodiol oral capsule 200 mg, 400 mg</i>	Tier 1	PA
<i>ursodiol oral capsule 300 mg</i>	Tier 1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	Tier 1	
Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists - Drugs For Ulcers And Stomach Acid		
<i>cimetidine hcl oral solution 300 mg/5 ml</i>	Tier 1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	Tier 1	
<i>famotidine oral suspension 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	Tier 1	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	Tier 1	
<i>nizatidine oral solution 150 mg/10 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (Ppis) - Drugs For Ulcers And Stomach Acid		
ACIPHEX SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 10 MG, 5 MG (rabeprazole sodium)	Tier 3	ST: Must meet 2 of the following requirements: Lansoprazole, Omeprazole, or Pantoprazole Sodium in 365 days; QL (1 EA per 1 day)
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG, 60 MG (dexlansoprazole)	Tier 2	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec) 20 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec) 40 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg</i>	Tier 1	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</i>	Tier 1	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (2 EA per 1 day)
<i>esomeprazole strontium oral capsule, delayed release(dr/ec) 49.3 mg</i>	Tier 3	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, or Pantoprazole Sodium in 120 days; QL (4 EA per 1 day)
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg, 30 mg</i>	Tier 1	
<i>lansoprazole oral tablet, disintegrat, delay rel 15 mg, 30 mg</i>	Tier 1	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, or Pantoprazole Sodium in 120 days
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 2.5 MG, 5 MG (esomeprazole magnesium)	Tier 2	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)
<i>omeprazole oral capsule, delayed release(dr/ec) 10 mg, 20 mg, 40 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pantoprazole oral granules dr for susp in packet 40 mg</i>	Tier 1	ST: Must meet any of the following requirements: Omeprazole Magnesium, Omeprazole, Pantoprazole Sodium, Prilosec OTC, or Prilosec in 120 days
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg, 40 mg</i>	Tier 1	
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 10 MG, 2.5 MG (omeprazole magnesium)	Tier 3	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days
<i>rabeprazole oral capsule, delayed rel sprinkle 10 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Lansoprazole, Omeprazole, or Pantoprazole Sodium in 365 days; QL (1 EA per 1 day)
<i>rabeprazole oral tablet, delayed release (dr/ec) 20 mg</i>	Tier 1	QL (1 EA per 1 day)
Gastric Acid Secretion Reducing-Proton Pump Inhibitor And Antacid Comb - Drugs For Ulcers And Stomach Acid		
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram, 40-1.1 mg-gram</i>	Tier 1	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i>	Tier 3	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)
<i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i>	Tier 1	ST: Must meet any of the following requirements: Lansoprazole, Omeprazole, Pantoprazole Sodium, or Prilosec OTC in 120 days; QL (1 EA per 1 day)
Gastric Mucosa - Cytoprotective Prostaglandin Analogs - Drugs For Ulcers And Stomach Acid		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	Tier 1	
Gastrointestinal - Prokinetic Agents - 5-Ht4 Receptor Agonists - Drugs For The Stomach		
MOTEGRITY ORAL TABLET 1 MG, 2 MG (prucalopride succinate)	Tier 3	ST: Must meet the following requirement: Linzess in 120 days; QL (1 EA per 1 day)
Gastrointestinal Antiflatulents - Drugs For The Stomach		
<i>activated charcoal oral capsule 260 mg</i>	Tier 3	
BEANAID ORAL CAPSULE 300 UNIT (alpha-D-galactosidase)	Tier 3	
BEANO ORAL TABLET 400 UNIT (alpha-D-galactosidase)	Tier 3	
GAS RELIEF-PREVENTION ORAL CAPSULE 600 UNIT (alpha-D-galactosidase)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-Ht4 Agonists - Drugs For The Stomach		
GIMOTI NASAL SPRAY WITH PUMP 15 MG/SPRAY (metoclopramide HCl)	Tier 4	PA
<i>metoclopramide hcl oral solution 5 mg/5 ml</i>	Tier 1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>metoclopramide hcl oral tablet, disintegrating 10 mg, 5 mg</i>	Tier 1	
Gi Antispasmodic - Belladonna Alkaloids - Drugs For Stomach Cramps		
ED-SPAZ ORAL TABLET, DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 1	
<i>hyoscyamine sulfate oral drops 0.125 mg/ml</i>	Tier 1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5 ml</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet extended release 12 hr 0.375 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet, disintegrating 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	Tier 1	
HYOSYNE ORAL DROPS 0.125 MG/ML (hyoscyamine sulfate)	Tier 1	
HYOSYNE ORAL ELIXIR 0.125 MG/5 ML (hyoscyamine sulfate)	Tier 1	
<i>methscopolamine oral tablet 2.5 mg, 5 mg</i>	Tier 1	
OSCIMIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
OSCIMIN SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
OSCIMIN SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMAX DUOTAB ORAL TABLET,EXT RELEASE MULTIPHASE 0.125 MG-0.25 MG (0.375 MG) (hyoscyamine sulfate)	Tier 3	
Gi Antispasmodic - Quaternary Ammonium Compounds - Drugs For Stomach Cramps		
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
Gi Antispasmodic - Synthetic Tertiary Amines - Drugs For Stomach Cramps		
<i>dicyclomine oral capsule 10 mg</i>	Tier 1	
<i>dicyclomine oral solution 10 mg/5 ml</i>	Tier 1	
<i>dicyclomine oral tablet 20 mg</i>	Tier 1	
Gi Antispasmodic Combinations Other - Drugs For Stomach Cramps		
<i>belladonna alkaloids-opium rectal suppository 16.2-30 mg, 16.2-60 mg</i>	Tier 1	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	Tier 1	
DONNATAL ORAL ELIXIR 16.2 MG-0.1037 MG/5 ML (5 ML), 16.2-0.1037 -0.0194 MG/5 ML (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (1200 ML per 30 days)
DONNATAL ORAL TABLET 16.2-0.1037 -0.0194 MG (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (8 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenobarb-hyoscy-atropine-scop oral elixir 16.2-0.1037 - 0.0194 mg/5 ml</i>	Tier 3	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (1200 ML per 30 days)
<i>phenobarb-hyoscy-atropine-scop oral tablet 16.2-0.1037 - 0.0194 mg</i>	Tier 1	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (8 EA per 1 day)
PHENOHYTRO ORAL ELIXIR 16.2-0.1037 -0.0194 MG/5 ML (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (1200 ML per 30 days)
PHENOHYTRO ORAL TABLET 16.2-0.1037 -0.0194 MG (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Must meet 2 of the following requirements: Dicyclomine HCL, Hyoscyamine Sulfate, or Symax Duotab in 365 days; QL (8 EA per 1 day)
Ibs Agent - Gastrointestinal Chloride Channel Activator Agents - Drugs For Irritable Bowel Syndrome		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	Tier 1	ST: Must meet the following requirement: Linzess or Movantik in 120 days; QL (2 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists - Drugs For Irritable Bowel Syndrome		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (linaclotide)	Tier 2	QL (1 EA per 1 day)
TRULANCE ORAL TABLET 3 MG (plecanatide)	Tier 3	ST: Must meet the following requirement: Linzess in 120 days; QL (1 EA per 1 day)
Ibs Agent - Selective Partial 5-Ht4 Receptor Agonists - Drugs For Irritable Bowel Syndrome		
ZELNORM ORAL TABLET 6 MG (tegaserod hydrogen maleate)	Tier 3	ST: Must meet the following requirement: Linzess in 120 days; QL (2 EA per 1 day); Age (Max 64 Years)
Inflammatory Bowel Agent - Interleukin-12 And Il-23 Inhibitors, Mc Ab - Drugs For Inflammatory Bowel Disease		
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab)	Tier 4	PA
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML (ustekinumab)	Tier 4	PA
Inflammatory Bowel Agent - Aminosalicylates And Related Agents - Drugs For Inflammatory Bowel Disease		
<i>balsalazide oral capsule 750 mg</i>	Tier 1	
DIPENTUM ORAL CAPSULE 250 MG (olsalazine sodium)	Tier 3	ST: Must meet any of the following requirements: Balsalazide Disodium, Mesalamine, or Pentasa in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIALDA ORAL TABLET, DELAYED RELEASE (DR/EC) 1.2 GRAM (mesalamine)	Tier 1	
<i>mesalamine oral capsule (with del rel tablets) 400 mg</i>	Tier 1	ST: Must meet any of the following requirements: Balsalazide Disodium, Mesalamine, or Pentasa in 120 days
<i>mesalamine oral capsule, extended release 24hr 0.375 gram</i>	Tier 1	
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	Tier 1	
<i>mesalamine rectal enema 4 gram/60 ml</i>	Tier 1	
<i>mesalamine rectal suppository 1,000 mg</i>	Tier 1	
<i>mesalamine with cleansing wipe rectal enema kit 4 gram/60 ml</i>	Tier 1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG, 500 MG (mesalamine)	Tier 2	
<i>sulfasalazine oral tablet 500 mg</i>	Tier 1	
<i>sulfasalazine oral tablet, delayed release (dr/ec) 500 mg</i>	Tier 1	
Inflammatory Bowel Agent - Glucocorticoids - Drugs For Inflammatory Bowel Disease		
<i>budesonide oral capsule, delayed, extend. release 3 mg</i>	Tier 1	
<i>budesonide oral tablet, delayed and ext. release 9 mg</i>	Tier 1	ST: Must meet the following requirement: Balsalazide Disodium in 120 days
CORTIFOAM RECTAL FOAM 10 % (80 MG) (hydrocortisone acetate)	Tier 3	
<i>hydrocortisone rectal enema 100 mg/60 ml</i>	Tier 1	
ORTIKOS ORAL CAPSULE, EXTENDED RELEASE 6 MG, 9 MG (budesonide)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UCERIS RECTAL FOAM 2 MG/ACTUATION (budesonide)	Tier 3	ST: Must meet the following requirement: Mesalamine enema in 120 days
Inflammatory Bowel Agent - Janus Kinase (Jak) Inhibitors - Drugs For Inflammatory Bowel Disease		
XELJANZ ORAL TABLET 10 MG, 5 MG (tofacitinib citrate)	Tier 4	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 22 MG (tofacitinib citrate)	Tier 4	PA
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers - Drugs For Inflammatory Bowel Disease		
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 4	PA
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 4	PA
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA PEN PSOR-UEVITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab)	Tier 4	PA
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 4	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML (golimumab)	Tier 2	PA
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML (golimumab)	Tier 2	PA
Intestinal Flora Modifiers - Drugs For Diarrhea		
<i>acidophilus-pectin</i> , citrus oral tablet 25 million cell -100 mg	Tier 3	
ADVANCED PROBIOTIC ORAL CAPSULE 625 MG (10 BILLION CELL) (<i>L.acidophilus/L.casei/L.lactis/L.rhamnosus/B.lactis/B.longum</i>)	Tier 3	
AZO COMPLETE FEMININE BALANCE ORAL CAPSULE 5 BILLION CELL (<i>Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus</i>)	Tier 3	
AZO DUAL PROTECTION ORAL CAPSULE 5 BILLION CELL- 15 MG (<i>L.crispatus/L.gasseri/L.jensenii/L.rhamnosus/bacteriophages</i>)	Tier 3	
BACICAP ORAL CAPSULE 20 BILLION CELL (<i>Lactobacillus acidophilus,paracasei,plantarum/B.animalis</i>)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOMEPRO ORAL CAPSULE,DELAYED RELEASE(DR/EC) 50 BILLION CELL (Lactobacillus acidophilus/Lactobacillus casei/L. rhamnosus)	Tier 3	
CHILDRENS CHEWABLE PROBIOTIC ORAL TABLET,CHEWABLE 1.5 BILLION CELL (L. acidophilus/L. rhamnosus/B. breve/S. thermophilus)	Tier 3	
CHILDREN'S PROBIOTIC ORAL TABLET,CHEWABLE 5 BILLION CELL (L.acidophilus,casei,rhamnosus/B.longum,breve)	Tier 3	
CULTURELLE BABY CALM-COMFORT ORAL DROPS 1.5B CELL-1 MG/ 5 DROPS (Lactobacillus rhamnosus GG/chamomile flowers extract)	Tier 3	
CULTURELLE BABY GROW-THRIVE ORAL POWDER IN PACKET 3.5 BILLION CELL-10 MCG (Lactobacillus rhamnosus/Bifidobacterium animalis/vitamin D3)	Tier 3	
CULTURELLE BABY PROBIOTIC-DHA ORAL DROPS 2.5 B CELL- 70 MG/0.5 ML (Lactobacillus rhamnosus GG/Bifidobacterium animalis/dha)	Tier 3	
CULTURELLE DIGESTIVE HEALTH ORAL CAPSULE 10 BILLION CELL -200 MG (Lactobacillus rhamnosus GG/inulin)	Tier 3	
CULTURELLE GUMMY ORAL TABLET,CHEWABLE 1.5 BILLION CELL-1 GRAM (Bacillus subtilis/inulin)	Tier 3	
CULTURELLE IMMUNE DEFENSE ORAL TABLET,CHEWABLE 10 BILLION CELL -90 MG-3 MG (L. rhamnosus GG/ascorbic acid/zinc oxide/elderberry fruit)	Tier 3	
CULTURELLE KIDS GROW-THRIVE ORAL POWDER IN PACKET 3.5 BILLION CELL-1 GRAM (Lactobacillus rhamnosus/Bifidobac animalis/fucosyllactose/D3)	Tier 3	
CULTURELLE KIDS GUMMY ORAL TABLET,CHEWABLE 1.5 BILLION CELL-1 GRAM (Bacillus subtilis/inulin)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CULTURELLE KIDS IMMUNE DEFENSE ORAL TABLET,CHEWABLE 5 BILLION CELL- 90 MG-1.88 MG (L. rhamnosus GG/ascorbic acid/zinc oxide/elderberry fruit)	Tier 3	
CULTURELLE KIDS PROBIOTICS ORAL POWDER IN PACKET 5 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE METABOLISM-WT MGMT ORAL CAPSULE 12 BILLION CELL -1.7 MG-2.4 MCG (Lactobacillus rhamnosus/Bifido animalis/vit B6/vit B12)	Tier 3	
CULTURELLE ORAL CAPSULE, SPRINKLE 15 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE PRENATAL PROBIOTIC ORAL TABLET,CHEWABLE 12 BILLION CELL (Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus)	Tier 3	
CULTURELLE TOTAL BALANCE ORAL CAPSULE 11 BILLION CELL (Lactobacillus paracasei/Lactobacillus rhamnosus)	Tier 3	
CULTURELLE ULTIMATE ORAL CAPSULE 20 BILLION CELL -200 MG (Lactobacillus rhamnosus GG/inulin)	Tier 3	
DERMACINRX LACTEROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROBITRAN ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROBITROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROMEROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DIGEST ADV PROBIO PLUS GAS ORAL CAPSULE 2 BILLION CELL (Bacillus coagulans/digestive enzymes combo no.10)	Tier 3	
DIGESTIVE ADV MULTISTRAIN GMMY ORAL TABLET,CHEWABLE 1 BILLION CELL (Bacillus coagulans/Bacillus subtilis)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIGESTIVE ADVANTAG KID PRO-PRE ORAL TABLET,CHEWABLE 400 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE ADVANCED ORAL CAPSULE 10 BILLION CELL (L.acidoph,paracasei, B.lactis)	Tier 3	
DIGESTIVE ADVANTAGE IMMUNE ORAL TABLET,CHEWABLE 250 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE INTENS BOW ORAL CAPSULE 1 BILLION CELL- 30,000 UNIT (Bacillus coagulans/protease/amylase/lipase)	Tier 3	
DIGESTIVE ADVANTAGE KID PROBIO ORAL TABLET,CHEWABLE 250 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE LACTOS SUP ORAL CAPSULE 500 MILLION CELL-3,000 UNIT (Bacillus coagulans/lactase)	Tier 3	
DIGESTIVE ADVANTAGE PROBIO-PRE ORAL TABLET 800 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE PROBIO-PRE ORAL TABLET,CHEWABLE 400 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE PROBIOTIC ORAL CAPSULE 2 BILLION CELL- 140 MG (Bacillus coagulans/calcium carbonate)	Tier 3	
DIGESTIVE PROBIOTIC ORAL CAPSULE, SPRINKLE 2 BILLION CELL (Bifido inf/Bifido longum/L. acidophilus/L. rhamnosus)	Tier 3	
ENVIVE ORAL CAPSULE 12 BILION CELL (L.acidoph,paracasei, B.lactis)	Tier 3	
FLORAJEN WOMEN ORAL CAPSULE 15 BILLION CELL (Lactobacillus acidophilus/Lactobacillus rhamnosus GG)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLORATUMMYS QUICK DISSOLVE ORAL TABLET, EFFERVESCENT 2 BILLION CELL (Lactobacillus reuteri/Bifidobacterium infantis/FOS)	Tier 3	
FOLIKA PROBIOTIC ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
GERBER GOOD START GROW KIDS ORAL TABLET,CHEWABLE 100 MILLION CELL (Lactobacillus reuteri)	Tier 3	
GERBER GOOD START GROW TODDLER ORAL POWDER IN PACKET 100 MILLION CELL (Lactobacillus reuteri)	Tier 3	
<i>lactobacillus acidophilus oral capsule 500 million cell</i>	Tier 3	
<i>lactobacillus acidophilus oral tablet 0.5 mg (100 million cell)</i>	Tier 3	
<i>lactobacillus acidophilus oral tablet 1 billion cell</i>	Tier 3	
<i>lactobacillus acidoph-l.bulgar oral tablet 1 million cell</i>	Tier 3	
PROBICHEW ORAL TABLET,CHEWABLE 21 BILLION CELL - 1 GRAM (Bacillus coagulans/inulin)	Tier 3	
PROBIOTIC (S.BOULARDII) ORAL CAPSULE 250 MG (Saccharomyces boulardii)	Tier 3	
PROBIOTIC (WITH VITAMIN D3) ORAL TABLET,CHEWABLE 2 BILLION CELL- 5 MCG (Bacillus coagulans/cholecalciferol (vit D3))	Tier 3	
PROBIOTIC FORMULA (INULIN) ORAL CAPSULE 1 BILLION-250 CELL-MG (Bacillus coagulans/inulin)	Tier 3	
PROBIOTIC PEARLS ACIDOPHILUS ORAL CAPSULE,DELAYED RELEASE(DR/EC) 1 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium longum)	Tier 3	
PROMELLA ORAL CAPSULE 32 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
QUAD-PROBIOTIC ORAL CAPSULE 8 BILLION CELL (L. acidophilus/L. paracasei/B. bifidum/S. thermophilus)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESISTANCE FORMULA PROBIOTIC ORAL CAPSULE 10 BILLION CELL (Saccharomyces boulardii)	Tier 3	
<i>saccharomyces boulardii oral capsule 250 mg</i>	Tier 3	
SIMILAC PROBIOTIC TRI-BLEND ORAL POWDER IN PACKET 1 BILLION CELL (Bifidobacterium animlis/Bifidobacterium infantis/S. thermoph)	Tier 3	
ULTIMATE FLORA BABY PROBIOTIC ORAL POWDER 4 BILLION CELL /GRAM (B. breve/B. bifidum/B. infantis/B. longum/L. rhamnosus)	Tier 3	
UP4 PROBIOTICS ADULT 50 PLUS ORAL CAPSULE 25 BILLION CELL (Lactobacillus acidophilus/L. plantarum/Bifido no.7)	Tier 3	
UP4 PROBIOTICS ADULT ORAL CAPSULE 15 BILLION CELL (Lactobacillus acidophilus/L. plantarum/Bifido no.7)	Tier 3	
UP4 PROBIOTICS KIDS CUBES ORAL TABLET,CHEWABLE 1 BILLION CELL- 20 MCG (Lactobacillus acidophilus/Bifidobacterium animalis/vit D2)	Tier 3	
UP4 PROBIOTICS PLUS PREBIOTIC ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	
UP4 PROBIOTICS ULTRA ORAL CAPSULE 50 BILLION CELL (Lactobacillus combination no.51/Bifidobacterium combo no.4)	Tier 3	
UP4 PROBIOTICS WOMEN'S ORAL CAPSULE 5 BILLION CELL- 250 MG (L.acidophilus/L.gasseri/L.plant/L.rham/B.animalis/cranberry)	Tier 3	
UP4 PROBIOTICS-PREBIOTICS KIDS ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WOMEN'S PROBIOTIC ORAL CAPSULE 25B CELL-25B CELL-50 MG (Lactobacillus no.76/Bifidobacterium animalis,breve/FOS/larch)	Tier 3	
Irritable Bowel Syndrome (lbs) Agents - Drugs For Irritable Bowel Syndrome		
<i>alosetron oral tablet 0.5 mg, 1 mg</i>	Tier 1	
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	Tier 1	ST: Must meet the following requirement: Linzess or Movantik in 120 days; QL (2 EA per 1 day)
VIBERZI ORAL TABLET 100 MG, 75 MG (eluxadoline)	Tier 3	PA
ZELNORM ORAL TABLET 6 MG (tegaserod hydrogen maleate)	Tier 3	ST: Must meet the following requirement: Linzess in 120 days; QL (2 EA per 1 day); Age (Max 64 Years)
Laxative - Bulk Forming - Drugs To Prevent Constipation		
CLEAR FIBER ORAL POWDER 3 GRAM/4 GRAM (dextrin)	Tier 3	
DAILY FIBER (PSYLLIUM-ASPART) ORAL POWDER IN PACKET 3 GRAM, 3.4 GRAM (psyllium husk/aspartame)	Tier 3	
DAILY FIBER (PSYLLIUM-SUCROSE) ORAL POWDER 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
DAILY FIBER ORAL CAPSULE 0.4 GRAM (psyllium husk)	Tier 3	
EASY FIBER ORAL POWDER 3 GRAM/3.8 GRAM (dextrin)	Tier 3	
FIBER THERAPY (PSYLLIUM-SUCRO) ORAL POWDER 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
KONSYL SUGAR-FREE ORAL POWDER IN PACKET 6 GRAM (psyllium husk)	Tier 3	
<i>psyllium husk oral capsule 0.4 gram</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REGULOID (ASPARTAME) ORAL POWDER 3 GRAM/5.8 GRAM (psyllium husk/aspartame)	Tier 3	
REGULOID (PSYLLIUM HUSK) ORAL CAPSULE 0.4 GRAM (psyllium husk)	Tier 3	
REGULOID (PSYLLIUM HUSK) ORAL POWDER 3 GRAM/5.4 GRAM (psyllium husk)	Tier 3	
REGULOID (PSYLLIUM HUSK-SUCRO) ORAL POWDER 3 GRAM/12 GRAM, 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
Laxative - Saline And Osmotic - Drugs To Prevent Constipation		
lactulose (Constulose Oral Solution 10 Gram/15 MI)	Tier 1	
lactulose (Kristalose Oral Packet 10 Gram)	Tier 3	ST: Must meet the following requirement: Generic Lactulose solution in 120 days; QL (3 EA per 1 day)
KRISTALOSE ORAL PACKET 20 GRAM (lactulose)	Tier 3	ST: Must meet the following requirement: Generic Lactulose solution in 120 days; QL (2 EA per 1 day)
<i>lactulose oral packet 10 gram</i>	Tier 1	ST: Must meet the following requirement: Generic Lactulose solution in 120 days; QL (3 EA per 1 day)
<i>lactulose oral solution 10 gram/15 ml</i>	Tier 1	
<i>lactulose oral solution 20 gram/30 ml</i>	Tier 1	
<i>sorbitol solution 70 %</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Laxative - Saline/Osmotic Mixtures - Drugs To Prevent Constipation		
GAVILYTE-C ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM (peg 3350/sod sulf/sod bicarb/sod chloride/potassium chloride)	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
peg 3350/sod sulf/sod bicarb/sod chloride/potassium chloride (Gavilyte-G Oral Recon Soln 236-22.74-6.74 -5.86 Gram)	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
sodium chloride/sodium bicarbonate/potassium chloride/peg (Gavilyte-N Oral Recon Soln 420 Gram)	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
NULYTELY LEMON-LIME ORAL RECON SOLN 420 GRAM (sodium chloride/sodium bicarbonate/potassium chloride/peg)	Tier 2	\$0 COPAY IF AGE 45-75 YEARS
OSMOPREP ORAL TABLET 1.5 GRAM (sodium phosphate,monobasic/sodium phosphate,dibasic)	Tier 3	\$0 COPAY IF AGE 45-75 YEARS
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
<i>peg3350-sod sul-nacl-kcl-asb-c oral powder in packet 100-7.5-2.691 gram</i>	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
<i>peg-electrolyte soln oral recon soln 420 gram</i>	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
PLENVU ORAL POWDER IN PACKET, SEQUENTIAL 140-9-5.2 GRAM (peg 3350/sodium sulfate/sod chloride/KCl/ascorbate sod/vit C)	Tier 3	\$0 COPAY IF AGE 45-75 YEARS
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM (sodium sulfate/potassium sulfate/magnesium sulfate)	Tier 2	\$0 COPAY IF AGE 45-75 YEARS
SUTAB ORAL TABLET 1.479-0.188- 0.225 GRAM (sodium sulfate/potassium chloride/magnesium sulfate)	Tier 2	\$0 COPAY IF AGE 45-75 YEARS

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Laxative - Stimulant - Drugs To Prevent Constipation		
SENOKOT-CHAMOMILE ORAL TEA 1,400 MG- 1,100 MG (senna leaf/herbal complex no.324)	Tier 3	
Laxative - Stimulant And Saline/Osmotic Combinations - Drugs To Prevent Constipation		
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM -12 GRAM/160 ML (sodium picosulfate/magnesium oxide/citric acid)	Tier 2	\$0 COPAY IF AGE 45-75 YEARS
PEG-PREP ORAL KIT 5-210 MG-GRAM (bisacodyl/sodium chlor/sodium bicarb/potassium chl/peg 3350)	Tier 1	\$0 COPAY IF AGE 45-75 YEARS
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives - Drugs For Ulcers And Stomach Acid		
<i>sucralfate oral suspension 100 mg/ml</i>	Tier 1	
<i>sucralfate oral tablet 1 gram</i>	Tier 1	
Peptic Ulcer - Treatment Of H. Pylori: Antibiotic-Bismuth Combinations - Drugs For Ulcers And Stomach Acid		
HELIDAC ORAL COMBO PACK 250-500-262.4 MG (bismuth subsalicylate/metronidazole/tetracycline HCl)	Tier 3	
PYLERA ORAL CAPSULE 140-125-125 MG (colloidal bismuth subcitrate/metronidazole/tetracycline HCl)	Tier 3	
Peptic Ulcer-Treatment H. Pylori-Proton Pump Inhibitor And Antibiotics - Drugs For Ulcers And Stomach Acid		
<i>amoxicil-clarithromy-lansopraz oral combo pack 500-500-30 mg</i>	Tier 1	QL (112 EA per 10 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG-500 MG (40) (omeprazole/clarithromycin/amoxicillin trihydrate)	Tier 3	
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE 10-250-12.5 MG (omeprazole magnesium/amoxicillin trihydrate/rifabutin)	Tier 3	QL (168 EA per 14 days); Age (Min 18 Years)
Short Bowel Syndrome (Sbs) - Glucagon-Like Peptide-2 (Glp-2) Analog - Drugs For The Stomach		
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG (teduglutide)	Tier 4	PA
GATTEX ONE-VIAL SUBCUTANEOUS KIT 5 MG (teduglutide)	Tier 4	PA
Short Bowel Syndrome (Sbs) Agents - Drugs For The Stomach		
SAIZEN SUBCUTANEOUS RECON SOLN 8.8 MG (somatropin)	Tier 4	PA
Genitourinary Therapy - Drugs For The Urinary System		
Bph Agent- 5-Alpha Reductase Inhib And Alpha-1 Adrenoceptor Antag Comb - Drugs For The Prostate		
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr 0.5-0.4 mg</i>	Tier 1	ST: Must meet any of the following requirements: Alfuzosin HCL, Doxazosin Mesylate, Finasteride 5mg, Prazosin HCL, Silodosin, Tamsulosin HCL, or Terazosin HCL in 120 days

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cystinosis Therapy (Cystine Depleting Agents) - Drugs For The Urinary System		
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (cysteamine bitartrate)	Tier 4	
PROCYSBI ORAL CAPSULE, DELAYED REL SPRINKLE 25 MG, 75 MG (cysteamine bitartrate)	Tier 4	PA
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET 300 MG, 75 MG (cysteamine bitartrate)	Tier 4	PA
G.U. Irrigants - Anti-Infective - Drugs For The Urinary System		
<i>neomycin-polymyxin b gu irrigation solution 40 mg-200,000 unit/ml</i>	Tier 1	
G.U. Irrigants - Drugs For The Urinary System		
<i>acetic acid irrigation solution 0.25 %</i>	Tier 1	
<i>glycine urologic solution irrigation solution 1.5 %</i>	Tier 1	
RENACIDIN IRRIGATION SOLUTION 1980.6 MG-59.4 MG-980.4MG/30ML (citric acid/gluconolactone/magnesium carbonate)	Tier 3	
<i>sorbitol irrigation solution 3 %</i>	Tier 1	
<i>sorbitol-mannitol transurethral solution 2.7-0.54 gram/100 ml</i>	Tier 1	
Interstitial Cystitis Agents - Drugs For The Urinary System		
ELMIRON ORAL CAPSULE 100 MG (pentosan polysulfate sodium)	Tier 2	
Kidney Stone Agents - Drugs For The Urinary System		
THIOLA EC ORAL TABLET, DELAYED RELEASE (DR/EC) 100 MG, 300 MG (tiopronin)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THIOLA ORAL TABLET 100 MG (tiopronin)	Tier 4	
<i>tiopronin oral tablet 100 mg</i>	Tier 4	
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist - Drugs For The Bladder		
GEMTESA ORAL TABLET 75 MG (vibegron)	Tier 3	ST: Must meet the following requirement: Myrbetriq or Toviaz in 120 days; QL (1 EA per 1 day); Age (Min 18 Years)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON 8 MG/ML (mirabegron)	Tier 3	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG (mirabegron)	Tier 2	
Phosphate Binders - Calcium-Based - Drugs For The Urinary System		
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML (calcium acetate)	Tier 3	
Phosphate Binders - Drugs For The Urinary System		
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	QL (12 EA per 1 day)
<i>calcium acetate(phosphat bind) oral capsule 667 mg</i>	Tier 1	
<i>calcium acetate(phosphat bind) oral tablet 667 mg</i>	Tier 1	
FOSRENOL ORAL POWDER IN PACKET 1,000 MG, 750 MG (lanthanum carbonate)	Tier 3	
<i>lanthanum oral tablet,chewable 1,000 mg, 500 mg, 750 mg</i>	Tier 1	
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML (calcium acetate)	Tier 3	
<i>sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram</i>	Tier 1	
<i>sevelamer carbonate oral tablet 800 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	Tier 1	
VELPHORO ORAL TABLET,CHEWABLE 500 MG (sucroferric oxyhydroxide)	Tier 2	
Phosphate Binders - Iron-Based - Drugs For The Urinary System		
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	QL (12 EA per 1 day)
VELPHORO ORAL TABLET,CHEWABLE 500 MG (sucroferric oxyhydroxide)	Tier 2	
Polycystic Kidney Disease - Vasopressin V2 Receptor Antagonists - Drugs For The Urinary System		
JYNARQUE ORAL TABLET 15 MG, 30 MG (tolvaptan)	Tier 4	PA
JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM) (tolvaptan)	Tier 4	PA
Prostatic Hypertrophy Agent - Alpha-1-Adrenoceptor Antagonists - Drugs For The Prostate		
<i>alfuzosin oral tablet extended release 24 hr 10 mg</i>	Tier 1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	Tier 1	ST: Must meet any of the following requirements: Alfuzosin HCL, Doxazosin Mesylate, Finasteride 5mg, Prazosin HCL, Silodosin, Tamsulosin HCL, or Terazosin HCL in 120 days
<i>tamsulosin oral capsule 0.4 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prostatic Hypertrophy Agent - Type II 5-Alpha Reductase Inhibitors - Drugs For The Prostate		
<i>finasteride oral tablet 5 mg</i>	Tier 1	
Prostatic Hypertrophy Agent-Type I And II 5-Alpha Reductase Inhibitors - Drugs For The Prostate		
<i>dutasteride oral capsule 0.5 mg</i>	Tier 1	
Urinary Acidifier - Bacterial Urease Inhibitor - Drugs For Infections		
LITHOSTAT ORAL TABLET 250 MG (acetohydroxamic acid)	Tier 3	
Urinary Acidifier - Phosphates - Drugs For Infections		
K-PHOS NO 2 ORAL TABLET 305-700 MG (sodium phosphate,monobasic/potassium phosphate,monobasic)	Tier 3	
K-PHOS ORIGINAL ORAL TABLET,SOLUBLE 500 MG (potassium phosphate,monobasic)	Tier 3	
Urinary Alkalinizer - Citrates - Drugs For Infections		
LITHOLYTE ORAL POWDER IN PACKET 10 MEQ (potassium citrate/magnesium citrate/sodium bicarbonate)	Tier 3	
ORACIT ORAL SOLUTION 490-640 MG/5 ML (citric acid/sodium citrate)	Tier 3	
<i>pot,sodium citrate-citric acid oral solution 550-500-334 mg/5 ml</i>	Tier 3	
<i>potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)</i>	Tier 1	
<i>potassium citrate-citric acid oral solution 1,100-334 mg/5 ml</i>	Tier 3	
<i>sodium citrate-citric acid oral solution 500-334 mg/5 ml</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Urinary Analgesics - Drugs For Infections		
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	Tier 1	
Urinary Antibacterial - Methenamine And Salts - Drugs For Infections		
UROQID-ACID NO.2 ORAL TABLET 500-500 MG (methenamine mandelate/sodium phosphate,monobasic)	Tier 3	
Urinary Antibacterial - Nitrofurantoin Derivatives - Drugs For Infections		
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>nitrofurantoin monohydr/m-cryst oral capsule 100 mg</i>	Tier 1	
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	Tier 1	
Urinary Antibacterial - Quinolones - Drugs For Infections		
CIPRO XR ORAL TABLET, ER MULTIPHASE 24 HR 1,000 MG, 500 MG (ciprofloxacin/ciprofloxacin HCl)	Tier 3	
Urinary Anti-Infective Methenamine-Antispas-Analg Combinations - Drugs For Infections		
URETRON D-S ORAL TABLET 81.6-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 2	
URIMAR-T ORAL TABLET 120-0.12-10.8 MG (methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)	Tier 3	
URO-458 ORAL TABLET 81-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	
URO-MP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
USTELL ORAL CAPSULE 120-0.12 MG (methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)	Tier 1	
Urinary Anti-Infective Methenamine-Antispasmodic Combinations - Drugs For Infections		
<i>methen-sod phos-meth blue-hyos oral tablet 81.6-40.8-0.12 mg</i>	Tier 1	
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder) - Drugs For The Bladder		
<i>darifenacin oral tablet extended release 24 hr 15 mg, 7.5 mg</i>	Tier 1	ST: Must meet the following requirement: Oxybutynin Chloride in 120 days
<i>solifenacin oral tablet 10 mg, 5 mg</i>	Tier 1	
VESICARE LS ORAL SUSPENSION 1 MG/ML (solifenacin succinate)	Tier 3	
Urinary Antispasmodic - Anticholinergics, Non-Selective - Drugs For The Bladder		
ED-SPAZ ORAL TABLET, DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 1	
HYOSYNE ORAL DROPS 0.125 MG/ML (hyoscyamine sulfate)	Tier 1	
HYOSYNE ORAL ELIXIR 0.125 MG/5 ML (hyoscyamine sulfate)	Tier 1	
OSCIMIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
OSCIMIN SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OSCIMIN SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 1	
SYMAX DUOTAB ORAL TABLET,EXT RELEASE MULTIPHASE 0.125 MG-0.25 MG (0.375 MG) (hyoscyamine sulfate)	Tier 3	
Urinary Antispasmodic - Smooth Muscle Relaxants - Drugs For The Bladder		
<i>flavoxate oral tablet 100 mg</i>	Tier 1	
GELNIQUE TRANSDERMAL GEL IN PACKET 10 % (100 MG/GRAM) (oxybutynin chloride)	Tier 3	ST: Must meet the following requirement: Oxybutynin Chloride in 120 days
<i>oxybutynin chloride oral syrup 5 mg/5 ml</i>	Tier 1	
<i>oxybutynin chloride oral tablet 5 mg</i>	Tier 1	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg</i>	Tier 1	
OXYTROL TRANSDERMAL PATCH SEMIWEEKLY 3.9 MG/24 HR (oxybutynin)	Tier 3	ST: Must meet the following requirement: Oxybutynin Chloride in 120 days
<i>tolterodine oral capsule,extended release 24hr 2 mg, 4 mg</i>	Tier 1	
<i>tolterodine oral tablet 1 mg, 2 mg</i>	Tier 1	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG (fesoterodine fumarate)	Tier 2	ST: Must meet the following requirement: Oxybutynin Chloride in 120 days
<i>trospium oral capsule,extended release 24hr 60 mg</i>	Tier 1	
<i>trospium oral tablet 20 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Urinary Retention Therapy - Parasympathomimetic Agents - Drugs For The Bladder		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	
Gout And Hyperuricemia Therapy - Drugs For Pain And Fever		
Gout Acute Therapy - Antimitotics - Gout Drugs		
<i>colchicine oral capsule 0.6 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>colchicine oral tablet 0.6 mg</i>	Tier 1	QL (4 EA per 1 day)
GLOPERBA ORAL SOLUTION 0.6 MG/5 ML (colchicine)	Tier 3	ST: Must meet the following requirement: Colchicine capsules or tablets in 120 days; QL (10 ML per 1 day)
Gout And Hyperuricemia - Antimitotic-Uricosuric Combinations - Gout Drugs		
<i>probenecid-colchicine oral tablet 500-0.5 mg</i>	Tier 1	
Hyperuricemia Therapy - Uricosurics - Gout Drugs		
<i>probenecid oral tablet 500 mg</i>	Tier 1	
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors - Gout Drugs		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	Tier 1	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	Tier 1	ST: Must meet the following requirement: Allopurinol in 120 days; QL (30 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hyperuricemia Tx - Urat1 Inhibitor And Xanthine Oxidase Inhibitor Comb - Gout Drugs		
DUZALLO ORAL TABLET 200-200 MG, 200-300 MG (lesinurad/allopurinol)	Tier 3	ST: Must meet the following requirement: Allopurinol in 120 days; QL (1 EA per 1 day)
Hematological Agents - Drugs For The Blood		
Agents To Treat Attp- Anti Von Willebrand Factor (Vwf) A1 Domain - Drugs For The Blood		
CABLIVI INJECTION KIT 11 MG (caplacizumab-yhdp)	Tier 4	PA
CABLIVI INJECTION RECON SOLN 11 MG (caplacizumab-yhdp)	Tier 4	PA
Agents To Treat Paroxysmal Nocturnal Hemoglobinuria (Pnh) - Drugs For The Blood		
EMPAVELI SUBCUTANEOUS SOLUTION 1,080 MG/20 ML (pegcetacoplan)	Tier 4	PA
Anticoagulants - Citrate-Based - Drugs To Prevent Blood Clots		
ACD SOLUTION A SOLUTION 2.45-2.2 GRAM- 800 MG/100 ML (dextrose-water/sodium citrate/citric acid)	Tier 3	
ACD-A SOLUTION (citrate dextrose solution)	Tier 3	
ACD-A SOLUTION 2.45-2.2 GRAM- 730 MG/100 ML (dextrose-water/sodium citrate/citric acid)	Tier 3	
<i>anticoag citrate phos dextrose solution 2.63-222 gram-mg/100ml</i>	Tier 1	
REGIOCIT (EUA) SOLUTION 5.03-5.29 GRAM/L (sodium chloride/sodium citrate)	Tier 3	
<i>sodium citrate in 0.9 % nacl solution 0.5 %</i>	Tier 3	
<i>sodium citrate intra-catheter syringe 4 % (3 ml), 4 % (5 ml)</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium citrate solution 4 gram /100 ml (4 %)</i>	Tier 1	
Anticoagulants - Coumarin - Drugs To Prevent Blood Clots		
warfarin sodium (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	Tier 1	
<i>warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	Tier 1	
Anti-Inhibitor Coagulation Complex - Drugs To Prevent Bleeding		
FEIBA NF INTRAVENOUS RECON SOLN 1,750-3,250 UNIT, 350-650 UNIT, 700-1,300 UNIT (anti-inhibitor coagulant complex)	Tier 4	
Blood Cell And Platelet Disorder Tx-Spleen Tyrosine Kinase Inhibitors - Drugs For The Blood		
TAVALISSE ORAL TABLET 100 MG, 150 MG (fostamatinib disodium)	Tier 4	PA
C1 Esterase Inhibitor Agents - Drugs For The Blood		
BERINERT INTRAVENOUS KIT 500 UNIT (10 ML) (C1 esterase inhibitor)	Tier 4	PA
BERINERT INTRAVENOUS RECON SOLN 500 UNIT (10 ML) (C1 esterase inhibitor)	Tier 4	PA
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML) (C1 esterase inhibitor)	Tier 4	PA
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT (C1 esterase inhibitor)	Tier 4	PA
RUCONEST INTRAVENOUS RECON SOLN 2,100 UNIT (C1 esterase inhibitor, recombinant)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Direct Factor Xa Inhibitors - Drugs To Prevent Blood Clots		
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS) (apixaban)	Tier 2	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG (apixaban)	Tier 2	QL (2 EA per 1 day)
ELIQUIS ORAL TABLET 5 MG (apixaban)	Tier 2	QL (74 EA per 30 days)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (edoxaban tosylate)	Tier 3	ST: Must meet the following requirement: Eliquis and Xarelto in 365 days; QL (30 EA per 30 days)
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9) (rivaroxaban)	Tier 2	QL (51 EA per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG (rivaroxaban)	Tier 2	QL (1 EA per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (rivaroxaban)	Tier 2	QL (2 EA per 1 day)
Erythropoietins - Drugs For The Blood		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (darbepoetin alfa in polysorbate 80)	Tier 4	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML (darbepoetin alfa in polysorbate 80)	Tier 4	PA
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML (epoetin alfa)	Tier 4	PA
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 150 MCG/0.3 ML, 200 MCG/0.3 ML, 30 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML (methoxy polyethylene glycol-epoetin beta)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML (epoetin alfa)	Tier 4	PA
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML (epoetin alfa-epbx)	Tier 4	PA
Factor IX Preparations - Drugs To Prevent Bleeding		
ALPHANINE SD INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX)	Tier 4	
ALPROLIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT (factor IX recombinant, Fc fusion protein)	Tier 4	
BENEFIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant)	Tier 4	
IDELVION INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX recombinant, albumin fusion protein)	Tier 4	
IXINITY INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant, threonine 148)	Tier 4	
MONONINE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT (factor IX)	Tier 4	
PROFILNINE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX complex, prothrombin cplx conc(pcc) no.4, 3-factor)	Tier 4	
REBINYN INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 500 (+/-) UNIT (factor IX (human) recombinant, pegylated)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIXUBIS INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant)	Tier 4	
Factor Vii Preparations - Drugs To Prevent Bleeding		
NOVOSEVEN RT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 2 MG (2,000 MCG), 5 MG (5,000 MCG), 8 MG (8,000 MCG) (coagulation factor VIIa (recombinant))	Tier 4	
SEVENFACT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 5 MG (5,000 MCG) (coagulation factor VIIa recombinant-jncw)	Tier 4	
Factor Viii Preparations (Ahf) - Drugs To Prevent Bleeding		
ADVATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant,full length)	Tier 4	
ADYNOVATE INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT, 750 (+/-) UNIT (antihemophilic factor (FVIII) recombinant, full length, peg)	Tier 4	
AFSTYLA INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT RANGE, 1,500 (+/-) UNIT RANGE, 2,000 (+/-) UNIT RANGE, 2,500 (+/-) UNIT RANGE, 250 (+/-) UNIT RANGE, 3,000 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE (antihemophilic factor VIII recomb,single-chn,B-dom truncated)	Tier 4	
ALPHANATE INTRAVENOUS RECON SOLN 1,000 (400 VWF) UNIT/10 ML, 1,500 (600 VWF) UNIT/10 ML, 2,000 (800 VWF) UNIT/10 ML, 250 (100 VWF) UNIT/5 ML, 500 (200 VWF) UNIT/5 ML (antihemophilic factor, human/von Willebrand factor,human)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELOCTATE INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 5,000 UNIT, 500 UNIT, 6,000 UNIT, 750 UNIT (antihemophilic factor (FVIII) recombinant, Fc fusion protein)	Tier 4	
ESPEROCT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) rec, B-dom truncated peg-exei)	Tier 4	
HEMOFIL M HIGH INTRAVENOUS RECON SOLN 801-1,500 UNIT (antihemophilic factor, human)	Tier 4	
HEMOFIL M LOW INTRAVENOUS RECON SOLN 220-400 UNIT (antihemophilic factor, human)	Tier 4	
HEMOFIL M MID INTRAVENOUS RECON SOLN 401-800 UNIT (antihemophilic factor, human)	Tier 4	
HEMOFIL M SUPER HIGH INTRAVENOUS RECON SOLN 1,501-2,000 UNIT (antihemophilic factor, human)	Tier 4	
HUMATE-P INTRAVENOUS RECON SOLN 1,000-2,400 UNIT, 250-600 UNIT, 500-1,200 UNIT (antihemophilic factor, human/von Willebrand factor, human)	Tier 4	
JIVI INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) rec, B-domain deleted peg-aucl)	Tier 4	
KOATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor, human)	Tier 4	
KOGENATE FS INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant, full length)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KOVALTRY INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant,full length)	Tier 4	
NOVOEIGHT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor VIII recombinant, B-domain truncated)	Tier 4	
NUWIQ INTRAVENOUS RECON SOLN 1000 (+/-) UNIT, 2,000 (+/-) UNIT, 2,500 UNIT, 250 (+/-) UNIT, 3,000 UNIT, 4,000 UNIT, 500 (+/-) UNIT (antihemophilic factor VIII rec HEK cell, B-domain deleted)	Tier 4	
OBIZUR INTRAVENOUS RECON SOLN 500 (+/-) UNIT RANGE (antihemophilic factor VIII, recombinant porcine sequence)	Tier 4	
RECOMBIMATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor VIII, human recombinant)	Tier 4	
WILATE INTRAVENOUS RECON SOLN 1,000-1,000 UNIT, 500-500 UNIT (antihemophilic factor, human/von Willebrand factor,human)	Tier 4	
XYNTHA INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (factor VIII) recomb,B-domain deleted)	Tier 4	
XYNTHA SOLOFUSE INTRAVENOUS SYRINGE 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (factor VIII) recomb,B-domain deleted)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Factor Viii-Mimetic Agent, Monoclonal Antibody - Drugs For The Blood		
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7 ML, 150 MG/ML, 30 MG/ML, 60 MG/0.4 ML (emicizumab-kxwh)	Tier 4	PA
Factor X Preparations - Drugs To Prevent Bleeding		
COAGADEX INTRAVENOUS RECON SOLN 250 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE (coagulation factor X)	Tier 4	
Factor Xiii Preparations - Drugs To Prevent Bleeding		
CORIFACT INTRAVENOUS RECON SOLN 1,000-1,600 UNIT (factor XIII)	Tier 4	
TRETEN INTRAVENOUS RECON SOLN 2,500 UNIT (factor XIII A-subunit, recombinant)	Tier 4	
Granulocyte Colony-Stimulating Factor (G-Csf) - Drugs For The Blood		
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-jmdb)	Tier 4	PA
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (tbo-filgrastim)	Tier 4	PA
GRANIX SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (tbo-filgrastim)	Tier 4	PA
NEULASTA ONPRO SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML (pegfilgrastim)	Tier 4	PA
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim)	Tier 4	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (filgrastim)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim)	Tier 4	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (filgrastim-aafi)	Tier 4	PA
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-aafi)	Tier 4	PA
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-apgf)	Tier 4	PA
UDENYCA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-cbqv)	Tier 4	PA
ZARXIO INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-sndz)	Tier 4	PA
ZIEXTENZO SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-bmez)	Tier 4	PA
Granulocyte-Macrophage Colony-Stimulating Factor (Gm-Csf) - Drugs For The Blood		
LEUKINE INJECTION RECON SOLN 250 MCG (sargramostim)	Tier 4	PA
Hematorheologic Agents - Drugs For The Blood		
<i>pentoxifylline oral tablet extended release 400 mg</i>	Tier 1	
Hemostatic Systemic - Antifibrinolytic Agents - Drugs To Prevent Bleeding		
<i>aminocaproic acid oral solution 250 mg/ml (25 %)</i>	Tier 1	
<i>aminocaproic acid oral tablet 1,000 mg, 500 mg</i>	Tier 1	
<i>tranexamic acid oral tablet 650 mg</i>	Tier 1	
Hemostatic Systemic- Von Willebrand Factor (Vwf) Preparations - Drugs To Prevent Bleeding		
VONVENDI INTRAVENOUS RECON SOLN 1,300 (+/-) UNIT RANGE, 650 (+/-) UNIT RANGE (von Willebrand factor (recombinant))	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hemostatic Topical Agents - Drugs To Prevent Bleeding		
ASTRINGYN TOPICAL SOLUTION 259 MG/G (ferric subsulfate)	Tier 3	
AVITENE FLOUR TOPICAL POWDER (microfibrillar collagen)	Tier 3	
AVITENE TOPICAL POWDER IN PACKET (microfibrillar collagen)	Tier 3	
AVITENE TOPICAL SHEET 35 X 35 MM, 70 X 35 MM, 70 X 70 MM (microfibrillar collagen)	Tier 3	
ENDO AVITENE TOPICAL SHEET 10 MM, 5 MM (microfibrillar collagen)	Tier 3	
GELFILM IMPLANT FILM (gelatin)	Tier 3	
GEL-FLOW NT TOPICAL SYRINGE (gelatin sponge,absorbable)	Tier 3	
GEL-FLOW TOPICAL SYRINGE KIT 5,000 UNIT (thrombin (bovine)/gelatin sponge,absorbable)	Tier 3	
GELFOAM JMI POWDER TOPICAL KIT 5,000 UNIT (thrombin (bovine)/gelatin sponge,absorbable)	Tier 3	
GELFOAM JMI SPONGE TOPICAL COMBO PACK 5,000 UNIT (thrombin (bovine)/gelatin sponge,absorbable)	Tier 3	
GELFOAM SPONGE SIZE 200 TOPICAL SPONGE 200 (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM TOPICAL SPONGE 4 (gelatin sponge,absorbable/porcine skin)	Tier 3	
MONSEL'S TOPICAL SOLUTION WITH APPLICATOR 0.2 TO 0.22 GRAM/ML (ferric subsulfate)	Tier 3	
RECOTHROM SPRAY KIT TOPICAL RECON SOLN 20,000 UNIT (thrombin (recombinant))	Tier 3	
RECOTHROM TOPICAL RECON SOLN 20,000 UNIT, 5,000 UNIT (thrombin (recombinant))	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURGIFLO TOPICAL SYRINGE (gelatin sponge,absorbable)	Tier 3	
SYRINGE AVITENE TOPICAL POWDER (microfibrillar collagen)	Tier 3	
THROMBI-GEL TOPICAL PADS, MEDICATED 10 CM2, 100 CM2, 40 CM2 (thrombin(bov)/calcium chlor/cmc/gel,pork/dressing,hemostatic)	Tier 3	
THROMBIN-JMI NASAL NASAL SPRAY SYRINGE 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL RECON SOLN 20,000 UNIT, 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL SPRAY SYRINGE 20,000 UNIT, 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL SPRAY,NON-AEROSOL 20,000 UNIT (thrombin (bovine))	Tier 1	
THROMBI-PAD TOPICAL PADS, MEDICATED 3 X 3 " (thrombin(bov)/calcium chlor/cme-cell sod/dressing,hemostatic)	Tier 3	
ULTRAFOAM TOPICAL SPONGE 2 X 6.25 X 7 CM-CM-MM, 8 X 12.5 X 1 CM, 8 X 12.5 X 3 CM-CM-MM, 8 X 6.25 X 1 CM (microfibrillar collagen)	Tier 3	
Hemostatic Topical Combinations - Drugs To Prevent Bleeding		
EVARREST TOPICAL ADHESIVE PATCH,MEDICATED 2 X 4 ", 4 X 4 " (fibrinogen/thrombin (human plasma derived))	Tier 3	
EVICEL TOPICAL SOLUTION 800-1,200 UNIT /ML (1 ML X 2), 800-1,200 UNIT /ML(2ML X 2), 800-1,200 UNIT /ML(5 ML X 2) (thrombin(human plasma derived)/fibrinogen/calcium chloride)	Tier 3	
TACHOSIL TOPICAL ADHESIVE PATCH,MEDICATED 4.8 X 4.8 CM, 9.5 X 4.8 CM (fibrinogen/thrombin (human plasma derived))	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VISTASEAL-FIBRIN SEALANT TOPICAL SYRINGE 500 UNIT-80 MG /ML (10 ML), 500 UNIT-80 MG /ML (2 ML), 500 UNIT-80 MG /ML (4 ML) (thrombin(human plasma derived)/fibrinogen/calcium chloride)	Tier 3	
Heparin Flush Formulations - Drugs To Prevent Blood Clots		
HEP FLUSH-10 (PF) INTRAVENOUS SOLUTION 10 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml)</i>	Tier 3	
<i>heparin lock flush (porcine) intravenous syringe 10 unit/ml</i>	Tier 1	
<i>heparin, porcine (pf) intravenous solution 100 unit/ml (1 ml)</i>	Tier 1	
Heparins - Drugs To Prevent Blood Clots		
HEP FLUSH-10 (PF) INTRAVENOUS SOLUTION 10 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml), 5,000 unit/500 ml (10 unit/ml)</i>	Tier 3	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	Tier 1	
<i>heparin (porcine) injection cartridge 5,000 unit/ml (1 ml)</i>	Tier 1	
<i>heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml</i>	Tier 1	
<i>heparin (porcine) injection syringe 5,000 unit/ml</i>	Tier 1	
<i>heparin flush(porcine)-0.9nacl intravenous kit 100 unit/ml</i>	Tier 1	
<i>heparin lock flush (porcine) intravenous solution 10 unit/ml, 100 unit/ml</i>	Tier 1	
<i>heparin lock flush (porcine) intravenous syringe 10 unit/ml</i>	Tier 1	
<i>heparin lock flush (porcine) intravenous syringe 100 unit/ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEPARIN LOCK FLUSH INTRAVENOUS SYRINGE 10 UNIT/ML (heparin sodium,porcine)	Tier 1	
HEPARIN LOCK INTRAVENOUS SOLUTION 100 UNIT/ML (heparin sodium,porcine)	Tier 1	
HEPARIN LOCKFLUSH(PORCINE)(PF) INTRAVENOUS SYRINGE 10 UNIT/ML, 100 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	
<i>heparin, porcine (pf) injection solution 1,000 unit/ml</i>	Tier 3	
<i>heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml, 5,000 unit/ml</i>	Tier 1	
<i>heparin, porcine (pf) intravenous solution 100 unit/ml (1 ml)</i>	Tier 1	
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml</i>	Tier 1	
<i>heparin, porcine (pf) intravenous syringe 10 unit/ml, 100 unit/ml</i>	Tier 1	
<i>heparin, porcine (pf) subcutaneous syringe 5,000 unit/0.5 ml</i>	Tier 1	
Indirect Factor Xa Inhibitors - Drugs To Prevent Blood Clots		
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml</i>	Tier 4	QL (24 ML per 30 days)
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	Tier 4	QL (15 ML per 30 days)
<i>fondaparinux subcutaneous syringe 5 mg/0.4 ml</i>	Tier 4	QL (12 ML per 30 days)
<i>fondaparinux subcutaneous syringe 7.5 mg/0.6 ml</i>	Tier 4	QL (18 ML per 30 days)
Low Molecular Weight Heparins - Drugs To Prevent Blood Clots		
<i>enoxaparin subcutaneous solution 300 mg/3 ml</i>	Tier 1	QL (30 ML per 30 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	Tier 1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML (dalteparin sodium,porcine)	Tier 4	QL (7.6 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML (dalteparin sodium,porcine)	Tier 4	QL (60 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 12,500 ANTI-XA UNIT/0.5 ML (dalteparin sodium,porcine)	Tier 4	QL (30 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 15,000 ANTI-XA UNIT/0.6 ML (dalteparin sodium,porcine)	Tier 4	QL (36 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 18,000 ANTI-XA UNIT/0.72 ML (dalteparin sodium,porcine)	Tier 4	QL (43.2 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML (dalteparin sodium,porcine)	Tier 4	QL (12 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 7,500 ANTI-XA UNIT/0.3 ML (dalteparin sodium,porcine)	Tier 4	QL (18 ML per 30 days)
Platelet Aggregation Inhib - Cyclopentyl-Triazolo-Pyrimidines (Cptps) - Drugs For The Blood		
BRILINTA ORAL TABLET 60 MG, 90 MG (ticagrelor)	Tier 2	QL (2 EA per 1 day)
Platelet Aggregation Inhibitor Combinations - Drugs For The Blood		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	Tier 1	
Platelet Aggregation Inhibitors - Phosphodiesterase Iii Inhibitors - Drugs For The Blood		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	Tier 1	
Platelet Aggregation Inhibitors - Quinazoline Agents - Drugs For The Blood		
<i>anagrelide oral capsule 0.5 mg, 1 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Platelet Aggregation Inhibitors - Salicylates - Drugs For The Blood		
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
ASPIRIN CHILDRENS ORAL TABLET,CHEWABLE 81 MG (aspirin)	Tier 0	
ASPIR-TRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	Tier 0	
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG (aspirin)	Tier 3	PA
LO-DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	Tier 0	
Platelet Aggregation Inhibitors - Thienopyridine Agents - Drugs For The Blood		
<i>clopidogrel oral tablet 300 mg</i>	Tier 1	QL (4 EA per 30 days)
<i>clopidogrel oral tablet 75 mg</i>	Tier 1	
<i>prasugrel oral tablet 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
Platelet Aggregation Inhibitors-Salicylates And Proton Pump Inhib Comb - Drugs For The Blood		
<i>aspirin-omeprazole oral tablet,ir,delayered rel,biphasic 325-40 mg, 81-40 mg</i>	Tier 1	PA
YOSPRALA ORAL TABLET,IR,DELAYED REL,BIPHASIC 325-40 MG, 81-40 MG (aspirin/omeprazole)	Tier 3	PA
Platelet Aggregation Inhib-Pdesterase And Adenosine Deaminase Inhibitr - Drugs For The Blood		
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Platelet Aggregation Inhib-Protease-Activ.Receptor-1(Par-1) Antagonist - Drugs For The Blood		
ZONTIVITY ORAL TABLET 2.08 MG (vorapaxar sulfate)	Tier 3	QL (1 EA per 1 day)
Pnh - Complement (C3) Inhibitors - Drugs For The Blood		
EMPAVELI SUBCUTANEOUS SOLUTION 1,080 MG/20 ML (pegcetacoplan)	Tier 4	PA
Sickle Cell Anemia Agents, Others - Drugs For The Blood		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (hydroxyurea)	Tier 3	
SIKLOS ORAL TABLET 1,000 MG (hydroxyurea)	Tier 3	ST: Must meet the following requirement: Droxia or Hydroxyurea in 365 days
SIKLOS ORAL TABLET 100 MG (hydroxyurea)	Tier 3	QL (2 EA per 1 day)
Sickle Hemoglobin (Hbs) Polymerization Inhibitor - Drugs For The Blood		
OXBRYTA ORAL TABLET 500 MG (voxelotor)	Tier 4	PA
Thrombin Inhibitor - Selective Direct And Reversible - Drugs To Prevent Blood Clots		
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG (dabigatran etexilate mesylate)	Tier 3	ST: Must meet the following requirements: Eliquis and Xarelto in 120 days; QL (2 EA per 1 day)
Thrombopoietin Receptor Agonists - Drugs For The Blood		
DOPTELET (10 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOPTLET (15 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 4	PA
DOPTLET (30 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 4	PA
MULPLETA ORAL TABLET 3 MG (lusutrombopag)	Tier 4	PA
PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG (eltrombopag olamine)	Tier 4	PA
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG (eltrombopag olamine)	Tier 4	PA
Hepatobiliary System Treatment Agents		
Ileal Bile Acid Transporter (Ibat) Inhibitor		
BYLVAY ORAL CAPSULE 1,200 MCG, 400 MCG (odevixibat)	Tier 4	PA
BYLVAY ORAL PELLETT 200 MCG, 600 MCG (odevixibat)	Tier 4	PA
LIVMARLI ORAL SOLUTION 9.5 MG/ML (maralixibat chloride)	Tier 4	PA
Hepatobiliary System Treatment Agents - Drugs For The Liver		
Farnesoid X Receptor (Fxr) Agonist, Bile Acid Analog - Drugs For The Liver		
OCALIVA ORAL TABLET 10 MG, 5 MG (obeticholic acid)	Tier 4	PA
Immunosuppressive Agents - Drugs For Organ Transplants		
Immunosuppressive - Calcineurin Inhibitors - Drugs For Organ Transplants		
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG, 5 MG (tacrolimus)	Tier 4	
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	Tier 1	
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG (tacrolimus)	Tier 4	
cyclosporine, modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1	
cyclosporine, modified (Gengraf Oral Solution 100 Mg/ML)	Tier 1	
LUPKYNIS ORAL CAPSULE 7.9 MG (voclosporin)	Tier 4	PA
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG (tacrolimus)	Tier 4	
SANDIMMUNE ORAL SOLUTION 100 MG/ML (cyclosporine)	Tier 4	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	Tier 1	
Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors - Drugs For Organ Transplants		
<i>mycophenolate mofetil oral capsule 250 mg</i>	Tier 1	
<i>mycophenolate mofetil oral suspension for reconstitution 200 mg/ml</i>	Tier 1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Tier 1	
<i>mycophenolate sodium oral tablet, delayed release (drlec) 180 mg, 360 mg</i>	Tier 1	
Immunosuppressive - Interleukin-6 (IL-6) Receptor Inhibitors - Drugs For Organ Transplants		
ENSPRYNG SUBCUTANEOUS SYRINGE 120 MG/ML (satralizumab-mwge)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Immunosuppressive - Mammalian Target Of Rapamycin (Mtor) Inhibitors - Drugs For Organ Transplants		
<i>everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg</i>	Tier 1	
<i>sirolimus oral solution 1 mg/ml</i>	Tier 1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
ZORTRESS ORAL TABLET 1 MG (everolimus)	Tier 4	
Immunosuppressive - Purine Analogs - Drugs For Organ Transplants		
azathioprine (Azasan Oral Tablet 100 Mg, 75 Mg)	Tier 3	
<i>azathioprine oral tablet 50 mg</i>	Tier 1	
Locomotor System - Drugs For Muscles, Ligaments, Tendons, And Bones		
Agents To Treat Periodic Paralysis - Carbonic Anhydrase Inhibitors - Drugs For Muscles, Ligaments, Tendons, And Bones		
KEVEYIS ORAL TABLET 50 MG (dichlorphenamide)	Tier 4	PA
Als Agents - Benzathiazoles - Drugs For Nerves And Muscles		
EXSERVAN ORAL FILM 50 MG (riluzole)	Tier 4	PA
<i>riluzole oral tablet 50 mg</i>	Tier 1	
TIGLUTIK ORAL SUSPENSION 50 MG/10 ML (riluzole)	Tier 4	PA
Antimyasthenic Agent - Reversible Cholinesterase Inhibitors - Drugs For Nerves And Muscles		
<i>pyridostigmine bromide oral syrup 60 mg/5 ml</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 30 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyridostigmine bromide oral tablet 60 mg</i>	Tier 1	
<i>pyridostigmine bromide oral tablet extended release 180 mg</i>	Tier 1	
Skeletal Muscle Relaxant - Analgesic Salicylate Combinations - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin oral tablet 200-325 mg</i>	Tier 1	
orphenadrine citrate/aspirin/caffeine (Norgesic Forte Oral Tablet 50-770-60 Mg)	Tier 3	QL (4 EA per 1 day)
<i>orphenadrine-asa-caffeine oral tablet 50-770-60 mg</i>	Tier 1	QL (4 EA per 1 day)
orphenadrine citrate/aspirin/caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)	Tier 1	QL (4 EA per 1 day)
Skeletal Muscle Relaxant - Central Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>baclofen oral tablet 10 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>baclofen oral tablet 20 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>baclofen oral tablet 5 mg</i>	Tier 1	QL (16 EA per 1 day)
<i>carisoprodol oral tablet 250 mg, 350 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg</i>	Tier 1	ST: Must meet the following requirement: Chlorzoxazone 500mg in 120 days; QL (4 EA per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>cyclobenzaprine oral capsule, extended release 24hr 15 mg, 30 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>cyclobenzaprine oral tablet 10 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (3 EA per 1 day)
CYCLOTENS REFILL COMBO PACK 10 MG (cyclobenzaprine HCl/TENS unit electrodes)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYCLOTENS STARTER COMBO PACK 10 MG (cyclobenzaprine HCl/TENS unit/TENS unit electrodes)	Tier 3	
<i>metaxalone oral tablet 400 mg</i>	Tier 3	QL (4 EA per 1 day)
<i>metaxalone oral tablet 800 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>methocarbamol oral tablet 500 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>methocarbamol oral tablet 750 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>orphenadrine citrate oral tablet extended release 100 mg</i>	Tier 1	QL (2 EA per 1 day)
OZOBAX ORAL SOLUTION 5 MG/5 ML (baclofen)	Tier 3	PA
<i>tizanidine oral capsule 2 mg</i>	Tier 1	QL (18 EA per 1 day)
<i>tizanidine oral capsule 4 mg</i>	Tier 1	QL (9 EA per 1 day)
<i>tizanidine oral capsule 6 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>tizanidine oral tablet 2 mg</i>	Tier 1	QL (18 EA per 1 day)
<i>tizanidine oral tablet 4 mg</i>	Tier 1	QL (9 EA per 1 day)
Skeletal Muscle Relaxant - Direct Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>dantrolene oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Skeletal Muscle Relaxant - Opioid Analgesic Combinations - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)
Skeletal Muscle Relaxant And Topical Irritant Counter-Irritant Comb. - Drugs For Muscles, Ligaments, Tendons, And Bones		
COMFORT PAC-CYCLOBENZAPRINE KIT 10 MG (cyclobenzaprine HCl/irritants counter-irritants combo no.2)	Tier 3	
COMFORT PAC-TIZANIDINE KIT 4 MG (tizanidine HCl/irritant counter-irritants combination no.2)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYCLOPAK KIT 5 MG-2.5 %- 2.5 % (cyclobenzaprine/lidocaine/prilocaine/glycerin)	Tier 3	
NOPIOID-LMC KIT COMBO PACK, TABLET AND PATCH 7.5 MG- 4 %-4 % (cyclobenzaprine HCl/lidocaine/menthol)	Tier 3	
Skeletal Muscle Relaxant, Salicylate, And Opioid Analgesic Comb. - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)
Spinal Muscular Atrophy - Motor Neuron 2 (Smn2) Splicing Modifier - Drugs For Nerves And Muscles		
EVRYSDI ORAL RECON SOLN 0.75 MG/ML (risdiplam)	Tier 4	
Medical Supplies And Durable Medical Equipment (Dme) - Medical Supplies And Durable Medical Equipment		
Medical Supplies And Dme - Blood Coagulation Testing Supplies - Medical Supplies And Durable Medical Equipment		
COAGUCHEK XS (prothrombin time/INR test meter)	Tier 3	
Medical Supplies And Dme - Blood Collection Needles - Medical Supplies And Durable Medical Equipment		
MONOJECT BLOOD COLLECTION NEEDLE 20 GAUGE X 1", 20 X 1 1/2 ", 21 GAUGE X 1", 22 GAUGE X 1" (needles, blood collection)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Blood Glucose Tests - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK AVIVA PLUS TEST STRP STRIP (blood sugar diagnostic)	DME	
ACCU-CHEK GUIDE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ACCU-CHEK SMARTVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	
ACCUTREND GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ADVANCED GLUC METER TEST STRIP STRIP (blood sugar diagnostic)	DME	
ADVOCATE REDI-CODE PLUS STRIP (blood sugar diagnostic)	DME	
ADVOCATE REDI-CODE STRIP (blood sugar diagnostic)	DME	
ADVOCATE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
AGAMATRIX AMP TEST STRIPS STRIP (blood sugar diagnostic)	DME	
AGAMATRIX PRESTO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ASSURE 4 STRIPS STRIP (blood sugar diagnostic)	DME	
ASSURE PLATINUM TEST STRIP STRIP (blood sugar diagnostic)	DME	
ASSURE PRISM MULTI STRIP STRIP (blood sugar diagnostic)	DME	
BIONIME RIGHTEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	
BLOOD GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREEZE 2 TEST STRIPS STRIP (blood sugar diagnostic, disc-type)	DME	
CARESENS N TEST STRIPS STRIP (blood sugar diagnostic)	DME	
CARETOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	
CHOICEDM CLARUS STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE MICRO TEST STRIP STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE PRO STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE TALK TEST STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE VOICE+ TEST STRIP (blood sugar diagnostic)	DME	
CONTOUR NEXT TEST STRIPS STRIP (blood sugar diagnostic)	DME	
CONTOUR TEST STRIPS STRIP (blood sugar diagnostic)	DME	
COOL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
DARIO BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
DIATRUE PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASY GLUCO G2 STRIP (blood sugar diagnostic)	DME	
EASY PLUS II TEST STRIP (blood sugar diagnostic)	DME	
EASY STEP STRIP (blood sugar diagnostic)	DME	
EASY TALK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH BLU LINK TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASY TOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASY TRAK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	
EASY TRAK II TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASYGLUCO PLUS STRIP (blood sugar diagnostic)	DME	
EASYGLUCO TEST STRIP (blood sugar diagnostic)	DME	
EASYMAX 15 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EASYMAX STRIP (blood sugar diagnostic)	DME	
ELEMENT COMPACT TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ELEMENT TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EMBRACE BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	
EMBRACE EVO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EMBRACE PRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EMBRACE TALK TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EVENCARE G2 STRIP (blood sugar diagnostic)	DME	
EVENCARE G3 TEST STRIP (blood sugar diagnostic)	DME	
EVENCARE MINI GLUCOSE TEST STR STRIP (blood sugar diagnostic)	DME	
EVENCARE PROVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE TEST STRIP (blood sugar diagnostic)	DME	
EVOLUTION TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EZ SMART PLUS TEST STRIP (blood sugar diagnostic)	DME	
EZ SMART TEST STRIP (blood sugar diagnostic)	DME	
FIFTY50 TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORA 6 CONNECT GLUCOSE STRIP STRIP (blood sugar diagnostic)	DME	
FORA D15G STRIPS STRIP (blood sugar diagnostic)	DME	
FORA D20 STRIP (blood sugar diagnostic)	DME	
FORA D40-G31 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA G20 STRIP (blood sugar diagnostic)	DME	
FORA G30-PREMIUM V10 TEST STRP STRIP (blood sugar diagnostic)	DME	
FORA GD50 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA GTEL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORA TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORA TN'G ADVAN PRO TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORA TN'G VOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA V10 STRIP (blood sugar diagnostic)	DME	
FORA V10-V12-D10-D20 STRIPS STRIP (blood sugar diagnostic)	DME	
FORA V12 GLUCOSE STRIP (blood sugar diagnostic)	DME	
FORA V20 STRIP (blood sugar diagnostic)	DME	
FORA V30A STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GD20 STRIP (blood sugar diagnostic)	DME	
FORACARE GD40 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORTISCARE G1 TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORTISCARE GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE INSULINX STRIP (blood sugar diagnostic)	DME	
FREESTYLE INSULINX TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE LITE STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE PRECISION NEO STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE TEST STRIP (blood sugar diagnostic)	DME	
GE100 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
GE333 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
GENSTRIP TEST STRIP STRIP (blood sugar diagnostic)	DME	
GENULTIMATE TEST STRIP STRIP (blood sugar diagnostic)	DME	
GLUCO NAVII TEST STRIP STRIP (blood sugar diagnostic)	DME	
GLUCOCARD 01 SENSOR PLUS STRIP (blood sugar diagnostic)	DME	
GLUCOCARD EXPRESSION STRIP (blood sugar diagnostic)	DME	
GLUCOCARD SHINE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
GLUCOCARD VITAL SENSOR STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD VITAL TEST STRIPS STRIP (blood sugar diagnostic)	DME	
GLUCOCOM GLUCOSE STRIP (blood sugar diagnostic)	DME	
GM100 STRIP (blood sugar diagnostic)	DME	
GOJJI BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
GOODLIFE AC-302 TEST STRIP STRIP (blood sugar diagnostic)	DME	
HARMONY GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
HEALTHPRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
IGLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
INFINITY TEST STRIPS STRIP (blood sugar diagnostic)	DME	
INFINITY VOICE TEST STRIP STRIP (blood sugar diagnostic)	DME	
MICRO BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	
MICRODOT XTRA BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	
MYGLUCOHEALTH STRIP (blood sugar diagnostic)	DME	
NEUTEK 2TEK TEST STRIPS STRIP (blood sugar diagnostic)	DME	
NOVA MAX GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	
ON CALL EXPRESS TEST STRIP STRIP (blood sugar diagnostic)	DME	
ON CALL PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ON CALL VIVID TEST STRIP STRIP (blood sugar diagnostic)	DME	
ONETOUCH ULTRA TEST STRIP (blood sugar diagnostic)	DME	
ONETOUCH VERIO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
OPTIUM EZ STRIP (blood sugar diagnostic)	DME	
OPTIUM TEST STRIP (blood sugar diagnostic)	DME	
OPTUMRX STRIP (blood sugar diagnostic)	DME	
PHARMACIST CHOICE STRIP (blood sugar diagnostic)	DME	
PRECISION PCX PLUS TEST STRIP (blood sugar diagnostic)	DME	
PRECISION PCX TEST STRIP (blood sugar diagnostic)	DME	
PRECISION POINT OF CARE TEST STRIP (blood sugar diagnostic)	DME	
PRECISION Q-I-D TEST STRIP (blood sugar diagnostic)	DME	
PRECISION XTRA TEST STRIP (blood sugar diagnostic)	DME	
PREMIER TEST STRIP STRIP (blood sugar diagnostic)	DME	
PREMIUM V10 STRIP (blood sugar diagnostic)	DME	
PRO VOICE V8-V9 TEST STRIP STRIP (blood sugar diagnostic)	DME	
PRODIGY NO CODING STRIP (blood sugar diagnostic)	DME	
QUINTET AC STRIP (blood sugar diagnostic)	DME	
QUINTET GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
REFUAH PLUS STRIP (blood sugar diagnostic)	DME	
RELION CONFIRM-MICRO STRIP (blood sugar diagnostic)	DME	
RELION PRIME TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RELION ULTIMA STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REVEAL TEST STRIP STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS250S TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS260 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS550 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS700 TEST STRIP STRIP (blood sugar diagnostic)	DME	
RIGHTEST GT333 TEST STRIP STRIP (blood sugar diagnostic)	DME	
RIGHTEST MAX TEST STRIP STRIP (blood sugar diagnostic)	DME	
SMART SENSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
SMARTEST TEST STRIP (blood sugar diagnostic)	DME	
SOLUS V2 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
SURE-TEST EASYPLUS MINI STRIP (blood sugar diagnostic)	DME	
TD GOLD TEST STRIP STRIP (blood sugar diagnostic)	DME	
TELCARE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
TEST N'GO TEST STRIP (blood sugar diagnostic)	DME	
TRUE METRIX GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
TRUE METRIX PRO TEST STRIP STRIP (blood sugar diagnostic)	DME	
TRUETEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	
TRUETRACK TEST STRIP (blood sugar diagnostic)	DME	
ULTIMA TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ULTRATRAK STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATRAK ULTIMATE STRIP (blood sugar diagnostic)	DME	
UNISTRIPI TEST STRIP STRIP (blood sugar diagnostic)	DME	
VERASENS TEST STRIP STRIP (blood sugar diagnostic)	DME	
VIVAGUARD INO TEST STRIP STRIP (blood sugar diagnostic)	DME	
WAVESENSE JAZZ STRIP (blood sugar diagnostic)	DME	
WAVESENSE PRESTO STRIP (blood sugar diagnostic)	DME	
Medical Supplies And Dme - Blood Glucose-Ketone Comb. Test Supplies - Medical Supplies And Durable Medical Equipment		
CARETOUCH KETONE-GLUCOSE MONIT DEVICE (blood ketone and glucose monitor)	DME	
FORA 6 CONNECT MULTIFUNCTN MTR DEVICE (blood ketone and glucose monitor)	DME	
FORA GTEL MULTI-FUNCTN MONITOR DEVICE (blood ketone and glucose monitor)	DME	
FORA TN'G ADVANCE PRO MONITOR DEVICE (blood ketone and glucose monitor)	DME	
NOVA MAX PLUS GLUC-KETON METER KIT (blood ketone and glucose monitor)	DME	
PRECISION XTRA KETONE-GLUCOSE KIT (blood ketone and glucose monitor)	DME	
Medical Supplies And Dme - Blood Pressure Device Combinations - Medical Supplies And Durable Medical Equipment		
ADVOCATE DUO DEVICE (blood-glucose meter and wrist blood pressure monitor)	DME	
FORA D10 KIT (blood-glucose meter and wrist blood pressure monitor)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA D15 GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
Medical Supplies And Dme - Cervical Caps - Medical Supplies And Durable Medical Equipment		
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical cap)	Tier 0	
Medical Supplies And Dme - Compression Stockings - Medical Supplies And Durable Medical Equipment		
T.E.D. KNEE LENGTH-M-LONG (compression stocking,knee high,long length,small circumferen)	Tier 3	
T.E.D. KNEE LENGTH-S-REGULAR (compression stocking, knee high, regular length, small)	Tier 3	
Medical Supplies And Dme - Covid-19 Miscellaneous Testing Supplies - Medical Supplies And Durable Medical Equipment		
BD VERITOR SYSTEM SARS-COV-2 KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVD AG CARD HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG CARD KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG SELF TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	
<i>covid19 test adm.by pharmacist</i>	Tier 3	
<i>covid-19 test specimen collect</i>	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELLUME COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	
ID NOW COVID-19 TEST KIT KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	
PIXEL COVID19 HOME COLLECT KIT (COVID-19 test specimen collection)	Tier 3	
QUICKVUE SARS ANTIGEN KIT (COVID-19 antigen immunoassay test)	Tier 3	
SOFIA SARS ANTIGEN FIA KIT (COVID-19 antigen immunoassay test)	Tier 3	
SOFIA2 FLU-SARS ANTIGEN FIA KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
VERITOR SARS-COV-2 AND FLU A-B KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
Medical Supplies And Dme - Dental Supplies Other - Medical Supplies And Durable Medical Equipment		
Q-CARE RX Q2 KIT 0.12 % (dental suction device/chlorhexidine/dental swab 1/mouthwash)	Tier 3	
Q-CARE RX Q4 KIT 0.12 % (dental suction device/chlorhexidine gl/dental swab comb no.1)	Tier 3	
Medical Supplies And Dme - Diaphragms - Medical Supplies And Durable Medical Equipment		
CAYA CONTOURED VAGINAL DIAPHRAGM 65-80 MM (diaphragms, contoured)	Tier 0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM (diaphragms, wide seal)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM (diaphragms, wide seal)	Tier 0	
Medical Supplies And Dme - Drug Application Supplies - Medical Supplies And Durable Medical Equipment		
PCCA ACCUPEN-15 DEVICE (topical cream metered-dose device)	Tier 3	
Medical Supplies And Dme - Feeding Tubes And Supplies - Medical Supplies And Durable Medical Equipment		
ENTERAL GRAVITY BAG SET-ENFIT (feeder container with gravity set, ENFit)	Tier 3	
KANGAROO 924 SAFETY SCREW (pump set)	Tier 3	
KANGAROO EPUMP SET (feeder container with pump set)	Tier 3	
KANGAROO GRAVITY SET (feeder container with gravity set)	Tier 3	
RELIZORB CARTRIDGE (enteral pump accessory for fat hydrolysis)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Female Condoms - Medical Supplies And Durable Medical Equipment		
FC2 FEMALE CONDOM (condoms, female)	Tier 0	QL (30 EA per 30 days)
Medical Supplies And Dme - Gauze Bandages - Medical Supplies And Durable Medical Equipment		
CURITY AMD TOPICAL BANDAGE 1 X 5 "-YARD, 1/4 X 36 " (gauze bandage)	Tier 3	
Medical Supplies And Dme - Gauze Pads And Dressings - Medical Supplies And Durable Medical Equipment		
ALLEVYN ADHESIVE DRESSING TOPICAL BANDAGE 9 X 9 " (foam bandage)	Tier 3	
CURITY IODOFORM PACKING STRIP TOPICAL BANDAGE 1 X 5 "-YARD, 1/2 X 5 "-YARD, 1/4 X 5 "-YARD, 2 X 5 "-YARD (iodoform)	Tier 3	
RESTORE TOPICAL BANDAGE 2 X 2 " (silver/calcium alginate)	Tier 3	
XEROFORM NON-OCCLUSIVE TOPICAL BANDAGE 4 X 3 "-YARD (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM DRESSING TOPICAL BANDAGE 1 X 8 ", 2 X 2 ", 4 X 3 "-YARD, 4 X 4 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM OVERWRAP TOPICAL BANDAGE 1 X 8 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM TOPICAL BANDAGE 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Glucose Monitoring Test Supplies - Medical Supplies And Durable Medical Equipment		
1ST TIER UNILET COMFORTOUCH 28 GAUGE, 30 GAUGE (lancets)	DME	
2-IN-1 LANCET DEVICE 30 GAUGE (lancets)	DME	
2TEK CONTROL (HIGH-NORMAL) SOLUTION (blood glucose calibration control solution, high and normal)	DME	
2TEK GLUCOSE/BLOOD PRESSURE KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK AVIVA PLUS METER (blood-glucose meter)	DME	
ACCU-CHEK COMPACT PLUS CARE KIT (blood-glucose meter, drum-type)	DME	
ACCU-CHEK FASTCLIX LANCET DRUM (lancets)	DME	
ACCU-CHEK FASTCLIX LANCING DEV KIT (lancing device/lancets)	DME	
ACCU-CHEK GUIDE GLUCOSE METER (blood-glucose meter)	DME	
ACCU-CHEK GUIDE L1-L2 CTRL SOL SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK GUIDE ME GLUCOSE MTR (blood-glucose meter)	DME	
ACCU-CHEK MULTICLIX LANCET (lancets)	DME	
ACCU-CHEK MULTICLIX LANCET KIT (lancing device/lancets)	DME	
ACCU-CHEK SAFE-T-PRO 23 GAUGE (lancets)	DME	
ACCU-CHEK SAFE-T-PRO PLUS 23 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SMARTVIEW CONTRL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
ACCU-CHEK SOFT DEV LANCETS KIT (lancing device/lancets)	DME	
ACCU-CHEK SOFTCLIX LANCETS (lancets)	DME	
ACCUTREND GLUCOSE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ACTI-LANCE LANCETS 17 GAUGE, 23 GAUGE, 28 GAUGE (lancets)	DME	
ADJUSTABLE LANCING DEVICE (lancing device)	DME	
ADVANCED GLUCOSE METER (blood-glucose meter)	DME	
ADVANCED LANCING DEVICE KIT (lancing device/lancets)	DME	
ADVANCED TRAVEL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
ADVOCATE BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	
ADVOCATE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
ADVOCATE DUO DEVICE (blood-glucose meter and wrist blood pressure monitor)	DME	
ADVOCATE LANCET 26 GAUGE, 30 GAUGE (lancets)	DME	
ADVOCATE LANCING DEVICE (lancing device)	DME	
ADVOCATE LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ADVOCATE RAPID-SAFE LANCING (lancing device)	DME	
ADVOCATE REDI-CODE GLU MONITOR (blood-glucose meter)	DME	
ADVOCATE REDI-CODE GLU MONITOR KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVOCATE REDI-CODE PLUS (blood-glucose meter)	DME	
ADVOCATE REDI-CODE+ CTRL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
ADVOCATE REDI-CODE+ CTRL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
AGAMATRIX AMP GLUC MONITOR SYS (blood-glucose meter)	DME	
AGAMATRIX CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
AGAMATRIX CONTROL NORM-HI SOLUTION (blood glucose calibration control solution, high and normal)	DME	
AGAMATRIX CONTROL SOLN-LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
AGAMATRIX CONTROL SOLN-LEVEL 4 SOLUTION (blood glucose calibration control solution, high)	DME	
ALKALINE BATTERIES (diabetic supplies, miscell)	DME	
ALTERNATE SITE LANCET 26 GAUGE (lancets)	DME	
ALTERNATE SITE LANCING DEVICE (lancing device)	DME	
AQUA LANCE LANCING DEVICE (lancing device)	DME	
ASSURE 4 CONTROL SOLUTION COMBO PACK (blood-glucose calib. control)	DME	
ASSURE DOSE NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ASSURE DOSE NORM-HI CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE HAEMOLANCE PLUS 1.2 MM (blade lancet, safety)	DME	
ASSURE HAEMOLANCE PLUS 18 GAUGE, 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
ASSURE LANCE 25 GAUGE, 28 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASSURE LANCE PLUS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
ASSURE PLATINUM GLUCOSE METER (blood-glucose meter)	DME	
ASSURE PRISM CONTROL 1-2 SOLN SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE PRISM MULTI METER (blood-glucose meter)	DME	
AUTO-LANCET MINI (lancing device)	DME	
AUTOLET IMPRESSION LANC DEV KIT (lancing device/lancets)	DME	
AUTOLET LANCING DEVICE (lancing device)	DME	
AUTOLET PLUS LANCING DEVICE (lancing device)	DME	
BD MAGNI-GUIDE SYRINGE MAGNIFI (diabetic supplies, miscell)	DME	
BD MICROTAINER LANCET 1.5 X 2 MM (blade lancet, safety)	DME	
BD MICROTAINER LANCET 21 GAUGE, 30 GAUGE (lancets)	DME	
BD ULTRA FINE LANCETS 33 GAUGE (lancets)	DME	
BD ULTRA-FINE II LANCETS 30 GAUGE (lancets)	DME	
BIONIME RIGHTEST GM300 SYSTEM KIT (blood-glucose meter)	DME	
BIOTEL CARE BGM-4 METER (blood-glucose meter)	DME	
<i>blood glucose contrl hi, normal solution</i>	DME	
<i>blood glucose control, normal solution</i>	DME	
<i>blood glucose ctl high, nml, low solution</i>	DME	
BLOOD GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
<i>blood-glucose meter</i>	DME	
<i>blood-glucose meter kit</i>	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREEZE 2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
BREEZE 2 CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
BREEZE 2 CONTROL SOLUTION, HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
BULLSEYE MINI SAFETY LANCETS 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
BUTTERFLY TOUCH LANCET 30 GAUGE (lancets)	DME	
CARELANCE ULT LANCING DEVICE (lancing device)	DME	
CAREONE LANCING DEVICE (lancing device)	DME	
CAREONE THIN LANCET (lancets)	DME	
CAREONE ULTRA THIN LANCET (lancets)	DME	
CARESENS CONTROL A AND B SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARESENS CONTROL A NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
CARESENS LANCETS 30 GAUGE (lancets)	DME	
CARESENS N (blood-glucose meter)	DME	
CARESENS N KIT (blood-glucose meter)	DME	
CARESENS N VOICE (blood-glucose meter)	DME	
CARESENS N VOICE KIT (blood-glucose meter)	DME	
CARESENS PREM LANCING DEVICE (lancing device)	DME	
CARETOUCH GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
CARETOUCH LANCING DEVICE (lancing device)	DME	
CARETOUCH SAFETY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
CARETOUCH TWIST LANCET 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEQUR SIMPLICITY INSERTER (diabetic supplies,miscell)	DME	
CHEMSTRIP BG LOG BOOK (diabetic supplies,miscell)	DME	
CHOICE DM CLARUS NORM CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CHOICEDM CLARUS (blood-glucose meter)	DME	
CLEVER CHEK BLOOD GLUCOSE (blood-glucose meter)	DME	
CLEVER CHEK BLOOD GLUCOSE SYST KIT (blood-glucose meter)	DME	
CLEVER CHEK LANCETS 30 GAUGE (lancets)	DME	
CLEVER CHOICE BLOOD GLUC SYS (blood-glucose meter)	DME	
CLEVER CHOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
CLEVER CHOICE LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
CLEVER CHOICE LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CLEVER CHOICE LEVEL 3 CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
CLEVER CHOICE MICRO (blood-glucose meter)	DME	
CLEVER CHOICE PRO (blood-glucose meter)	DME	
CLEVER CHOICE TALK GLUCOSE SYS (blood-glucose meter)	DME	
COAGUCHEK LANCETS (lancets)	DME	
COLOR LANCETS 21 GAUGE (lancets)	DME	
COMFORT EZ LANCETS 21 GAUGE, 23 GAUGE, 28 GAUGE (lancets)	DME	
COMFORT LANCETS (lancets)	DME	
COMFORT TOUCH PLUS SAFETY LANC 30 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT TOUCH ULT THIN LANCETS 31 GAUGE (lancets)	DME	
CONTOUR CONTROL SOLUTION, HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
CONTOUR CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR METER (blood-glucose meter)	DME	
CONTOUR METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT EZ METER (blood-glucose meter)	DME	
CONTOUR NEXT EZ METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT GLUCOSE METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT LEV 1 CONTROL SOL SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR NEXT LEV 2 CONTROL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR NEXT LINK 2.4 KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT LINK KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT METER (blood-glucose meter)	DME	
CONTOUR NEXT ONE METER (blood-glucose meter)	DME	
CONTROL AST MONITORING SYSTEM (blood-glucose meter)	DME	
COOL BLOOD GLUCOSE METER (blood-glucose meter)	DME	
COOL BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
COOL CONTROL A SOLUTION SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COOL CONTROL B SOLUTION SOLUTION (blood glucose calibration control solution, high)	DME	
DARIO BLOOD GLUCOSE MONITOR DEVICE (blood-glucose meter,for mobile device)	DME	
DEXCOM G4 RECEIVER (blood-glucose meter,continuous)	DME	PA
DEXCOM G4 RECEIVER PEDIATRIC (blood-glucose meter,continuous)	DME	PA
DEXCOM G4 RECEIVER-SHARE (PED) (blood-glucose meter,continuous)	DME	PA
DEXCOM G4 RECEIVER-SHARE KIT (blood-glucose meter,continuous)	DME	PA
DEXCOM G4 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
DEXCOM G5 RECEIVER (blood-glucose meter,continuous)	DME	PA
DEXCOM G5 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
DEXCOM G5-G4 SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
DEXCOM G6 RECEIVER (blood-glucose meter,continuous)	DME	PA
DEXCOM G6 SENSOR DEVICE (blood-glucose sensor)	Tier 2	PA
DEXCOM G6 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 2	PA
DEXCOM RECEIVER (blood-glucose meter,continuous)	DME	PA
DIATRUE CONTROL SOLN NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
DIATRUE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
DIATRUE CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
DIATRUE PLUS BLOOD GLUCOSE MET (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPLET GENTEEL LANCING DEVICE (lancing device)	DME	
DROPLET LANCETS 30 GAUGE (lancets)	DME	
DROPLET LANCING DEVICE (lancing device)	DME	
EASY CHECK BLOOD GLUCOSE KIT (blood-glucose meter)	DME	
EASY COMFORT LANCETS 30 GAUGE (lancets)	DME	
EASY MINI EJECT LANCING DEVICE (lancing device)	DME	
EASY PLUS II BLOOD GLUCOSE MET (blood-glucose meter)	DME	
EASY PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY STEP HIGH CONTROL SOLN SOLUTION (blood glucose calibration control solution, high)	DME	
EASY STEP LOW CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP NORMAL CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TALK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TALK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TOUCH BLU CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH BLU LINK GLUC SYST (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH GLUCOSE MONITOR (blood-glucose meter)	DME	
EASY TOUCH HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH LANCING DEVICE (lancing device)	DME	
EASY TOUCH SAFETY LANCETS 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH TWIST LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
EASY TRAK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TRAK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TRAK II CTRL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TRAK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TWIST AND CAP LANCETS 28 GAUGE (lancets)	DME	
EASYGLUCO METER KIT (blood-glucose meter)	DME	
EASYGLUCO MONITORING SYSTEM KIT (blood-glucose meter)	DME	
EASYGLUCO PLUS NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX 15 LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX NG (blood-glucose meter)	DME	
EASYMAX NG KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYMAX NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX V SPEAKING GLUCOSE SYS (blood-glucose meter)	DME	
EASY-TOUCH BLOOD GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT COMPACT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT COMPACT V GLUCOSE MTR (blood-glucose meter)	DME	
ELEMENT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ELEMENT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT PLUS BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
EMBRACE BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
EMBRACE EVO BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
EMBRACE EVO LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE GLUCOSE CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE GLUCOSE CONTROL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE LANCETS 30 GAUGE (lancets)	DME	
EMBRACE LANCING DEVICE (lancing device)	DME	
EMBRACE PRO GLUCOSE METER (blood-glucose meter)	DME	
EMBRACE PRO SOLUTION (blood glucose calibration control solution, high and normal)	DME	
EMBRACE TALK BLOOD GLUCOSE SYS KIT (blood-glucose meter)	DME	
EMBRACE TALK CONTROL-HIGH (L2) SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE TALK CONTROL-LOW (L1) SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE TALK GLUCOSE MONITOR (blood-glucose meter)	DME	
ENLITE GLUCOSE SENSOR DEVICE (blood-glucose sensor)	Tier 3	
ENLITE SERTER (diabetic supplies, miscell)	DME	
ENLITE SYSTEM (blood-glucose transmitter/blood-glucose sensor)	Tier 3	
EVENCARE G2 (blood-glucose meter)	DME	
EVENCARE G2 SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G3 CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G3 GLUCOSE METER KIT (blood-glucose meter)	DME	
EVENCARE KIT (blood-glucose meter)	DME	
EVENCARE MINI GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE MINI MONITOR SYSTEM (blood-glucose meter)	DME	
EVENCARE PROVIEW CONTROL-L2,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE SOLUTION (blood glucose calibration control high and low)	DME	
EVERSENSE SMART TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
EVOLUTION BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
EVOLUTION NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
E-Z JECT LANCETS , 26 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
E-Z JECT THIN LANCETS 28 GAUGE (lancets)	DME	
EZ SMART CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EZ SMART LANCETS 28 GAUGE (lancets)	DME	
EZ SMART PLUS SYSTEM KIT (blood-glucose meter)	DME	
EZ SMART SYSTEM KIT (blood-glucose meter)	DME	
EZ-LETS 26 GAUGE (lancets)	DME	
FIFTY50 SAFETY SEAL LANCETS 30 GAUGE, 32 GAUGE (lancets)	DME	
FINE 30 UNIVERSAL LANCETS 30 GAUGE (lancets)	DME	
FINGERSTIX LANCETS (lancets)	DME	
FORA D10 KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
FORA D15 GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D20 KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA G20 KIT (blood-glucose meter)	DME	
FORA G30A (blood-glucose meter)	DME	
FORA GD50 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORA LANCING DEVICE (lancing device)	DME	
FORA LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORA NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORA PREMIUM V10 GLUCOSE METER (blood-glucose meter)	DME	
FORA TEST N'GO VOICE METER (blood-glucose meter)	DME	
FORA TN'G VOICE METER (blood-glucose meter)	DME	
FORA V10 KIT (blood-glucose meter)	DME	
FORA V12 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA V12 BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
FORA V20 KIT (blood-glucose meter)	DME	
FORA V30A (blood-glucose meter)	DME	
FORA V30A KIT (blood-glucose meter)	DME	
FORACARE GD20 GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GD40A GLUCOSE METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GD40B GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GDH HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORACARE GDH LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORACARE GDH NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORACARE LANCETS 30 GAUGE (lancets)	DME	
FORTISCARE HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
FORTISCARE LOW SOLUTION (blood glucose calibration control solution, low)	DME	
FORTISCARE NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORTISCARE T1 BLOOD GLUC SYS (blood-glucose meter)	DME	
FREESTYLE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
FREESTYLE FLASH SYSTEM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM LITE KIT (blood-glucose meter)	DME	
FREESTYLE INSULINX (blood-glucose meter)	DME	
FREESTYLE LANCETS 28 GAUGE (lancets)	DME	
FREESTYLE LIBRE 14 DAY READER (flash glucose scanning reader)	Tier 3	PA
FREESTYLE LIBRE 14 DAY SENSOR KIT (flash glucose sensor)	Tier 3	PA
FREESTYLE LIBRE 2 READER (flash glucose scanning reader)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 SENSOR KIT (flash glucose sensor)	Tier 3	PA
FREESTYLE LITE METER KIT (blood-glucose meter)	DME	
FREESTYLE NAVIGATOR GLUC SENS DEVICE (blood-glucose sensor)	Tier 3	
FREESTYLE PRECISION NEO METER (blood-glucose meter)	DME	
FREESTYLE SIDEKICK II KIT (blood-glucose meter)	DME	
FREESTYLE SYSTEM KIT KIT (blood-glucose meter)	DME	
FREESTYLE UNISTIK 2 (lancets)	DME	
GDRIVE KIT (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
GE100 CONTROL SOLUTION NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GE333 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE333 CONTROL SOLUTION NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCO NAVII GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
GLUCOCARD 01 HI-NORMAL CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
GLUCOCARD 01 METER KIT (blood-glucose meter)	DME	
GLUCOCARD 01 NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD EXPRESSION (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION KIT (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD SHINE CONNEX METER (blood-glucose meter)	DME	
GLUCOCARD SHINE EXPRESS METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER KIT KIT (blood-glucose meter)	DME	
GLUCOCARD SHINE SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD SHINE XL METER (blood-glucose meter)	DME	
GLUCOCARD VITAL KIT (blood-glucose meter)	DME	
GLUCOCOM AUTOLINK (diabetic supplies, miscell)	DME	
GLUCOCOM BLOOD GLUCOSE KIT (blood-glucose meter)	DME	
GLUCOCOM CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
GLUCOCOM CONTROL NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCOM LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOSE KETONE CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
GM100 KIT (blood-glucose meter)	DME	
GOJJI GLUCOSE CNTRL SOL-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GOJJI LANCETS 30 GAUGE (lancets)	DME	
GOJJI LANCING DEVICE (lancing device)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GOODLIFE AC-302 GLUCOSE METER (blood-glucose meter)	DME	
GUARDIAN CONNECT TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN LINK 3 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	
GUARDIAN RT CHARGER (diabetic supplies,miscell)	DME	
GUARDIAN RT TEST PLUG DEVICE (diabetic supplies,miscell)	DME	
GUARDIAN RT TRANSMITTER TAPE (diabetic supplies,miscell)	DME	
GUARDIAN SENSOR 3 DEVICE (blood-glucose sensor)	Tier 3	PA
HARMONY CONTROL L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
HEALTHPRO GLUCOSE MONITOR (blood-glucose meter)	DME	
HEALTHPRO HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
HEALTHY ACCENTS AUTOLET (lancing device)	DME	
HEALTHY ACCENTS UNILET LANCET 30 GAUGE (lancets)	DME	
HYPOLANCE AST LANCING KIT (lancing device/lancets)	DME	
IGLUCOSE BLOOD GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
INCONTROL LANCING DEVICE (lancing device)	DME	
INCONTROL SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
INCONTROL ULTRA THIN LANCETS 28 GAUGE (lancets)	DME	
INFINITY CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
INFINITY CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFINITY CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
INFINITY METER KIT KIT (blood-glucose meter)	DME	
INFINITY STARTER KIT KIT (blood-glucose meter)	DME	
INFINITY VOICE CTRL SOLN-LVL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
INFINITY VOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
INJECT EASE LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
INSUL-CAP (diabetic supplies,miscell)	DME	
INSUL-EZE (diabetic supplies,miscell)	DME	
INVACARE LANCETS 30 GAUGE (lancets)	DME	
JAZZ WIRELESS 2 METER KIT KIT (blood-glucose meter)	DME	
<i>lancets , 21 gauge, 26 gauge, 28 gauge, 30 gauge, 33 gauge</i>	DME	
LANCETS, SUPER THIN (lancets)	DME	
LANCETS,THIN , 23 GAUGE, 28 GAUGE (lancets)	DME	
LANCETS,ULTRA THIN , 26 GAUGE (lancets)	DME	
<i>lancing device</i>	DME	
LANCING DEVICE WITH LANCETS (lancing device)	DME	
<i>lancing device with lancets kit</i>	DME	
LANCING SYSTEM (lancing device)	DME	
LANZO LANCING DEVICE KIT (lancing device/lancets)	DME	
LITE TOUCH LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
LITE TOUCH LANCING DEVICE (lancing device)	DME	
MEDISENSE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE CONTROLS 1-HI 1-LO COMBO PACK (blood-glucose calib. control)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDISENSE GLUCOSE KETONE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MEDISENSE THIN LANCETS 28 GAUGE (lancets)	DME	
MEDLANCE PLUS LANCETS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
MEDLANCE PLUS SPECIAL BLADE 0.8 X 2 MM (blade lancet, safety)	DME	
MEDPOINT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MEDTRONIC REMOTE CONTROL (diabetic supplies, miscell)	DME	
METER-CHECK SOLUTION (blood glucose calibration control solution, normal)	DME	
MICRO THIN LANCETS 33 GAUGE (lancets)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
MICRODOT HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
MICRODOT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MICROLET 2 LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLET LANCET (lancets)	DME	
MICROLET NEXT LANCING DEVICE KIT (lancing device/lancets)	DME	
MINI LANCING DEVICE (lancing device)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED QUICK-SERTER-MMT 395 (diabetic supplies,miscell)	DME	
MONOLET LANCETS 21 GAUGE (lancets)	DME	
MONOLET THIN LANCETS 28 GAUGE (lancets)	DME	
MULTI-LANCET DEVICE 2 KIT (lancing device/lancets)	DME	
MYGLUCOHEALTH CONTROL SOLUTION SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
MYGLUCOHEALTH KIT (blood-glucose meter)	DME	
MYGLUCOHEALTH LANCETS 30 GAUGE (lancets)	DME	
NOVA MAX GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
NOVA SAFETY LANCETS 23 GAUGE, 28 GAUGE (lancets)	DME	
NOVA SUREFLEX LANCETS (lancets)	DME	
NOVAMAX PLUS GLU-KET SOLUTION (blood glucose and ketone control, normal)	DME	
ON CALL EXPRESS CONTROL SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
ON CALL EXPRESS METER (blood-glucose meter)	DME	
ON CALL EXPRESS METER KIT (blood-glucose meter)	DME	
ON CALL LANCET 30 GAUGE (lancets)	DME	
ON CALL LANCING DEVICE (lancing device)	DME	
ON CALL PLUS CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ON CALL PLUS LANCET 30 GAUGE (lancets)	DME	
ON CALL PLUS LANCING DEVICE (lancing device)	DME	
ON CALL PLUS METER (blood-glucose meter)	DME	
ON CALL PLUS METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ON CALL VIVID CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ON CALL VIVID METER (blood-glucose meter)	DME	
ON CALL VIVID METER KIT (blood-glucose meter)	DME	
ON CALL VIVID PAL METER (blood-glucose meter)	DME	
ON CALL VIVID PAL METER KIT (blood-glucose meter)	DME	
ONETOUCH DELICA LANC DEVICE KIT (lancing device/lancets)	DME	
ONETOUCH DELICA LANCETS 30 GAUGE, 33 GAUGE (lancets)	DME	
ONETOUCH DELICA PLUS LANC DEV KIT (lancing device/lancets)	DME	
ONETOUCH DELICA PLUS LANCET 30 GAUGE, 33 GAUGE (lancets)	DME	
ONETOUCH DELICA SAFETY LANCET 30 GAUGE (lancets)	DME	
ONETOUCH SURESOFT LANCING DEV 18 GAUGE, 21 GAUGE, 28 GAUGE (lancets)	DME	
ONETOUCH ULTRA CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH ULTRA2 METER (blood-glucose meter)	DME	
ONETOUCH ULTRA2 METER KIT (blood-glucose meter)	DME	
ONETOUCH ULTRAMINI KIT (blood-glucose meter)	DME	
ONETOUCH ULTRASOFT LANCETS (lancets)	DME	
ONETOUCH VERIO FLEX METER (blood-glucose meter)	DME	
ONETOUCH VERIO FLEX START KIT (blood-glucose meter)	DME	
ONETOUCH VERIO HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ONETOUCH VERIO IQ METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH VERIO IQ METER KIT (blood-glucose meter)	DME	
ONETOUCH VERIO METER (blood-glucose meter)	DME	
ONETOUCH VERIO MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH VERIO REFLECT METER (blood-glucose meter)	DME	
ONETOUCH VERIO REFLECT START KIT (blood-glucose meter)	DME	
ON-THE-GO LANCETS 30 GAUGE (lancets)	DME	
OPTUMRX (blood-glucose meter)	DME	
OPTUMRX KIT (blood-glucose meter)	DME	
OPTUMRX SOLUTION (blood glucose calibration control solution, high and normal)	DME	
OVAL TAPE (diabetic supplies, miscell)	DME	
PHARMACIST CHOICE GLUCOSE SYS (blood-glucose meter)	DME	
PIP LANCET 28 GAUGE, 30 GAUGE (lancets)	DME	
POGO AUTOMATIC BLOOD GLUC SYS (blood-glucose meter)	DME	
PRECISION (blood-glucose meter)	DME	
PRECISION GLUCOSE CONTROL SOLN COMBO PACK (blood-glucose calib. control)	DME	
PRECISION GLUCOSE/KETONE CONTR COMBO PACK (blood-glucose calib. control)	DME	
PRECISION XTRA MONITOR (blood-glucose meter)	DME	
PREMIER BLU GLUCOSE METER (blood-glucose meter)	DME	
PREMIER CLASSIC GLUCOSE METER (blood-glucose meter)	DME	
PREMIER COMPACT GLUCOSE METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMIER VOICE GLUCOSE METER (blood-glucose meter)	DME	
PREMIUM BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	
PREMIUM V10 (blood-glucose meter)	DME	
PRESSURE ACTIVATED LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
PRESTO PRO BLOOD GLUCOSE METER (blood-glucose meter)	DME	
PRO COMFORT LANCET 30 GAUGE, 31 GAUGE (lancets)	DME	
PRO VOICE V8 GLUCOSE MONITOR (blood-glucose meter)	DME	
PRO VOICE V9 GLUCOSE MONITOR (blood-glucose meter)	DME	
PRODIGY AUTOCODE METER KIT (blood-glucose meter)	DME	
PRODIGY AUTOCODE MONITOR SYST (blood-glucose meter)	DME	
PRODIGY CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
PRODIGY CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
PRODIGY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
PRODIGY LANCING DEVICE (lancing device)	DME	
PRODIGY POCKET METER KIT (blood-glucose meter)	DME	
PRODIGY TWIST TOP LANCET 28 GAUGE (lancets)	DME	
PRODIGY VOICE GLUCOSE METER KIT (blood-glucose meter)	DME	
PURE COMFORT LANCETS 30 GAUGE (lancets)	DME	
PURE COMFORT SAFETY LANCETS 30 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PUSH BUTTON SAFETY LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
QUINTET AC (blood-glucose meter)	DME	
QUINTET BLOOD GLUCOSE METER (blood-glucose meter)	DME	
READYLANCE SAFETY LANCETS 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
REFUAH PLUS GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
REFUAH PLUS GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
RELIAMED LANCET 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED MINI LANCING DEVICE (lancing device)	DME	
RELIAMED SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED TWIST AND CAP LANCET 28 GAUGE (lancets)	DME	
RELION ALL-IN-ONE METER KIT (blood-glucose meter)	DME	
RELION CONFIRM KIT (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
RELION PRIME METER (blood-glucose meter)	DME	
RELION THIN LANCETS 26 GAUGE (lancets)	DME	
RELION ULTRA THIN PLUS LANCETS (lancets)	DME	
REVEAL BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIGHTEST CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
RIGHTEST CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GC250S CNTRL SOL NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GC700 LEV 2 CTRL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GD500 LANCING DEVICE (lancing device)	DME	
RIGHTEST GL300 LANCETS 30 GAUGE (lancets)	DME	
RIGHTEST GM250S GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GM260 GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GM550 SYSTEM KIT (blood-glucose meter)	DME	
RIGHTEST GM700SB GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GT333 GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GT333 LEV 2 CTRL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST MAX PLUS GLUCOSE MTR (blood-glucose meter)	DME	
SAFETY LANCETS 21 GAUGE, 26 GAUGE, 28 GAUGE (lancets)	DME	
SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SAFETY-LET LANCETS 30 GAUGE (lancets)	DME	
SINGLE-LET (lancets)	DME	
SMART CARESENS N KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMART SENSE LANCETS 21 GAUGE, 26 GAUGE, 33 GAUGE (lancets)	DME	
SMART SENSE MONITORING SYSTEM (blood-glucose meter)	DME	
SMARTDIABETES VANTAGE (lancing device)	DME	
SMARTEST CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
SMARTEST EJECT KIT (blood-glucose meter)	DME	
SMARTEST LANCET (lancets)	DME	
SMARTEST PERSONA GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PERSONA STARTER KIT (blood-glucose meter)	DME	
SMARTEST PRONTO GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PRONTO STARTER KIT (blood-glucose meter)	DME	
SMARTEST PROTEGE KIT (blood-glucose meter)	DME	
SMARTEST SMART CODE METER KIT (blood-glucose meter)	DME	
SMARTEST TALKING METER KIT (blood-glucose meter)	DME	
SOFT TOUCH LANCETS (lancets)	DME	
SOLUS V2 AUDIBLE METER (blood-glucose meter)	DME	
SOLUS V2 AUDIBLE METER KIT (blood-glucose meter)	DME	
SOLUS V2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
SOLUS V2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
SOLUS V2 LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SOLUS V2 LANCING DEVICE KIT (lancing device/lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STERILANCE TL 30 GAUGE, 32 GAUGE (lancets)	DME	
SUPER THIN LANCETS , 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT LANCETS 18 GAUGE, 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT LANCING PEN (lancing device)	DME	
SUREFLEX DEVICE WITH LANCETS KIT (lancing device/lancets)	DME	
SUREFLEX LANCING DEVICE (lancing device)	DME	
SURE-LANCE , 26 GAUGE, 28 GAUGE (lancets)	DME	
SURE-LANCE ULTRA THIN 30 GAUGE (lancets)	DME	
SURE-PEN LANCING DEVICE (lancing device)	DME	
SURE-TEST EASYPLUS MINI METER (blood-glucose meter)	DME	
SURE-TEST EASYPLUS MINI SOLUTION (blood glucose calibration control solution, normal)	DME	
SURE-TOUCH LANCET (lancets)	DME	
TD GOLD BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	
TD GOLD LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
TD GOLD LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
TD GOLD LEVEL 3 CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
TD GOLD VOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
TECHLITE LANCETS 25 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
TELCARE BGM KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TELCARE BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
TELCARE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
TELCARE LANCETS 30 GAUGE (lancets)	DME	
TEST N'GO BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
THIN LANCETS 26 GAUGE (lancets)	DME	
TOPCARE UNIVERSAL1 LANCET , 33 GAUGE (lancets)	DME	
TRUE COMFORT LANCET 30 GAUGE (lancets)	DME	
TRUE METRIX AIR GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX AIR GLUCOSE METER KIT (blood-glucose meter)	DME	
TRUE METRIX GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX GLUCOSE METER KIT (blood-glucose meter)	DME	
TRUE METRIX GO GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
TRUE METRIX LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
TRUE METRIX LEVEL 3 SOLUTION (blood glucose calibration control solution, high)	DME	
TRUE2GO BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUECONTROL LEVEL 0 SOLUTION (blood glucose calibration control solution, high)	DME	
TRUECONTROL LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUEDRAW LANCING DEVICE (lancing device)	DME	
TRUEPLUS LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
TRUERESULT BLOOD GLUCOSE SYSTM KIT (blood-glucose meter)	DME	
TRUETRACK BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUETRACK SMART SYSTEM KIT (blood-glucose meter)	DME	
TWIST LANCETS 30 GAUGE, 32 GAUGE (lancets)	DME	
ULTI-LANCE (lancing device)	DME	
ULTI-LANCE KIT (lancing device/lancets)	DME	
ULTILET BASIC LANCETS 30 GAUGE (lancets)	DME	
ULTILET CLASSIC LANCETS , 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET SAFETY LANCETS 23 GAUGE (lancets)	DME	
ULTIMA MONITOR (blood-glucose meter)	DME	
ULTRA FINE LANCETS 30 GAUGE (lancets)	DME	
ULTRA THIN II LANCETS 30 GAUGE (lancets)	DME	
ULTRA THIN LANCETS , 28 GAUGE, 30 GAUGE, 31 GAUGE, 33 GAUGE (lancets)	DME	
ULTRA THIN PLUS LANCETS 33 GAUGE (lancets)	DME	
ULTRA TLC LANCETS (lancets)	DME	
ULTRA-CARE LANCETS 30 GAUGE (lancets)	DME	
ULTRALANCE LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
ULTRA-THIN II LANCETS 28 GAUGE (lancets)	DME	
ULTRATRAK GLUCOSE METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATRAK GLUCOSE METER KIT (blood-glucose meter)	DME	
ULTRATRAK HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ULTRATRAK NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ULTRATRAK ULTIMATE (blood-glucose meter)	DME	
ULTRATRAK ULTIMATE SOLUTION (blood glucose calibration control high and low)	DME	
UNILET COMFORTOUCH LANCET , 26 GAUGE (lancets)	DME	
UNILET EXCELITE II LANCET (lancets)	DME	
UNILET EXCELITE LANCET (lancets)	DME	
UNILET GP LANCET (lancets)	DME	
UNILET LANCET 28 GAUGE, 33 GAUGE (lancets)	DME	
UNILET LANCETS 30 GAUGE (lancets)	DME	
UNILET SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
UNISTIK 2 DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 2 EXTRA KIT (lancing device/lancets)	DME	
UNISTIK 2 NORMAL LANCET,DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 3 COMFORT DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 3 COMFORT LANCET (lancets)	DME	
UNISTIK 3 EXTRA LANCET 21 GAUGE (lancets)	DME	
UNISTIK 3 GENTLE 30 GAUGE (lancets)	DME	
UNISTIK 3 KIT (lancing device/lancets)	DME	
UNISTIK 3 LANCETS 21 GAUGE (lancets)	DME	
UNISTIK 3 NEONATAL DEVICE KIT (lancing device/lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISTIK 3 NEONATAL KIT (lancing device/lancets)	DME	
UNISTIK 3 NORMAL LANCET 23 GAUGE (lancets)	DME	
UNISTIK COMFORT LANCETS 28 GAUGE (lancets)	DME	
UNISTIK CZT LANCET 23 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK EXTRA LANCETS 21 GAUGE (lancets)	DME	
UNISTIK NORMAL LANCETS 23 GAUGE (lancets)	DME	
UNISTIK PRO LANCET 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK SAFETY 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTIK TOUCH LANCETS 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTRIP HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
UNISTRIP LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
UNIVERSAL 1 LANCETS 21 GAUGE, 26 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
VERASENS BLOOD GLUCOSE METER (blood-glucose meter)	DME	
VERASENS CONTROL SOLN-LEVEL 1 SOLUTION (blood glucose calibration control solution, normal)	DME	
VERASENS METER STARTER KIT KIT (blood-glucose meter)	DME	
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
VIVAGUARD INO CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
VIVAGUARD INO CTRL SOLN-L2 SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVAGUARD INO GLUCOSE METER (blood-glucose meter)	DME	
VIVAGUARD INO SMART GLUC METER (blood-glucose meter)	DME	
VIVAGUARD LANCET 30 GAUGE (lancets)	DME	
VIVAGUARD LANCING DEVICE (lancing device)	DME	
WAVESENSE AMP KIT (blood-glucose meter)	DME	
WAVESENSE CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, normal)	DME	
WAVESENSE PRESTO (blood-glucose meter)	DME	
WAVESENSE PRESTO KIT (blood-glucose meter)	DME	
Medical Supplies And Dme - Incontinence Supplies - Medical Supplies And Durable Medical Equipment		
CURITY DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
FLEXI-SEAL SIGNAL FMS RECTAL (fecal collector with charcoal filter/catheter/syringe)	Tier 3	
MONO-FLO DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
NIGHTTIME UNDERPANTS L-XL (diaper,brief,youth,disposable)	Tier 3	
Medical Supplies And Dme - Infant Diapers - Medical Supplies And Durable Medical Equipment		
BOYS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 1 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 2 (diaper/brief,infant-toddler, disposable)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAPERS, UNISEX SIZE 3 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 4 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 5 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 6 (diaper/brief,infant-toddler, disposable)	Tier 3	
GIRLS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	
Medical Supplies And Dme - Insulin Needles- Syringes And Admin Supplies - Medical Supplies And Durable Medical Equipment		
1ST TIER UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
1ST TIER UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ABOUTTIME PEN NEEDLE NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVOCATE SYRINGES SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ASSURE ID INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
ASSURE ID PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16", 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
AUTOJECT 2 INJECTION DEVICE SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 1 TO 21 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 2 TO 42 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
BD AUTOSHIELD DUO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic disposable, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 30 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE (HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
BD INSULIN SYRINGE MICRO-FINE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE SAFETY-LOK SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD INSULIN SYRINGE SLIP TIP SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
BD INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
BD INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD INSULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 25 X 1", 1 ML 26 X 1/2", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE U-500 SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe, insulin U-500 with needle, disposable, 0.5 mL)	Tier 1	
BD INSULIN SYRINGE ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
BD INSULIN SYRINGE ULTRA-FINE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD INSULIN SYRINGE ULTRA-FINE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD LO-DOSE MICRO-FINE IV SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD LO-DOSE ULTRA-FINE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD NANO 2ND GEN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD ULTRA-FINE MICRO PEN NEEDLE NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
BD ULTRA-FINE MINI PEN NEEDLE NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
BD ULTRA-FINE NANO PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
BD ULTRA-FINE ORIG PEN NEEDLE NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic)	Tier 1	
BD ULTRA-FINE SHORT PEN NEEDLE NEEDLE 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
BD VEO INSULIN SYR (HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
BD VEO INSULIN SYRINGE UF SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD VEO INSULIN SYRINGE UF SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD VEO INSULIN SYRINGE UF SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
CAREFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 1 ML 28 X 5/16", 1 ML 29 GAUGE X 5/16, 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
CARETOUCH PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CLICKFINE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT EZ INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
COMFORT EZ PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT TOUCH PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 31 GAUGE X 5/32", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16", 0.5ML 30 GAUGE X 15/64" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
DROPLET MICRON PEN NEEDLE NEEDLE 34 GAUGE X 9/64" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPLET PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY COMFORT PEN NEEDLES NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY GLIDE PEN NEEDLE NEEDLE 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.3 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2" (syringe with needle, insulin, 0.5 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, disposable, insulin 1 mL)	Tier 1	
EASY TOUCH LUER LOCK INSULIN SYRINGE 1 ML (syringe without needle, insulin disposable, 1 mL)	Tier 1	
EASY TOUCH NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY TOUCH PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16", 30 GAUGE X 1/4", 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH UNI-SLIP SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
EXEL INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
EXEL INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
EXEL INSULIN SYRINGE 1 ML 30 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEALTHWISE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
HEALTHY ACCENTS UNIFINE PENTIP NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic, safety)	Tier 1	
HEALTHY ACCENTS UNIFINE PENTIP NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INCONTROL PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INPEN (FOR HUMALOG) SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
INPEN (FOR NOVOLOG OR FIASP) SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
<i>insulin syrlndl u100 half mark syringe 0.3 ml 31 gauge x 1/4"</i>	Tier 1	
INSULIN SYRINGE MICROFINE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
INSULIN SYRINGE MICROFINE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
<i>insulin syringe needleless syringe 1 ml</i>	Tier 1	
INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 0.3 ml 29 gauge x 1/2", 0.3 ml 30, 0.3 ml 30 gauge x 1/2", 0.3 ml 30 gauge x 5/16", 0.3 ml 31 gauge x 1/4", 0.3 ml 31 gauge x 15/64", 0.3 ml 31 gauge x 5/16", 0.5 ml 29 gauge x 1/2", 0.5 ml 30 gauge x 1/2", 0.5 ml 30 gauge x 5/16", 0.5 ml 31 gauge x 5/16", 1 ml 27 gauge x 1/2", 1 ml 28 gauge, 1 ml 28 gauge x 1/2", 1 ml 29 gauge x 1/2", 1 ml 29 gauge x 7/16", 1 ml 30 gauge x 1/2", 1 ml 30 gauge x 3/8", 1 ml 30 gauge x 5/16, 1 ml 30 gauge x 7/16", 1 ml 31 gauge x 1/4", 1 ml 31 gauge x 15/64", 1 ml 31 gauge x 5/16, 1/2 ml 27 gauge x 1/2", 1/2 ml 28 gauge, 1/2 ml 28 gauge x 1/2", 1/2 ml 29, 1/2 ml 30 gauge, 1/2 ml 31 gauge x 1/4", 1/2 ml 31 gauge x 15/64"</i>	Tier 1	
INSUPEN NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
LITE TOUCH INSULIN PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
LITE TOUCH INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
LITE TOUCH INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE, 1/2 ML 28 GAUGE X 1/2", 1/2 ML 29, 1/2 ML 30 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
LITE TOUCH INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE, 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.3 ML 29 X 1/2" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.3 ML 30 X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAXICOMFORT II PEN NEEDLE NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1/2 ML 27 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
MICRODOT INSULIN PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
MINI ULTRA-THIN II NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED SYRINGE RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
MINIMED SYRINGE RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRING SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRING SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRING SYRINGE 29 GAUGE X 1/2" (syringe with needle,insulin disposable)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 1 ML , 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
NOVOFINE AUTOCOVER NEEDLE 30 GAUGE X 1/3" (pen needle, diabetic, safety)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6" (pen needle, diabetic)	Tier 1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
NOVOTWIST NEEDLE 32 GAUGE X 1/5" (pen needle, diabetic)	Tier 1	
OMNIPOD DASH PDM KIT (insulin pump controller)	Tier 2	
PARADIGM RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
PARADIGM RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
<i>pen needle, diabetic needle 29 gauge x 1/2", 30 gauge x 5/16", 31 gauge x 1/4", 31 gauge x 3/16", 31 gauge x 5/16", 32 gauge x 1/4", 32 gauge x 3/16", 32 gauge x 5/32", 33 gauge x 5/32"</i>	Tier 1	
<i>pen needle, diabetic needle 31 gauge x 1/3", 31 gauge x 1/6", 31 gauge x 15/64"</i>	Tier 1	
PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PIP PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PREVENT DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
PRO COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRO COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PRO COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PURE COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
RELION NEEDLES NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
RELION PEN NEEDLES NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16" (syringe w-needle 0.3 mL,insulin,safety w-self-cont.dis.unit)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (insulin syringe-needle,safety,disposal unit,0.5 mL)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle 1 mL,insulin,safety w-self-con.disp.unit)	Tier 1	
SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
SECURESAFE PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE COMFORT INS. SYR. U-100 SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
SURE COMFORT PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
SURE-FINE PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE-JECT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
TECHLITE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.3 ML 30 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THINPRO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8", 0.3 ML 31 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8", 1 ML 31 X 3/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TOPCARE CLICKFINE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE COMFORT PRO INS SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16", 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUEPLUS PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 1/4" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTICARE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTICARE SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 0.3 ML 30 X 1/2", 0.3 ML 31 X 5/16" (syringe with needle,insulin disposable,0.3 mL/empty containr)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1 ML 30 X 1/2", 1 ML 31 X 5/16" (syringe with needle, insulin,1 mL and sharps container)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1/2 ML 30 X 1/2", 1/2 ML 31 X 5/16" (syringe-needle,insulin,0.5 mL/container,empty)	Tier 1	
ULTIGUARD SAFEPAK-PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, remover and disposal unit)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE, 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 (syringe with needle,insulin,0.5 mL)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULILET PEN NEEDLE NEEDLE 29 GAUGE, 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA CMFT INS SYR (HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30, 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE, 1/2 ML 28 GAUGE X 1/2", 1/2 ML 29, 1/2 ML 30 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE, 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA FLO PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRACARE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRACARE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II (SHORT) PEN NDL NEEDLE 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INS PEN NEEDLES NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNIFINE PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS NEEDLE 29 GAUGE, 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS PLUS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VANISHPOINT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 3/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2" (syringe with needle, insulin, 0.5 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle, disposable, insulin 1 mL)	Tier 1	
VERIFINE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
Medical Supplies And Dme - Iv Sets-Tubing - Medical Supplies And Durable Medical Equipment		
BD INSYTE AUTOGUARD INFUSION SET 24 GAUGE X 3/4" (intravenous catheter)	Tier 3	
BD SAF-T-INTIMA INFUSION SET 22 GAUGE X 3/4" (intravenous catheter kit)	Tier 3	
FILTERED EXTENSION SET INFUSION SET (intravenous administration extension set with filter)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HI-VOLUME PUMPING CHAMBER SET (transfer sets)	Tier 3	
INSYTE IV CATHETER INFUSION SET 14 X 1.75 ", 20 X 1.16 " (intravenous catheter)	Tier 3	
MICROBORE EXTENSION SET INFUSION SET (intravenous administration extension set)	Tier 3	
NEXIVA INFUSION SET 18 X 1 1/4 ", 18 X 1 3/4 ", 20 GAUGE X 1", 20 X 1 1/4 ", 20 X 1 3/4 ", 22 GAUGE X 1", 24 GAUGE X 3/4", 24 X 0.56 " (intravenous catheter)	Tier 3	
PHASEAL SECONDARY SET INFUSION SET (intravenous piggyback administration set)	Tier 3	
PHASEAL Y-SITE (y-site line connector, closed system)	Tier 3	
RATE FLOW REGULATOR IV SET INFUSION SET (intravenous administration set)	Tier 3	
Medical Supplies And Dme - Male Erectile Dysfunction Aids - Medical Supplies And Durable Medical Equipment		
RAPPORT VACUUM THERAPY KIT (vacuum erection device system)	Tier 3	
Medical Supplies And Dme - Miscellaneous Other - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK SPIRIT CLIP CASE (subcutaneous infusion pump accessory)	Tier 3	
AMIELLE VAGINAL TRAINER KIT (medical supply, miscellaneous)	Tier 3	
ARGYLE TRACHEOSTOMY CARE TRAY (medical supply, miscellaneous)	Tier 3	
CEFALY COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNIPOD DASH 5 PACK POD SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 2	
OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 2	
PRO COMFORT TENS ELECTRODE PAD (tens unit electrodes)	Tier 3	
PRO COMFORT TENS UNIT COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
PRO-CEPTION VAGINAL (medical supply, miscellaneous)	Tier 3	
RECONSTITUTE KIT (medical supply, miscellaneous)	Tier 3	
SAFE-CLIP NEEDLE STORAGE DEV DEVICE (needle clipping and storage device)	DME	
SUPPOSITORY SHELL, SMALL DEVICE (suppository mold)	Tier 3	
T.E.D. ANTI-EMBOLISM STOCKING (compression stocking, knee high, regular length, small)	Tier 3	
T:FLEX SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	
T:SLIM X2 SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	
TENS 502 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
TENS 504 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
Medical Supplies And Dme - Nebulizers - Medical Supplies And Durable Medical Equipment		
AEROECLIPSE II NEBULIZER (nebulizer)	Tier 3	
AERONEB GO NEBULIZER (nebulizer)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIRS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
ALTERA NEBULIZER (nebulizer)	Tier 3	
ALTERA NEBULIZER SYSTEM (nebulizer)	Tier 3	
AURA PORTANEB (nebulizer)	Tier 3	
DEVILBISS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
FLYP NEBULIZER (nebulizer)	Tier 3	
INNOSPIRE GO NEBULIZER (nebulizer)	Tier 3	
LC PLUS (nebulizer)	Tier 3	
LC PLUS NEBULIZER-PED MASK (nebulizer)	Tier 3	
MICROAIR MESH NEBULIZER (nebulizer)	Tier 3	
MINI PLUS NEBULIZER (nebulizer)	Tier 3	
PARI LC SPRINT NEBULIZER SET (nebulizer)	Tier 3	
PARI LC SPRINT SINUS (nebulizer)	Tier 3	
PRODIGY MINI-MIST NEBULIZER (nebulizer)	Tier 3	
SIDESTREAM (nebulizer)	Tier 3	
SIDESTREAM NEBULIZER (nebulizer)	Tier 3	
SIDESTREAM PLUS (nebulizer)	Tier 3	
SINUSTAR NEBULIZER (nebulizer)	Tier 3	
SOOTHENEB MESH NEBULIZER (nebulizer)	Tier 3	
TRUNEB NEBULIZER (nebulizer)	Tier 3	
VIXONE NEBULIZER (nebulizer)	Tier 3	
VIXONE NEBULIZER-ADULT MASK (nebulizer)	Tier 3	
VIXONE NEBULIZER-PEDIATRIC MSK (nebulizer)	Tier 3	
Medical Supplies And Dme - Needles And Syringes - Medical Supplies And Durable Medical Equipment		
ALLERGIST TRAY 1/2 ML 27GX3/8" SYRINGE 1/2 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGIST TRAY INTRADERMAL BEV SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGIST TRAY REGULAR BEVEL SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL TRAY 1/2 ML 27 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
BD ALLERGY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD BLUNT PLASTIC CANNULA SYRINGE 17 X 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD ECCENTRIC TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD ECLIPSE LUER-LOK NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 22 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD FILTER NEEDLE-5 MICRON NEEDLE 19 X 1 1/2 " (needles, filter)	Tier 3	
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
BD INTEGRA SYRINGE SYRINGE 3 ML 22 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD INTERLINK BLUNT PLASTIC CAN SYRINGE 17 X 5 ML (syringe with cannula, disposable, 5 mL)	Tier 1	
BD INTERLINK SYRINGE SYRINGE 17 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
BD LAB ECCENTRIC NON-STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD LUER-LOK BULK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2", 10 ML 22 X 1", 10 ML 23X 1 1/4 " (syringe with needle,disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE SYRINGE 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2 ", 3 ML 25 X 5/8", 3 ML 26 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD LUER-LOK TIP CONTROL SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD PRECISIONGLIDE SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 10 ML 22 X 1 1/2" (syringe with needle,disposable, 10 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 22 X 1 1/2", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SAFETYGLIDE SYRINGE SYRINGE 5 ML 22 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
BD SAFETYGLIDE TB REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 26 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
BD SAFETY-LOK TUBERCULIN SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
B-D SLIP TIP SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SLIP TIP SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SPECIALTY USE NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
BD SYRINGE CATH TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE CATHETER TIP SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD SYRINGE-DUAL CANNULA SYRINGE 10 ML 20 GAUGE AND 17 GAUGE (syringe with needle and cannula, disposable, 10 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1 ML 21 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1/2 ML 27 X 1/2 " (syringe with needle,disposable, 0.5 mL)	Tier 1	
<i>blunt needle, disposable needle 18 x 1 1/2 "</i>	Tier 3	
CAREPOINT LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT LUER LOCK SYR-NEEDLE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
CAREPOINT LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CAREPOINT LUER SLIP SYRING-NDL SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
DAVOL IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
DAVOL PISTON IRRIGATION SYRINGE (syringe disposable irrigation)	Tier 1	
DOVER BULB SYRINGE SYRINGE 60 ML (syringe disposable irrig,60 mL)	Tier 1	
EASY GLIDE CATHETER TIP SYRING SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE DENTAL IRRIG SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY GLIDE LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE LUER SLIP TB SYRING SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH FLIPLOCK NEEDLE NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 10 ML 18 GAUGE X 1 1/2", 10 ML 18 GAUGE X 1", 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 5 ML 18 GAUGE X 1", 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1", 5 ML 25 GAUGE X 5/8" (syringe,safety with needle,5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH FLURINGE FLIPLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SHEATHLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH HYPODERMIC NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 10 ML 21 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 5 ML 21 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
EASY TOUCH TUBERCULIN FLIPLOCK SYRINGE 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TUBERCULIN SHEATHLK SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH UNI-SLIP SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
ECLIPSE NEEDLE NEEDLE 23 GAUGE X 1", 25 X 5/8 ", 27 GAUGE X 1/2" (needles, safety)	Tier 3	
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
EXCEL SYRINGE SYRINGE 3 ML 23 X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL HYPODERMIC NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXEL SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EXEL SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
EXEL SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
<i>filter needles needle 19 x 1 ", 19 x 1 1/2 "</i>	Tier 3	
INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
INTERLINK SYRINGE AND CANNULA SYRINGE 15 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
LUER LOCK SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
LUER SLIP TIP SYRINGE TRAY SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
LUER-LOK TIP SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
MAGELLAN SAFETY NEEDLE NEEDLE 23 GAUGE X 5/8" (needles, safety)	Tier 3	
MAGELLAN SAFETY SYRINGE SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT 140CC PISTON SYRINGE SYRINGE (syringe, disposable)	Tier 1	
MONOJECT 35CC SYRINGE CATH TIP SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT 3CC SYR 25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT ALLERGY TRAY DETACH TRAY 1 ML 27 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 0.5 ML 28 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 1 ML 28 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT CONTROL SYRINGE LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT DISPOSABLE SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT HYPODERMIC NEEDLES NEEDLE 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1 1/2", 27 GAUGE X 1/2", 30 GAUGE X 3/4" (needles, disposable)	Tier 3	
MONOJECT LUER-LOCK TIP SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT LUER-LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT MAGELLAN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE SYRINGE 3 ML 20 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT PHARMACY TRAY REG TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SAFETY LUER LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE (syringe with needle,disposable)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML 20 X 1 1/2", 12 ML 21X 1 1/2" (syringe,safety with needle,12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 6 ML (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 12 ML (syringe with cannula,disposable 12 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 6 ML (syringe with cannula, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE ECCENTRI LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE REGULAR LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SYRINGE SYRINGE 12 ML 18 GAUGE X 1", 12 ML 20 X 1 1/2", 12 ML 21 GAUGE X 1 1/2", 12 ML 21 GAUGE X 1" (syringe with needle,disposable, 12 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 140 ML (syringe, disposable, 140 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 20 X 3/4", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/4", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML 20 X 1 1/2", 6 ML 21 X 1 1/2", 6 ML 21 X 1", 6 ML 22 X 1 1/2" (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE TOOMEY TYPE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT TB LUER LOK SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB REGULAR LUER TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT TB SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2", 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1/2 ML 28 X 1/2" (syringe with needle,disposable, 0.5 mL)	Tier 1	
NORM-JECT SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
NORM-JECT SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
NORM-JECT TUBERKULIN SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
POLY HUB NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
SAFESNAP SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2" (syringe,needle,safety 1 mL,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML (syringe, safety 10 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 GAUGE X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1" (syringe,safety needle 10 mL and self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML (syringe, safety 3 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe 3 mL with safety needle,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML (syringe, safety 5 mL, self-contained disposal unit)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAFESNAP SYRINGE SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1" (syringe, safety needle 5 mL and self-contained disposal unit)	Tier 1	
<i>safety needles needle 18 gauge x 1 1/2"</i>	Tier 3	
SURGUARD2 SAFETY NEEDLE 18 GAUGE X 1 1/2", 18 GAUGE X 1", 19 GAUGE X 1 1/2", 19 GAUGE X 1", 20 GAUGE X 1 1/2", 20 GAUGE X 1", 21 GAUGE X 1 1/2", 21 GAUGE X 1", 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1 1/2", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 X 5/8 ", 26 GAUGE X 1/2", 27 GAUGE X 1/2" (needles, safety)	Tier 3	
SURGUARD2 SAFETY NEEDLE 30 GAUGE X 1 1/2" (needles, safety)	Tier 1	
SURGUARD2 SAFETY SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
<i>syringe (disposable) syringe 20 ml, 3 ml, 30 ml, 5 ml, 60 ml</i>	Tier 1	
SYRINGE 3CC/20GX1" SYRINGE 3 ML 20 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGE 3CC/21GX1" SYRINGE 3 ML 21 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1-1/2" SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX1" SYRINGE 3 ML 22 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX3/4" SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
<i>syringe with needle syringe 1 ml 25 gauge x 1", 3 ml 20 gauge x 1 1/2", 3 ml 21 gauge x 1 1/2", 3 ml 22 x 1 1/2", 3 ml 23 gauge x 1 1/2"</i>	Tier 1	
<i>syringe with needle, safety syringe 1 ml 25 gauge x 5/8", 3 ml 22 gauge x 1"</i>	Tier 1	
SYRINGE WITHOUT NEEDLE SYRINGE (syringe, disposable)	Tier 1	
TERUMO ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
TERUMO HYPODERMIC NEEDLE/SYRIN SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
TOOMEY SYRINGE SYRINGE 70 ML (syringe, disposable irrigation, 70 mL)	Tier 1	
TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
<i>tuberculin-allergy syringes syringe 1 ml 26 gauge x 3/8"</i>	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 1 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 3 ML 22 X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML (syringe, safety 3 mL)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE TB SAFETY SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 5 mL)	Tier 1	
VANISHPOINT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
Medical Supplies And Dme - Parenteral Therapy Supplies - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK LINKASSIST INS DEV (subcutaneous infusion pump accessory)	Tier 3	
ACCU-CHEK SPIRIT ADAPTER (subcutaneous infusion pump accessory)	Tier 3	
ACCU-CHEK SPIRIT CARTRIDGE SYS (subcutaneous infusion pump accessory)	Tier 3	
ACCU-CHEK SPIRIT CLIP CASE (subcutaneous infusion pump accessory)	Tier 3	
INTERLINK LEVER LOCK CANNULA (syringe accessory)	Tier 3	
I-PORT (injection ports)	Tier 3	
I-PORT ADVANCE 6 MM INJEC PORT (injection ports)	Tier 3	
I-PORT ADVANCE 9 MM INJEC PORT (injection ports)	Tier 3	
KENDALL DISINFECTANT CAP (alcohol swab cap)	Tier 3	
MONOJECT LUER ADAPTER INTRAVENOUS ADMIX ACCESSORY (intravenous equipment)	Tier 3	
<i>myelogram tray tray</i>	Tier 3	
PARADIGM SILHOUETTE INFUS SET (subcutaneous infusion pump accessory)	Tier 3	
PHASEAL ASSEMBLY FIXTURE DEVICE (assembly system, vial to transfer device, closed system)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHASEAL CONNECTOR LUER LOCK (connector luer lock, closed system)	Tier 3	
PHASEAL INFUSION ADAPTER (infusion adapter, closed system)	Tier 3	
PHASEAL INFUSION CLAMP (clamp, IV tubing)	Tier 3	
PHASEAL INJECTOR LUER (needle injector, luer, closed system)	Tier 3	
PHASEAL INJECTOR LUER LOCK (needle injector, luer lock, closed system)	Tier 3	
PHASEAL PROTECTOR DEVICE 13 MM, 20 MM, 28 MM (transfer device, closed system)	Tier 3	
SURE-T INFUSION SET (subcutaneous infusion pump accessory)	Tier 3	
VARITHENA ADMINISTRATION PACK (transfer set/syringe, disposable/bandages,compression/tubing)	Tier 3	
Medical Supplies And Dme - Peak Flow Meters - Medical Supplies And Durable Medical Equipment		
AEROGear ACTION ASTHMA KIT KIT (peak flow meter/inhaler, assist devices)	DME	
AIRZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
ASTHMA CHECK METER DEVICE (peak flow meter)	DME	
ASTHMAPACK CHILDREN'S KIT (peak flow meter/inhaler, assist devices)	DME	
CLEVER CHOICE PEAK FLOW METER DEVICE (peak flow meter)	DME	
IN-CHECK NASAL WITH MASK DEVICE (peak flow meter)	DME	
IN-CHECK ORAL FLOW METER DEVICE (peak flow meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICROLIFE PEAK FLOW METER DEVICE (peak flow meter)	DME	
MINI WRIGHT PEAK FLOW METER DEVICE (peak flow meter)	DME	
PEAK AIR PEAK FLOW METER DEVICE (peak flow meter)	DME	
PERSONAL BEST FULL RANGE DEVICE (peak flow meter)	DME	
PERSONAL BEST LOW RANGE DEVICE (peak flow meter)	DME	
PIKO 1 DEVICE (peak flow meter)	DME	
POCKET PEAK FLOW METER DEVICE (peak flow meter)	DME	
PURECOMFORT PEAK FLOW METER DEVICE (peak flow meter)	DME	
TRUZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
Medical Supplies And Dme - Respiratory Therapy Supplies - Medical Supplies And Durable Medical Equipment		
ACE AEROSOL CLOUD ENHANCER SPACER (inhaler, assist devices)	Tier 3	
AEROBIKA OSCILLATING PEP SYSTM DEVICE (mucus clearing device)	Tier 3	
AEROCHAMBER MINI SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MV SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,L MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,M MSK SPACER (inhaler,assist device with medium mask)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AEROCHAMBER PLUS FLOW-VU,S MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT LG MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS Z STAT MD MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SM MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER WITH FLOWSIGNAL SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER Z-STAT PLUS-FLW SG SPACER (inhaler, assist devices)	Tier 3	
AERONEB GO (nebulizer accessories)	Tier 3	
AEROTRACH PLUS SPACER (inhaler, assist devices)	Tier 3	
AEROVENT PLUS SPACER (inhaler, assist devices)	Tier 3	
ALL FLOW 1000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 1000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 3000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 3000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 4000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 4000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 5000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 5000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 6000 PFT FILTER (nebulizer accessories)	Tier 3	
BREATHERITE MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE SPACER-MASK, NEO. SPACER (inhaler,assist device with small mask)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREATHERITE SPACER-MASK,ADULT SPACER (inhaler,assist device with large mask)	Tier 3	
BREATHERITE SPACER-MASK,CHILD SPACER (inhaler,assist device with medium mask)	Tier 3	
BREATHERITE SPACER-MASK,INFANT SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE SPACER-MASK,S.CHLD SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE VALVED MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE VALVED MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
CLEVER CHOICE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
CLEVER CHOICE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
CLEVER CHOICE CHAMBER-SM MASK SPACER (inhaler,assist device with small mask)	Tier 3	
CLEVER CHOICE NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
CLEVER CHOICE WHISPER AIRE PED DEVICE (nebulizer and compressor)	Tier 3	
COMPACT SPACE CHAMBER PLUS SPACER (inhaler, assist devices)	Tier 3	
COMPACT SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
COMPACT SPACE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
COMPACT SPACE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPACT SPACE CHAMBER-SM MASK SPACER (inhaler, assist device with small mask)	Tier 3	
COMP-AIR NEBULIZER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
DEVILBISS PULMO-AIDE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMOMATE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMONEB LT COMP-NEB DEVICE (nebulizer and compressor)	Tier 3	
DEVILBISS TRAVELER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
EASIVENT HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
EASIVENT MASK LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK MEDIUM DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK SMALL DEVICE (inhaler, assist devices, accessories)	Tier 3	
EBASE CONTROLLER DEVICE (compressor, for nebulizer)	Tier 3	
FLEXICHAMBER SPACER (inhaler, assist devices)	Tier 3	
FLEXICHAMBER-LG CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM ADULT MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
HOME NEBULIZER PLUS SIDESTREAM DEVICE (nebulizer and compressor)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERSONIQ NEBULIZER CARTRIDGE (nebulizer accessories)	Tier 3	
INNOSPIRE DELUXE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ELEGANCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ESSENCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE MINI DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE REPLACEMENT FILTER (nebulizer accessories)	Tier 3	
INSPIRACHAMBER SPACER (inhaler, assist devices)	Tier 3	
INSPIRACHAMBER WITH MASK-LARGE SPACER (inhaler, assist device with large mask)	Tier 3	
INSPIRACHAMBER WITH MASK-MED SPACER (inhaler, assist device with medium mask)	Tier 3	
INSPIRACHAMBER WITH MASK-SMALL SPACER (inhaler, assist device with small mask)	Tier 3	
INSPIRATION ELITE FILTER (nebulizer accessories)	Tier 3	
LITE TOUCH-MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITEAIRE MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
LITETOUCH-LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITETOUCH-SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
MICROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
MICROSPACER SPACER (inhaler, assist devices)	Tier 3	
MISTASSIST DEVICE (spirometers and accessories)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MISTASSIST KIT DEVICE (spirometer with drug delivery adapters)	Tier 3	
<i>nebulizer and compressor device</i>	Tier 3	
NOSE CLIP (nebulizer accessories)	Tier 3	
OMBRA COMPRESSOR SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
OPTICHAMBER ADULT MASK-LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
OPTICHAMBER DIAMOND LG MASK SPACER (inhaler, assist device with large mask)	Tier 3	
OPTICHAMBER DIAMOND VHC SPACER (inhaler, assist devices)	Tier 3	
OPTICHAMBER DIAMOND-MED MSK SPACER (inhaler, assist device with medium mask)	Tier 3	
OPTICHAMBER DIAMOND-SML MASK SPACER (inhaler, assist device with small mask)	Tier 3	
PARI BABY CONV KIT - SIZE 1 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 2 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 3 KIT (nebulizer accessories)	Tier 3	
PARI SINUS AEROSOL SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMBO PACK DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMPACT COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S PORTABLE PWR KIT (nebulizer accessories)	Tier 3	
PEDIATRIC BEAR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC COMP-AIR COMPRES NEB DEVICE (nebulizer and compressor)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC DINOSAUR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC DOG NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC FROG NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PFLEX INSPIRATORY TRAINER DEVICE (spirometers and accessories)	Tier 3	
PILLOW MASK CHILD (nebulizer accessories)	Tier 3	
POCKET CHAMBER SPACER (inhaler, assist devices)	Tier 3	
PORTABLE NEBULIZER SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
PRIMEAIRE SPACER (inhaler, assist devices)	Tier 3	
PRO COMFORT SPACER-ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	
PRO COMFORT SPACER-CHILD MASK SPACER (inhaler,assist device with small mask)	Tier 3	
PROCARE COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE PEDIATRIC NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE SPACER WITH ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	
PROCARE SPACER WITH CHILD MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
PROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
PRONEB ULTRA II FILTER ASSEM (nebulizer accessories)	Tier 3	
PROVENT NASAL DEVICE (nasal exhalation resistance device)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROVENT STARTER NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PULMO-AIDE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
PULMONEB LT COMPRESSOR NEBUL DEVICE (nebulizer and compressor)	Tier 3	
QUAKE VIBRATORY PEP DEVICE (mucus clearing device)	Tier 3	
REUSABLE NEBULIZER KIT KIT (nebulizer accessories)	Tier 3	
RITEFLO AEROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
RUBBER MOUTHPIECE (nebulizer accessories)	Tier 3	
SAMI THE SEAL DEVICE (nebulizer and compressor)	Tier 3	
SAMI THE SEAL MASK (nebulizer accessories)	Tier 3	
SIDESTREAM MASK (nebulizer accessories)	Tier 3	
SILICONE MASK (nebulizer accessories)	Tier 3	
SILICONE MASK - INFANT DEVICE (inhaler, assist devices, accessories)	Tier 3	
SOOTHENEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
SPACE CHAMBER PLUS SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER WITH LARGE MASK SPACER (inhaler,assist device with large mask)	Tier 3	
SPACE CHAMBER WITH MEDIUM MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
SPACE CHAMBER WITH SMALL MASK SPACER (inhaler,assist device with small mask)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUNRISE COMPRESSOR-NEBULIZER DEVICE (compressor, for nebulizer)	Tier 3	
THRESHOLD IMT TRAINER DEVICE (spirometers and accessories)	Tier 3	
THRESHOLD PEP DEVICE DEVICE (spirometers and accessories)	Tier 3	
VIOS AEROSOL DELIVERY SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
VORTEX HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
VORTEX VHC FROG MASK-CHILD SPACER (inhaler,assist device with medium mask)	Tier 3	
VORTEX VHC LADYBUG MASK-TODDLR SPACER (inhaler,assist device with small mask)	Tier 3	
WILLIS THE WHALE COMPRESSR NEB DEVICE (nebulizer and compressor)	Tier 3	
Medical Supplies And Dme - Scar Treatments - Medical Supplies And Durable Medical Equipment		
CELACYN TOPICAL GEL WITH PUMP (emollient combination no.60)	Tier 3	
CELLPAD TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CICASIL TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CICATRACE PAD TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
DERM-SILK TOPICAL PAD 2.5 X 2 " (gel-matrix pad dressing, silicone)	Tier 3	
KELOTOP TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUVA III TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAGEL TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAZIL II TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
POLYTOZA TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
PROSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARCARE TOPICAL KIT 2 X 5.5 " (gel-matrix pad, silicone-dimethicone-dime-decameoct-oct-vit E)	Tier 3	
SCARCINPAD TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SILADERM TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SILIVEX TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SIL-K TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SILTREX TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SKARLITE TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SZOSIL TOPICAL STRIP 1.4 X 6 " (silicone adhesive)	Tier 3	
ZILACAINE PATCH TOPICAL COMBO PACK 5 % (lidocaine/silicone, adhesive)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Subcutaneous Administration Supply - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK RAPID-D LINK 70 CM (subcutaneous administration set)	Tier 3	
ACCU-CHEK RAPID-D LINK INFUSION SET 10 X 20 MM-CM (subcutaneous administration set)	Tier 3	
INSUFロン INFUSION SET 25 X 18 MM (subcutaneous administration set)	Tier 3	
Medical Supplies And Dme - Subcutaneous Insulin Delivery Devices - Medical Supplies And Durable Medical Equipment		
CEQUR SIMPLICITY DEVICE 2 UNIT (subcutaneous bolus insulin patch pump, 200 unit, disposable)	Tier 3	
V-GO 20 DEVICE (sub-q insulin delivery device, 20 unit, disposable)	Tier 2	
V-GO 30 DEVICE (sub-q insulin delivery device, 30 unit, disposable)	Tier 2	
V-GO 40 DEVICE (sub-q insulin delivery device, 40 unit, disposable)	Tier 2	
Medical Supplies And Dme - Subcutaneous Insulin Pump - Medical Supplies And Durable Medical Equipment		
MINIMED 770G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
OMNIPOD INSULIN MANAGEMENT (subcutaneous insulin pump)	Tier 2	
T:SLIM X2 BASAL-IQ INSULIN PMP (subcutaneous insulin pump)	Tier 3	PA
T:SLIM X2 CONTROL-IQ (subcutaneous insulin pump)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Urinary Catheters And Related Devices - Medical Supplies And Durable Medical Equipment		
ADVANCE PLUS INTERMITTENT 10 FR, 10-16 FR-", 12 FR, 12-16 FR-", 14-16 FR-", 16-16 FR-", 18-16 FR-", 6-16 FR-", 8-16 FR-" (catheter)	Tier 3	
ADVANCE PLUS INTERMITTENT COMBO PACK 6 FR, 8-14 FR-" (urinary bag/catheter)	Tier 3	
APOGEE IC INTERMIT CATHETER 14-6 FR-" (catheter)	Tier 3	
APOGEE PLUS INTERMITT CATHETER 16-16 FR-" (catheter)	Tier 3	
BARDEX I.C. FOLEY CATHETER 24 FR (catheter)	Tier 3	
DOVER COATED LATEX FOLEY COMBO PACK (urinary bag/catheterization tray)	Tier 3	
DOVER FOLEY CATHETER 24 FR (catheter)	Tier 3	
DOVER LATEX FOLEY CATHETER 16 FR, 28 FR (catheter)	Tier 3	
DOVER RED RUBBER ROBINSON CATH 8 FR (catheter)	Tier 3	
DOVER UNIVERSAL TRAY (catheterization tray)	Tier 3	
FEMALE CATHETER 14 FR (catheter)	Tier 3	
KENGUARD FOLEY CATHETER 18-16 FR-" (catheter)	Tier 3	
KENGUARD FOLEY CATHETER TRAY (catheterization tray)	Tier 3	
LOFRIC 12-16 FR-", 14-16 FR-" (catheter)	Tier 3	
LOFRIC ORIGO 14-16 FR-" (catheter)	Tier 3	
LOFRIC PRIMO NELATON CATHETER 16-16 FR-" (catheter)	Tier 3	
LOFRIC SENSE NELATON CATHETER 14-6 FR-" (catheter)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAGIC3 INTERMITTENT CATHETER 10-16 FR-", 12-16 FR-" (catheter)	Tier 3	
ROBINSON CLEAR VINYL CATHETER 16 FR (catheter)	Tier 3	
SELF-CATHETER, FEMALE 14 FR (catheter)	Tier 3	
SILASTIC FOLEY CATHETER 20 FR (catheter)	Tier 3	
SPEEDICATH (FEMALE) 16 FR (catheter)	Tier 3	
TOUCH-TROL 10 FR (catheter)	Tier 3	
VAPRO PLUS INTERMITT CATHETER COMBO PACK 12 FR- 8", 14 FR- 16", 14 FR- 8" (urinary bag/catheter)	Tier 3	
Medical Supplies And Dme - Urine Ketone Tests - Medical Supplies And Durable Medical Equipment		
KETONE CARE STRIP (urine acetone test,strips)	DME	
Medical Supplies And Dme- Blood Collection Sets With Local Anesthetics - Medical Supplies And Durable Medical Equipment		
CADIRA COMPLIANT BLOOD STAT KIT 21 GAUGE X 3/4" -2.5 %-2.5 % (blood collection set/lidocaine/prilocaine)	Tier 3	
LIDO BDK KIT 21 GAUGE X 1"- 2.5 %-2.5 % (blood collection set/lidocaine/prilocaine)	Tier 3	
Medical Supplies And Dme-Eustachian Tube/Middle Ear Ventilator Devices - Medical Supplies And Durable Medical Equipment		
EAR POPPER INFLATION DEVICE NASAL DEVICE (middle ear inflation device)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme-Glucose Monitoring And Insulin Admin Supplies - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK COMBO SYSTEM KIT (insulin pump/infusion set/blood-glucose meter)	Tier 3	
AUTOSOFT 30 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT 90 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED MIO ADVANCE INF SET23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED MIO ADVANCE INF SET43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 23" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED SILHOUETTE 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
QUICK-SET PARADIGM 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
TRUSTEEL INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
TRUSTEEL INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
Medical Supply, Fdb Superset		
Medical Supply, Fdb Superset		
2-IN-1 LANCET DEVICE 30 GAUGE (lancets)	DME	
ABOUTTIME PEN NEEDLE NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION (blood glucose calibration control high and low)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK COMBO SYSTEM KIT (insulin pump/infusion set/blood-glucose meter)	Tier 3	
ACCU-CHEK COMPACT PLUS CARE KIT (blood-glucose meter, drum-type)	DME	
ACCU-CHEK FASTCLIX LANCET DRUM (lancets)	DME	
ACCU-CHEK FASTCLIX LANCING DEV KIT (lancing device/lancets)	DME	
ACCU-CHEK GUIDE ME GLUCOSE MTR (blood-glucose meter)	DME	
ACCU-CHEK MULTICLIX LANCET KIT (lancing device/lancets)	DME	
ACCU-CHEK RAPID-D LINK 70 CM (subcutaneous administration set)	Tier 3	
ACCU-CHEK RAPID-D LINK INFUSION SET 10 X 20 MM-CM (subcutaneous administration set)	Tier 3	
ACCU-CHEK SAFE-T-PRO PLUS 23 GAUGE (lancets)	DME	
ACCU-CHEK SMARTVIEW CONTRL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
ACCU-CHEK SOFT DEV LANCETS KIT (lancing device/lancets)	DME	
ACCU-CHEK SPIRIT ADAPTER (subcutaneous infusion pump accessory)	Tier 3	
ACCU-CHEK SPIRIT CARTRIDGE SYS (subcutaneous infusion pump accessory)	Tier 3	
ACCU-CHEK SPIRIT CLIP CASE (subcutaneous infusion pump accessory)	Tier 3	
ACCUTREND GLUCOSE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ACE AEROSOL CLOUD ENHANCER SPACER (inhaler, assist devices)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVANCE PLUS INTERMITTENT 10 FR, 10-16 FR-", 12 FR, 6-16 FR-", 8-16 FR-" (catheter)	Tier 3	
ADVANCE PLUS INTERMITTENT COMBO PACK 6 FR, 8-14 FR-" (urinary bag/catheter)	Tier 3	
ADVANCED TRAVEL LANCETS 30 GAUGE (lancets)	DME	
ADVOCATE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
ADVOCATE DUO DEVICE (blood-glucose meter and wrist blood pressure monitor)	DME	
ADVOCATE LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ADVOCATE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE RAPID-SAFE LANCING (lancing device)	DME	
ADVOCATE REDI-CODE GLU MONITOR KIT (blood-glucose meter)	DME	
ADVOCATE REDI-CODE+ CTRL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
ADVOCATE REDI-CODE+ CTRL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
ADVOCATE SYRINGES SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ADVOCATE TEST STRIPS STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AEROBIKA OSCILLATING PEP SYSTM DEVICE (mucus clearing device)	Tier 3	
AEROCHAMBER MINI SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MV SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS Z STAT LG MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS Z STAT MD MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SM MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER WITH FLOWSIGNAL SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER Z-STAT PLUS-FLW SG SPACER (inhaler, assist devices)	Tier 3	
AEROECLIPSE II NEBULIZER (nebulizer)	Tier 3	
AEROGear ACTION ASTHMA KIT KIT (peak flow meter/inhaler, assist devices)	DME	
AEROTRACH PLUS SPACER (inhaler, assist devices)	Tier 3	
AEROVENT PLUS SPACER (inhaler, assist devices)	Tier 3	
AGAMATRIX AMP GLUC MONITOR SYS (blood-glucose meter)	DME	
AGAMATRIX AMP TEST STRIPS STRIP (blood sugar diagnostic)	DME	
AGAMATRIX CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
AGAMATRIX CONTROL NORM-HI SOLUTION (blood glucose calibration control solution, high and normal)	DME	
AGAMATRIX CONTROL SOLN-LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGAMATRIX CONTROL SOLN-LEVEL 4 SOLUTION (blood glucose calibration control solution, high)	DME	
AGAMATRIX PRESTO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
AIRS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
AIRZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
ALLERGIST TRAY 1/2 ML 27GX3/8" SYRINGE 1/2 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 0.5 mL)	Tier 1	
ALLERGIST TRAY INTRADERMAL BEV SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGIST TRAY REGULAR BEVEL SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLEVYN ADHESIVE DRESSING TOPICAL BANDAGE 3 X 3 ", 5 X 5 ", 9 X 9 " (foam bandage)	Tier 3	
ALLEVYN HEEL TOPICAL BANDAGE 4 1/2 X 5 1/2 " (foam bandage)	Tier 3	
ALLEVYN LIFE DRESSING TOPICAL BANDAGE 4 X 4 ", 5 1/16 X 5 1/16 ", 6 1/16 X 6 1/16 ", 8 1/4 X 8 1/4 " (foam bandage)	Tier 3	
ALLEVYN TOPICAL BANDAGE 2 X 2 ", 4 X 4 ", 6 X 6 ", 8 X 8 " (foam bandage)	Tier 3	
ALTERA NEBULIZER (nebulizer)	Tier 3	
ALTERA NEBULIZER SYSTEM (nebulizer)	Tier 3	
ALTERNATE SITE LANCET 26 GAUGE (lancets)	DME	
ALTERNATE SITE LANCING DEVICE (lancing device)	DME	
APOGEE IC INTERMIT CATHETER 14-6 FR-" (catheter)	Tier 3	
APOGEE PLUS INTERMITT CATHETER 16-16 FR-" (catheter)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARGYLE TRACHEOSTOMY CARE TRAY (medical supply, miscellaneous)	Tier 3	
ASSURE ID INSULIN SAFETY SYRINGE 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
ASTHMA CHECK METER DEVICE (peak flow meter)	DME	
ASTHMAPACK CHILDREN'S KIT (peak flow meter/inhaler, assist devices)	DME	
AURA PORTANEB (nebulizer)	Tier 3	
AUTO-LANCET MINI (lancing device)	DME	
AUTOPEN 1 TO 21 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 2 TO 42 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOSOFT XC INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
BARDEX I.C. FOLEY CATHETER 24 FR (catheter)	Tier 3	
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL TRAY 1/2 ML 27 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
BD ALLERGY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD AUTOSHIELD DUO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic disposable, safety)	Tier 1	
BD BLUNT PLASTIC CANNULA SYRINGE 17 X 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD BULK SYRINGE SLIP TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD ECCENTRIC TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD ECLIPSE LUER-LOK NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 30 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 22 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD FILTER NEEDLE-5 MICRON NEEDLE 19 X 1 1/2 " (needles, filter)	Tier 3	
BD INSULIN SYRINGE MICRO-FINE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE SAFETY-LOK SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE SLIP TIP SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
BD INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
BD INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD INSULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 25 X 1", 1 ML 26 X 1/2", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD INSULIN SYRINGE U-500 SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe, insulin U-500 with needle, disposable, 0.5 mL)	Tier 1	
BD INSYTE AUTOGUARD INFUSION SET 24 GAUGE X 3/4" (intravenous catheter)	Tier 3	
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
BD INTEGRA SYRINGE SYRINGE 3 ML 22 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD INTERLINK BLUNT PLASTIC CAN SYRINGE 17 X 5 ML (syringe with cannula, disposable, 5 mL)	Tier 1	
BD INTERLINK SYRINGE SYRINGE 17 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
BD LAB ECCENTRIC NON-STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD LO-DOSE MICRO-FINE IV SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD LO-DOSE ULTRA-FINE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD LUER-LOK BULK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2", 10 ML 22 X 1", 10 ML 23X 1 1/4 " (syringe with needle,disposable, 10 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2 ", 3 ML 25 X 5/8", 3 ML 26 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD LUER-LOK TIP CONTROL SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD MAGNI-GUIDE SYRINGE MAGNIFI (diabetic supplies,miscell)	DME	
BD MICROTAINER LANCET 1.5 X 2 MM (blade lancet, safety)	DME	
BD MICROTAINER LANCET 21 GAUGE, 30 GAUGE (lancets)	DME	
BD NANO 2ND GEN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
BD PRECISIONGLIDE SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 10 ML 22 X 1 1/2" (syringe with needle,disposable, 10 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 22 X 1 1/2", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 5 ML 22 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
BD SAFETYGLIDE TB REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 26 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETY-LOK DETACHABLE NEEDL SYRINGE 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
BD SAFETY-LOK TUBERCULIN SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD SAFETY-LOK WITH LUER-LOK SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SAF-T-INTIMA INFUSION SET 22 GAUGE X 3/4" (intravenous catheter kit)	Tier 3	
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
B-D SLIP TIP SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SPECIALTY USE NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
BD SYRINGE CATH TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE CATHETER TIP SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD SYRINGE-DUAL CANNULA SYRINGE 10 ML 20 GAUGE AND 17 GAUGE (syringe with needle and cannula, disposable, 10 mL)	Tier 1	
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD TUBERCULIN SYRINGE SYRINGE 1 ML 21 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1/2 ML 27 X 1/2 " (syringe with needle,disposable, 0.5 mL)	Tier 1	
BD ULTRA FINE LANCETS 33 GAUGE (lancets)	DME	
BD ULTRA-FINE MICRO PEN NEEDLE NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
BD VERITOR SYSTEM SARS-COV-2 KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVD AG CARD HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG CARD KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG SELF TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	
BIONIME RIGHTEST GM300 SYSTEM KIT (blood-glucose meter)	DME	
BIONIME RIGHTEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	
BIOSTEP TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/sodium alginate/carboxymethylcellulose)	Tier 3	
BIOTEL CARE BGM-4 METER (blood-glucose meter)	DME	
<i>blood glucose contrl hi,normal solution</i>	DME	
<i>blood glucose ctl high,nml,low solution</i>	DME	
BLOOD GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
<i>blunt needle, disposable needle 18 x 1 1/2 "</i>	Tier 3	
BOYS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREEZE 2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
BREEZE 2 CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
BREEZE 2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
BREEZE 2 TEST STRIPS STRIP (blood sugar diagnostic, disc-type)	DME	
BUTTERFLY TOUCH LANCET 30 GAUGE (lancets)	DME	
CAREFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CARELANCE ULT LANCING DEVICE (lancing device)	DME	
CAREONE THIN LANCET (lancets)	DME	
CAREPOINT LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT LUER LOCK SYR-NEEDLE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
CAREPOINT LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CAREPOINT LUER SLIP SYRING-NDL SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
CARESENS CONTROL A AND B SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARESENS CONTROL A NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
CARESENS LANCETS 30 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARESENS N KIT (blood-glucose meter)	DME	
CARESENS N VOICE (blood-glucose meter)	DME	
CARESENS N VOICE KIT (blood-glucose meter)	DME	
CARESENS PREM LANCING DEVICE (lancing device)	DME	
CARETOUCH GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
CARETOUCH INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 1 ML 28 X 5/16", 1 ML 29 GAUGE X 5/16, 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
CARETOUCH KETONE-GLUCOSE MONIT DEVICE (blood ketone and glucose monitor)	DME	
CARETOUCH LANCING DEVICE (lancing device)	DME	
CARETOUCH PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CARETOUCH SAFETY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
CARETOUCH TWIST LANCET 28 GAUGE, 33 GAUGE (lancets)	DME	
CAYA CONTOURED VAGINAL DIAPHRAGM 65-80 MM (diaphragms, contoured)	Tier 0	
CEFALY COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CELLPAD TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CEQUR SIMPLICITY DEVICE 2 UNIT (subcutaneous bolus insulin patch pump, 200 unit, disposable)	Tier 3	
CEQUR SIMPLICITY INSERTER (diabetic supplies,miscell)	DME	
CHEMSTRIP BG LOG BOOK (diabetic supplies,miscell)	DME	
CHOICE DM CLARUS NORM CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CHOICEDM CLARUS (blood-glucose meter)	DME	
CHOICEDM CLARUS STRIP (blood sugar diagnostic)	DME	
CICASIL TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CICATRACE PAD TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
CLEVER CHEK BLOOD GLUCOSE (blood-glucose meter)	DME	
CLEVER CHOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
CLEVER CHOICE LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
CLEVER CHOICE LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CLEVER CHOICE LEVEL 3 CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
CLEVER CHOICE MICRO (blood-glucose meter)	DME	
CLEVER CHOICE MICRO TEST STRIP STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
CLEVER CHOICE PEAK FLOW METER DEVICE (peak flow meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE PRO (blood-glucose meter)	DME	
CLEVER CHOICE PRO STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE TALK GLUCOSE SYS (blood-glucose meter)	DME	
CLEVER CHOICE TALK TEST STRIP (blood sugar diagnostic)	DME	
CLEVER CHOICE WHISPER AIRE PED DEVICE (nebulizer and compressor)	Tier 3	
COAGUCHEK LANCETS (lancets)	DME	
COAGUCHEK XS (prothrombin time/INR test meter)	Tier 3	
COLOR LANCETS 21 GAUGE (lancets)	DME	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
COMFORT EZ PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 32 GAUGE X 5/16", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
COMFORT TOUCH PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 31 GAUGE X 5/32", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT TOUCH PLUS SAFETY LANC 30 GAUGE (lancets)	DME	
COMFORT TOUCH ULT THIN LANCETS 31 GAUGE (lancets)	DME	
COMPACT SPACE CHAMBER PLUS SPACER (inhaler, assist devices)	Tier 3	
COMPACT SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
COMP-AIR NEBULIZER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
CONCEPTION KIT (conception assistance supplies combination no.1)	Tier 3	
CONTOUR CONTROL SOLUTION, HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
CONTOUR CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT EZ METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT GLUCOSE METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT LEV 1 CONTROL SOL SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR NEXT LEV 2 CONTROL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR NEXT LINK 2.4 KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT METER (blood-glucose meter)	DME	
CONTOUR NEXT ONE METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTROL AST MONITORING SYSTEM (blood-glucose meter)	DME	
COOL BLOOD GLUCOSE METER (blood-glucose meter)	DME	
COOL BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
COOL CONTROL A SOLUTION SOLUTION (blood glucose calibration control solution, normal)	DME	
COOL CONTROL B SOLUTION SOLUTION (blood glucose calibration control solution, high)	DME	
COOL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
<i>covid19 test adm.by pharmacist</i>	Tier 3	
<i>covid-19 test specimen collect</i>	Tier 3	
CURAFIL GEL WOUND TOPICAL GEL (gel dressing)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL SPONGE 0.2 %- 2" X 2" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL STRIP 0.2 %- 1/2" X 3 FEET (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD TOPICAL BANDAGE 1 X 5 "-YARD, 1/4 X 36 " (gauze bandage)	Tier 3	
CURITY DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
CURITY IODOFORM PACKING STRIP TOPICAL BANDAGE 1 X 5 "-YARD, 1/2 X 5 "-YARD, 1/4 X 5 "-YARD, 2 X 5 "-YARD (iodoform)	Tier 3	
DARIO BLOOD GLUCOSE MONITOR DEVICE (blood-glucose meter,for mobile device)	DME	
DAVOL IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAVOL PISTON IRRIGATION SYRINGE (syringe disposable irrigation)	Tier 1	
DERM-SILK TOPICAL PAD 2.5 X 2 " (gel-matrix pad dressing, silicone)	Tier 3	
DEVILBISS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
DEVILBISS PULMO-AIDE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMOMATE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMONEB LT COMP-NEB DEVICE (nebulizer and compressor)	Tier 3	
DEXCOM G4 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
DEXCOM G5 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
DEXCOM G5-G4 SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
DEXCOM G6 RECEIVER (blood-glucose meter,continuous)	DME	PA
DEXCOM G6 SENSOR DEVICE (blood-glucose sensor)	Tier 2	PA
DEXCOM G6 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 2	PA
DEXCOM RECEIVER (blood-glucose meter,continuous)	DME	PA
DIAPERS, UNISEX SIZE 1 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 2 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 4 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIATRUE CONTROL SOLN NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
DIATRUE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIATRUE CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
DIATRUE PLUS BLOOD GLUCOSE MET (blood-glucose meter)	DME	
DIATRUE PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	
DOVER BULB SYRINGE SYRINGE 60 ML (syringe disposable irrig,60 mL)	Tier 1	
DOVER COATED LATEX FOLEY COMBO PACK (urinary bag/catheterization tray)	Tier 3	
DOVER FOLEY CATHETER 24 FR (catheter)	Tier 3	
DOVER LATEX FOLEY CATHETER 16 FR, 28 FR (catheter)	Tier 3	
DOVER RED RUBBER ROBINSON CATH 8 FR (catheter)	Tier 3	
DOVER UNIVERSAL TRAY (catheterization tray)	Tier 3	
DROPLET GENTEEL LANCING DEVICE (lancing device)	DME	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5ML 30 GAUGE X 15/64" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
DROPLET MICRON PEN NEEDLE NEEDLE 34 GAUGE X 9/64" (pen needle, diabetic)	Tier 1	
DROPLET PEN NEEDLE NEEDLE 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EAR POPPER INFLATION DEVICE NASAL DEVICE (middle ear inflation device)	Tier 3	
EASIVENT MASK LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK MEDIUM DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK SMALL DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASY CHECK BLOOD GLUCOSE KIT (blood-glucose meter)	DME	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY COMFORT PEN NEEDLES NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY GLIDE CATHETER TIP SYRING SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE DENTAL IRRIG SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY GLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE LUER SLIP TB SYRING SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY GLIDE PEN NEEDLE NEEDLE 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY GLUCO G2 STRIP (blood sugar diagnostic)	DME	
EASY MINI EJECT LANCING DEVICE (lancing device)	DME	
EASY PLUS II BLOOD GLUCOSE MET (blood-glucose meter)	DME	
EASY PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY PLUS II TEST STRIP (blood sugar diagnostic)	DME	
EASY STEP BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY STEP HIGH CONTROL SOLN SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY STEP LOW CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP NORMAL CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY STEP STRIP (blood sugar diagnostic)	DME	
EASY TALK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TALK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	
EASY TALK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TOUCH BLU CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH BLU LINK GLUC SYST (blood-glucose meter)	DME	
EASY TOUCH BLU LINK TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH FLIPLOCK NEEDLE NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 10 ML 18 GAUGE X 1 1/2", 10 ML 18 GAUGE X 1", 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 5 ML 18 GAUGE X 1", 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1", 5 ML 25 GAUGE X 5/8" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH FLURINGE FLIPLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SHEATHLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH HYPODERMIC NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH INSULIN SAFETY SYR SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH LANCING DEVICE (lancing device)	DME	
EASY TOUCH LUER LOCK INSULIN SYRINGE 1 ML (syringe without needle, insulin disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY TOUCH PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
EASY TOUCH SAFETY LANCETS 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16", 30 GAUGE X 1/4", 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 10 ML 21 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 5 ML 21 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
EASY TOUCH TUBERCULIN FLIPLOCK SYRINGE 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TUBERCULIN SHEATHLK SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TWIST LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
EASY TOUCH UNI-SLIP SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TRAK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TRAK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	
EASY TRAK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TRAK II CTRL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TRAK II TEST STRIP STRIP (blood sugar diagnostic)	DME	
EASY TRAK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TWIST AND CAP LANCETS 28 GAUGE (lancets)	DME	
EASYGLUCO PLUS NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYGLUCO PLUS STRIP (blood sugar diagnostic)	DME	
EASYMAX 15 LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
EBASE CONTROLLER DEVICE (compressor, for nebulizer)	Tier 3	
ECLIPSE NEEDLE NEEDLE 23 GAUGE X 1", 25 X 5/8 ", 27 GAUGE X 1/2" (needles, safety)	Tier 3	
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
ELEMENT COMPACT GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELEMENT COMPACT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT COMPACT TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ELEMENT COMPACT V GLUCOSE MTR (blood-glucose meter)	DME	
ELEMENT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ELEMENT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT PLUS BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
ELEMENT TEST STRIPS STRIP (blood sugar diagnostic)	DME	
ELLUME COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	
EMBRACE BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
EMBRACE EVO BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
EMBRACE EVO LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE EVO TEST STRIPS STRIP (blood sugar diagnostic)	DME	
EMBRACE GLUCOSE CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE GLUCOSE CONTROL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE LANCETS 30 GAUGE (lancets)	DME	
EMBRACE LANCING DEVICE (lancing device)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE PRO SOLUTION (blood glucose calibration control solution, high and normal)	DME	
EMBRACE TALK CONTROL-HIGH (L2) SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE TALK CONTROL-LOW (L1) SOLUTION (blood glucose calibration control solution, low)	DME	
ENLITE GLUCOSE SENSOR DEVICE (blood-glucose sensor)	Tier 3	
ENLITE SERTER (diabetic supplies, miscell)	DME	
ENLITE SYSTEM (blood-glucose transmitter/blood-glucose sensor)	Tier 3	
ENTERAL GRAVITY BAG SET-ENFit (feeder container with gravity set, ENFit)	Tier 3	
EVENCARE KIT (blood-glucose meter)	DME	
EVENCARE MINI GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EVENCARE PROVIEW CONTROL-L2,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE PROVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	
EVENCARE SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE TEST STRIP (blood sugar diagnostic)	DME	
EVERSENSE SMART TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
EVOLUTION BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
EVOLUTION NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EVOLUTION TEST STRIPS STRIP (blood sugar diagnostic)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXCEL SYRINGE SYRINGE 3 ML 23 X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL HYPODERMIC NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
EXEL SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EXEL SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
EXEL SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
E-Z JECT LANCETS 26 GAUGE, 32 GAUGE (lancets)	DME	
EZ SMART LANCETS 28 GAUGE (lancets)	DME	
EZ SMART PLUS SYSTEM KIT (blood-glucose meter)	DME	
EZ SMART PLUS TEST STRIP (blood sugar diagnostic)	DME	
EZ SMART SYSTEM KIT (blood-glucose meter)	DME	
EZ-LETS 26 GAUGE (lancets)	DME	
FC2 FEMALE CONDOM (condoms, female)	Tier 0	QL (30 EA per 30 days)
FEMALE CATHETER 14 FR (catheter)	Tier 3	
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical cap)	Tier 0	
FIFTY50 TEST STRIP STRIP (blood sugar diagnostic)	DME	
<i>filter needles needle 19 x 1 ", 19 x 1 1/2 "</i>	Tier 3	
FINGERSTIX LANCETS (lancets)	DME	
FLEXICHAMBER SPACER (inhaler, assist devices)	Tier 3	
FLEXICHAMBER-LG CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM ADULT MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLEXICHAMBER-SM CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXI-SEAL SIGNAL FMS RECTAL (fecal collector with charcoal filter/catheter/syringe)	Tier 3	
FORA 6 CONNECT GLUCOSE STRIP STRIP (blood sugar diagnostic)	DME	
FORA 6 CONNECT MULTIFUNCTN MTR DEVICE (blood ketone and glucose monitor)	DME	
FORA D10 KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
FORA D15 GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D15G STRIPS STRIP (blood sugar diagnostic)	DME	
FORA D20 KIT (blood-glucose meter)	DME	
FORA D20 STRIP (blood sugar diagnostic)	DME	
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D40-G31 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA G20 KIT (blood-glucose meter)	DME	
FORA G30A (blood-glucose meter)	DME	
FORA G30-PREMIUM V10 TEST STRP STRIP (blood sugar diagnostic)	DME	
FORA GD50 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA GD50 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA GTEL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORA GTEL MULTI-FUNCTN MONITOR DEVICE (blood ketone and glucose monitor)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORA LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORA PREMIUM V10 GLUCOSE METER (blood-glucose meter)	DME	
FORA TEST N'GO VOICE METER (blood-glucose meter)	DME	
FORA TN'G ADVANCE PRO MONITOR DEVICE (blood ketone and glucose monitor)	DME	
FORA TN'G VOICE METER (blood-glucose meter)	DME	
FORA TN'G VOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORA V10 KIT (blood-glucose meter)	DME	
FORA V12 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA V12 BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
FORA V20 KIT (blood-glucose meter)	DME	
FORA V20 STRIP (blood sugar diagnostic)	DME	
FORA V30A (blood-glucose meter)	DME	
FORA V30A KIT (blood-glucose meter)	DME	
FORA V30A STRIP (blood sugar diagnostic)	DME	
FORACARE GD20 GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GD20 STRIP (blood sugar diagnostic)	DME	
FORACARE GD40 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORACARE GD40A GLUCOSE METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GD40B GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GDH HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORACARE GDH LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORACARE GDH NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORACARE LANCETS 30 GAUGE (lancets)	DME	
FORTISCARE G1 TEST STRIP STRIP (blood sugar diagnostic)	DME	
FORTISCARE GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FORTISCARE HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
FORTISCARE LOW SOLUTION (blood glucose calibration control solution, low)	DME	
FORTISCARE NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORTISCARE T1 BLOOD GLUC SYS (blood-glucose meter)	DME	
FREESTYLE FLASH SYSTEM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM KIT (blood-glucose meter)	DME	
FREESTYLE INSULINX TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE LANCETS 28 GAUGE (lancets)	DME	
FREESTYLE LIBRE 14 DAY READER (flash glucose scanning reader)	Tier 3	PA
FREESTYLE LIBRE 14 DAY SENSOR KIT (flash glucose sensor)	Tier 3	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 READER (flash glucose scanning reader)	Tier 3	PA
FREESTYLE LIBRE 2 SENSOR KIT (flash glucose sensor)	Tier 3	PA
FREESTYLE NAVIGATOR GLUC SENS DEVICE (blood-glucose sensor)	Tier 3	
FREESTYLE PRECISION SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
FREESTYLE SIDEKICK II KIT (blood-glucose meter)	DME	
FREESTYLE UNISTIK 2 (lancets)	DME	
GDRIVE KIT (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE333 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE333 CONTROL SOLUTION NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GIRLS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	
GLUCO NAVII GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
GLUCOCOM AUTOLINK (diabetic supplies,miscell)	DME	
GLUCOCOM CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
GLUCOCOM CONTROL NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCOM GLUCOSE STRIP (blood sugar diagnostic)	DME	
GLUCOCOM LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GM100 KIT (blood-glucose meter)	DME	
GM100 STRIP (blood sugar diagnostic)	DME	
GOJJI BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
GOJJI GLUCOSE CNTRL SOL-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GOJJI LANCETS 30 GAUGE (lancets)	DME	
GOJJI LANCING DEVICE (lancing device)	DME	
GOJJI MULTI-FUNCTIONAL METER DEVICE (blood ketone and glucose monitor)	DME	
GOJJI MULTI-FUNCTIONAL METER KIT (blood ketone and glucose monitor)	DME	
GOODLIFE AC-302 GLUCOSE METER (blood-glucose meter)	DME	
GOODLIFE AC-302 TEST STRIP STRIP (blood sugar diagnostic)	DME	
GUARDIAN RT CHARGER (diabetic supplies,miscell)	DME	
GUARDIAN RT TRANSMITTER TAPE (diabetic supplies,miscell)	DME	
HARMONY CONTROL L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
HARMONY GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEALTHWISE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
HEALTHWISE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
HEALTHY ACCENTS UNIFINE PENTIP NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
HI-VOLUME PUMPING CHAMBER SET (transfer sets)	Tier 3	
HYPERSONIQU NEBULIZER CARTRIDGE (nebulizer accessories)	Tier 3	
ID NOW COVID-19 TEST KIT KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	
IN-CHECK NASAL WITH MASK DEVICE (peak flow meter)	DME	
IN-CHECK ORAL FLOW METER DEVICE (peak flow meter)	DME	
INCONTROL LANCING DEVICE (lancing device)	DME	
INCONTROL PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
INCONTROL SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
INCONTROL ULTRA THIN LANCETS 28 GAUGE (lancets)	DME	
INFINITY CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
INFINITY CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
INFINITY CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
INFINITY METER KIT KIT (blood-glucose meter)	DME	
INFINITY VOICE CTRL SOLN-LVL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFINITY VOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
INFINITY VOICE TEST STRIP STRIP (blood sugar diagnostic)	DME	
INJECT EASE LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
INNOSPIRE DELUXE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE GO NEBULIZER (nebulizer)	Tier 3	
INNOSPIRE REPLACEMENT FILTER (nebulizer accessories)	Tier 3	
INSPIRACHAMBER SPACER (inhaler, assist devices)	Tier 3	
INSPIRACHAMBER WITH MASK-LARGE SPACER (inhaler,assist device with large mask)	Tier 3	
INSPIRACHAMBER WITH MASK-MED SPACER (inhaler,assist device with medium mask)	Tier 3	
INSPIRACHAMBER WITH MASK-SMALL SPACER (inhaler,assist device with small mask)	Tier 3	
INSPIRATION ELITE FILTER (nebulizer accessories)	Tier 3	
INSUFロン INFUSION SET 25 X 18 MM (subcutaneous administration set)	Tier 3	
INSUL-CAP (diabetic supplies,miscell)	DME	
INSUL-EZE (diabetic supplies,miscell)	DME	
<i>insulin syrlndl u100 half mark syringe 0.3 ml 31 gauge x 1/4"</i>	Tier 1	
INSULIN SYRINGE MICROFINE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
INSULIN SYRINGE MICROFINE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
<i>insulin syringe needleless syringe 1 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
<i>insulin syringe-needle u-100 syringe 0.3 ml 31 gauge x 1/4", 1 ml 28 gauge, 1 ml 29 gauge x 7/16", 1 ml 30 gauge x 3/8", 1 ml 31 gauge x 1/4", 1/2 ml 28 gauge, 1/2 ml 31 gauge x 1/4"</i>	Tier 1	
INSUPEN NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INSYTE IV CATHETER INFUSION SET 14 X 1.75 ", 20 X 1.16 " (intravenous catheter)	Tier 3	
INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
INTERLINK LEVER LOCK CANNULA (syringe accessory)	Tier 3	
INTERLINK SYRINGE AND CANNULA SYRINGE 15 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
INVACARE LANCETS 30 GAUGE (lancets)	DME	
I-PORT ADVANCE 6 MM INJEC PORT (injection ports)	Tier 3	
I-PORT ADVANCE 9 MM INJEC PORT (injection ports)	Tier 3	
IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
KANGAROO 924 SAFETY SCREW (pump set)	Tier 3	
KANGAROO EPUMP SET (feeder container with pump set)	Tier 3	
KANGAROO GRAVITY SET (feeder container with gravity set)	Tier 3	
KELOTOP TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
KENDALL DISINFECTANT CAP (alcohol swab cap)	Tier 3	
KENGUARD FOLEY CATHETER 18-16 FR-" (catheter)	Tier 3	
KENGUARD FOLEY CATHETER TRAY (catheterization tray)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERAGEL TOPICAL GEL (gel dressing)	Tier 3	
KETONE CARE STRIP (urine acetone test,strips)	DME	
KETONE URINE TEST STRIP (urine acetone test,strips)	DME	
KETOSTIX STRIP (urine acetone test,strips)	DME	
LANCETS, SUPER THIN (lancets)	DME	
LANCETS,THIN 28 GAUGE (lancets)	DME	
LANCETS,ULTRA THIN (lancets)	DME	
LANCING SYSTEM (lancing device)	DME	
LANZO LANCING DEVICE KIT (lancing device/lancets)	DME	
LC PLUS NEBULIZER-PED MASK (nebulizer)	Tier 3	
LITE TOUCH INSULIN PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
LITE TOUCH INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE, 1/2 ML 28 GAUGE X 1/2", 1/2 ML 29 , 1/2 ML 30 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
LITE TOUCH INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE, 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
LITE TOUCH LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
LITE TOUCH LANCING DEVICE (lancing device)	DME	
LITE TOUCH-MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITEAIRE MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
LITETOUCH-LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LITETOUCH-SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LOFRIC 12-16 FR-", 14-16 FR-" (catheter)	Tier 3	
LOFRIC ORIGO 14-16 FR-" (catheter)	Tier 3	
LOFRIC SENSE NELATON CATHETER 14-6 FR-" (catheter)	Tier 3	
LUER LOCK SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
LUER SLIP TIP SYRINGE TRAY SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
LUER-LOK TIP SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.3 ML 29 X 1/2" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MAGELLAN SAFETY NEEDLE NEEDLE 23 GAUGE X 5/8" (needles, safety)	Tier 3	
MAGELLAN SAFETY SYRINGE SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.3 ML 30 X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MAGIC3 INTERMITTENT CATHETER 10-16 FR-", 12-16 FR-" (catheter)	Tier 3	
MAXICOMFORT II PEN NEEDLE NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1/2 ML 27 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MEDIHONEY (CAL ALGINATE-HONEY) TOPICAL BANDAGE 2 X 2 ", 3/4 X 12 ", 4 X 5 " (calcium alginate/honey)	Tier 3	
MEDIHONEY (HYDROCOLLOID-HONEY) TOPICAL BANDAGE 2 X 2 ", 4 X 5 " (honey/hydrocolloid dressing)	Tier 3	
MEDISENSE CONTROLS 1-HI 1-LO COMBO PACK (blood-glucose calib. control)	DME	
MEDPOINT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MEDTRONIC REMOTE CONTROL (diabetic supplies,miscell)	DME	
MICRO BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	
MICROBORE EXTENSION SET INFUSION SET (intravenous administration extension set)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICRODOT BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
MICRODOT HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
MICRODOT INSULIN PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
MICRODOT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MICRODOT XTRA BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	
MICROLET 2 LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLET NEXT LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLIFE PEAK FLOW METER DEVICE (peak flow meter)	DME	
MINI LANCING DEVICE (lancing device)	DME	
MINI PLUS NEBULIZER (nebulizer)	Tier 3	
MINI ULTRA-THIN II NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
MINIMED QUICK SET 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK-SERTER-MMT 395 (diabetic supplies, miscell)	DME	
MINIMED SILHOUETTE 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 18" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED SYRINGE RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
MINIMED SYRINGE RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
MISTASSIST DEVICE (spirometers and accessories)	Tier 3	
MISTASSIST KIT DEVICE (spirometer with drug delivery adapters)	Tier 3	
MONO-FLO DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
MONOJECT 35CC SYRINGE CATH TIP SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT 3CC SYR 25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT ALLERGY TRAY DETACH TRAY 1 ML 27 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 0.5 ML 28 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 1 ML 28 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT BLOOD COLLECTION NEEDLE 20 GAUGE X 1", 20 X 1 1/2 ", 21 GAUGE X 1", 22 GAUGE X 1" (needles, blood collection)	Tier 3	
MONOJECT CONTROL SYRINGE LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT HYPODERMIC NEEDLES NEEDLE 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1 1/2", 27 GAUGE X 1/2", 30 GAUGE X 3/4" (needles, disposable)	Tier 3	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 29 GAUGE X 1/2" (syringe with needle,insulin disposable)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MONOJECT LUER ADAPTER INTRAVENOUS ADMIX ACCESSORY (intravenous equipment)	Tier 3	
MONOJECT LUER-LOCK TIP SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT LUER-LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT MAGELLAN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE SYRINGE 3 ML 20 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SAFETY LUER LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SAFETY SYRINGES SYRINGE 12 ML 20 X 1 1/2", 12 ML 21X 1 1/2" (syringe,safety with needle,12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 6 ML (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 12 ML (syringe with cannula,disposable 12 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 6 ML (syringe with cannula, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE ECCENTRI LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE REGULAR LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 12 ML 20 X 1 1/2", 12 ML 21 GAUGE X 1 1/2", 12 ML 21 GAUGE X 1" (syringe with needle,disposable, 12 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 140 ML (syringe, disposable, 140 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SYRINGE SYRINGE 3 ML 20 X 3/4", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML 22 X 1 1/2" (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE TOOMEY TYPE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT TB LUER LOK SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB REGULAR LUER TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT TB SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1/2 ML 28 X 1/2" (syringe with needle,disposable, 0.5 mL)	Tier 1	
MONOJECT ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOLET THIN LANCETS 28 GAUGE (lancets)	DME	
MULTI-LANCET DEVICE 2 KIT (lancing device/lancets)	DME	
<i>myelogram tray tray</i>	Tier 3	
MYGLUCOHEALTH CONTROL SOLUTION SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
MYGLUCOHEALTH KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYGLUCOHEALTH LANCETS 30 GAUGE (lancets)	DME	
MYGLUCOHEALTH STRIP (blood sugar diagnostic)	DME	
nebulizer and compressor device	Tier 3	
NEXIVA INFUSION SET 18 X 1 1/4 ", 18 X 1 3/4 ", 20 GAUGE X 1", 20 X 1 1/4 ", 20 X 1 3/4 ", 24 GAUGE X 3/4", 24 X 0.56 " (intravenous catheter)	Tier 3	
NIGHTTIME UNDERPANTS L-XL (diaper,brief,youth,disposable)	Tier 3	
NORM-JECT SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
NORM-JECT SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
NORM-JECT TUBERKULIN SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
NOSE CLIP (nebulizer accessories)	Tier 3	
NOVA MAX GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
NOVA MAX PLUS GLUC-KETON METER DEVICE (blood ketone and glucose monitor)	DME	
NOVA MAX PLUS GLUC-KETON METER KIT (blood ketone and glucose monitor)	DME	
NOVA SUREFLEX LANCETS (lancets)	DME	
NOVAMAX PLUS GLU-KET SOLUTION (blood glucose and ketone control, normal)	DME	
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
NOVOFINE AUTOCOVER NEEDLE 30 GAUGE X 1/3" (pen needle, diabetic, safety)	Tier 1	
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6" (pen needle, diabetic)	Tier 1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOTWIST NEEDLE 32 GAUGE X 1/5" (pen needle, diabetic)	Tier 1	
NUVA III TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAGEL TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAZIL II TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
OASIS ULTRA FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX MESHED TOPICAL SHEET 5 X 7 CM, 7 X 10 CM, 7 X 20 CM (porcine acell submucosa, meshed)	Tier 3	
OMBRA COMPRESSOR SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
OMNIPOD DASH 5 PACK POD SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 2	
OMNIPOD DASH PDM KIT (insulin pump controller)	Tier 2	
OMNIPOD INSULIN MANAGEMENT (subcutaneous insulin pump)	Tier 2	
OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 2	
ON CALL EXPRESS CONTROL SOLUTION (blood glucose calibration control solutions high, normal, low)	DME	
ON CALL EXPRESS METER (blood-glucose meter)	DME	
ON CALL EXPRESS METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ON CALL EXPRESS TEST STRIP STRIP (blood sugar diagnostic)	DME	
ON CALL LANCET 30 GAUGE (lancets)	DME	
ON CALL LANCING DEVICE (lancing device)	DME	
ON CALL PLUS CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ON CALL PLUS LANCET 30 GAUGE (lancets)	DME	
ON CALL PLUS LANCING DEVICE (lancing device)	DME	
ON CALL PLUS METER KIT (blood-glucose meter)	DME	
ON CALL PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	
ON CALL VIVID CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ON CALL VIVID METER KIT (blood-glucose meter)	DME	
ON CALL VIVID PAL METER KIT (blood-glucose meter)	DME	
ONETOUCH DELICA LANC DEVICE KIT (lancing device/lancets)	DME	
ONETOUCH DELICA LANCETS 30 GAUGE (lancets)	DME	
ONETOUCH DELICA PLUS LANC DEV KIT (lancing device/lancets)	DME	
ONETOUCH DELICA PLUS LANCET 30 GAUGE, 33 GAUGE (lancets)	DME	
ONETOUCH DELICA SAFETY LANCET 30 GAUGE (lancets)	DME	
ONETOUCH SURESOFT LANCING DEV 18 GAUGE, 21 GAUGE, 28 GAUGE (lancets)	DME	
ONETOUCH ULTRASOFT LANCETS (lancets)	DME	
ONETOUCH VERIO HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ONETOUCH VERIO IQ METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH VERIO IQ METER KIT (blood-glucose meter)	DME	
ONETOUCH VERIO METER (blood-glucose meter)	DME	
ONETOUCH VERIO MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH VERIO REFLECT METER (blood-glucose meter)	DME	
ONETOUCH VERIO REFLECT START KIT (blood-glucose meter)	DME	
OPTICHAMBER ADULT MASK-LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
OPTICHAMBER DIAMOND LG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
OPTICHAMBER DIAMOND VHC SPACER (inhaler, assist devices)	Tier 3	
OPTICHAMBER DIAMOND-MED MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
OPTICHAMBER DIAMOND-SML MASK SPACER (inhaler,assist device with small mask)	Tier 3	
OPTUMRX (blood-glucose meter)	DME	
OPTUMRX KIT (blood-glucose meter)	DME	
OPTUMRX SOLUTION (blood glucose calibration control solution, high and normal)	DME	
OPTUMRX STRIP (blood sugar diagnostic)	DME	
OVAL TAPE (diabetic supplies,miscell)	DME	
PARADIGM RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
PARADIGM RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
PARI BABY CONV KIT - SIZE 1 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 2 KIT (nebulizer accessories)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PARI BABY CONV KIT - SIZE 3 KIT (nebulizer accessories)	Tier 3	
PARI LC SPRINT NEBULIZER SET (nebulizer)	Tier 3	
PARI LC SPRINT SINUS (nebulizer)	Tier 3	
PARI SINUS AEROSOL SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMBO PACK DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMPACT COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S PORTABLE PWR KIT (nebulizer accessories)	Tier 3	
PCCA ACCUPEN-15 DEVICE (topical cream metered-dose device)	Tier 3	
PEAK AIR PEAK FLOW METER DEVICE (peak flow meter)	DME	
PEDIATRIC BEAR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC COMP-AIR COMPRES NEB DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC DINOSAUR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC DOG NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC FROG NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
<i>pen needle, diabetic needle 30 gauge x 5/16", 32 gauge x 3/16"</i>	Tier 1	
<i>pen needle, diabetic needle 31 gauge x 15/64"</i>	Tier 1	
PERSONAL BEST FULL RANGE DEVICE (peak flow meter)	DME	
PERSONAL BEST LOW RANGE DEVICE (peak flow meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PFLEX INSPIRATORY TRAINER DEVICE (spirometers and accessories)	Tier 3	
PHARMACIST CHOICE STRIP (blood sugar diagnostic)	DME	
PHASEAL ASSEMBLY FIXTURE DEVICE (assembly system, vial to transfer device, closed system)	Tier 3	
PHASEAL INFUSION ADAPTER (infusion adapter, closed system)	Tier 3	
PHASEAL INJECTOR LUER (needle injector, luer, closed system)	Tier 3	
PHASEAL PROTECTOR DEVICE 28 MM (transfer device, closed system)	Tier 3	
PHASEAL SECONDARY SET INFUSION SET (intravenous piggyback administration set)	Tier 3	
PHASEAL Y-SITE (y-site line connector, closed system)	Tier 3	
PIKO 1 DEVICE (peak flow meter)	DME	
PILLOW MASK CHILD (nebulizer accessories)	Tier 3	
PIP LANCET 28 GAUGE (lancets)	DME	
PIP PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PIXEL COVID19 HOME COLLECT KIT (COVID-19 test specimen collection)	Tier 3	
POCKET PEAK FLOW METER DEVICE (peak flow meter)	DME	
POGO AUTOMATIC BLOOD GLUC SYS (blood-glucose meter)	DME	
POLY HUB NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
POLYTOZA TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
PORTABLE NEBULIZER SYSTEM DEVICE (nebulizer and compressor)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRECISION (blood-glucose meter)	DME	
PRECISION GLUCOSE CONTROL SOLN COMBO PACK (blood-glucose calib. control)	DME	
PRECISION GLUCOSE/KETONE CONTR COMBO PACK (blood-glucose calib. control)	DME	
PRECISION XTRA KETONE-GLUCOSE KIT (blood ketone and glucose monitor)	DME	
PREMIER BLU GLUCOSE METER (blood-glucose meter)	DME	
PREMIER CLASSIC GLUCOSE METER (blood-glucose meter)	DME	
PREMIER COMPACT GLUCOSE METER KIT (blood-glucose meter)	DME	
PREMIER VOICE GLUCOSE METER (blood-glucose meter)	DME	
PREMIUM V10 (blood-glucose meter)	DME	
PREMIUM V10 STRIP (blood sugar diagnostic)	DME	
PRESSURE ACTIVATED LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
PRESTO PRO BLOOD GLUCOSE METER (blood-glucose meter)	DME	
PREVENT DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
PRIMEAIRE SPACER (inhaler, assist devices)	Tier 3	
PRO COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRO COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRO COMFORT LANCET 30 GAUGE, 31 GAUGE (lancets)	DME	
PRO COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PRO COMFORT SPACER-ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	
PRO COMFORT SPACER-CHILD MASK SPACER (inhaler,assist device with small mask)	Tier 3	
PRO COMFORT TENS ELECTRODE PAD (tens unit electrodes)	Tier 3	
PRO COMFORT TENS UNIT COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
PRO VOICE V8 GLUCOSE MONITOR (blood-glucose meter)	DME	
PRO VOICE V8-V9 TEST STRIP STRIP (blood sugar diagnostic)	DME	
PRO VOICE V9 GLUCOSE MONITOR (blood-glucose meter)	DME	
PROCARE COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE SPACER WITH ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	
PROCARE SPACER WITH CHILD MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
PRO-CEPTION VAGINAL (medical supply, miscellaneous)	Tier 3	
PROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
PRODIGY AUTOCODE MONITOR SYST (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
PRODIGY INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PRODIGY LANCETS 28 GAUGE (lancets)	DME	
PRODIGY LANCING DEVICE (lancing device)	DME	
PRODIGY VOICE GLUCOSE METER KIT (blood-glucose meter)	DME	
PRONEB ULTRA II FILTER ASSEM (nebulizer accessories)	Tier 3	
PROSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
PROVENT NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PROVENT STARTER NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PULMONEB LT COMPRESSOR NEBUL DEVICE (nebulizer and compressor)	Tier 3	
PURE COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PURE COMFORT SAFETY LANCETS 30 GAUGE (lancets)	DME	
PUSH BUTTON SAFETY LANCETS 21 GAUGE (lancets)	DME	
QUAKE VIBRATORY PEP DEVICE (mucus clearing device)	Tier 3	
QUICK-SET PARADIGM 43" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUICKVUE AT-HOME COVID-19 TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	
QUICKVUE SARS ANTIGEN KIT (COVID-19 antigen immunoassay test)	Tier 3	
QUINTET AC (blood-glucose meter)	DME	
QUINTET AC STRIP (blood sugar diagnostic)	DME	
QUINTET BLOOD GLUCOSE METER (blood-glucose meter)	DME	
QUINTET GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RAPPORT VACUUM THERAPY KIT (vacuum erection device system)	Tier 3	
RATE FLOW REGULATOR IV SET INFUSION SET (intravenous administration set)	Tier 3	
READYLANCE SAFETY LANCETS 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
RECONSTITUTE KIT (medical supply, miscellaneous)	Tier 3	
REFUAH PLUS GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
REFUAH PLUS GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
REFUAH PLUS STRIP (blood sugar diagnostic)	DME	
RELIAMED LANCET 23 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED MINI LANCING DEVICE (lancing device)	DME	
RELIAMED SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED TWIST AND CAP LANCET 28 GAUGE (lancets)	DME	
RELION ALL-IN-ONE METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELION MICRO GLUCOSE MONITOR (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
RELION NEEDLES NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
RELION PEN NEEDLES NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
RELION THIN LANCETS 26 GAUGE (lancets)	DME	
RELION ULTIMA STRIP (blood sugar diagnostic)	DME	
RELION ULTRA THIN PLUS LANCETS (lancets)	DME	
RELIZORB CARTRIDGE (enteral pump accessory for fat hydrolysis)	Tier 3	
REPLICARE DRESSING TOPICAL BANDAGE 1 1/2 X 2 1/2 ", 4 X 4 ", 6 X 6 ", 8 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE THIN TOPICAL BANDAGE 2 X 2 3/4 ", 3 1/2 X 5 1/2 ", 6 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE ULTRA DRESSING TOPICAL BANDAGE 4 X 4 ", 6 X 6 ", 7 X 8 " (hydrocolloid dressing)	Tier 3	
RESTORE TOPICAL BANDAGE 2 X 2 " (silver/calcium alginate)	Tier 3	
RIGHTEST CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
RIGHTEST CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GC250S CNTRL SOL NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GC700 LEV 2 CTRL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GD500 LANCING DEVICE (lancing device)	DME	
RIGHTEST GL300 LANCETS 30 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIGHTEST GM250S GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GM260 GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GM550 SYSTEM KIT (blood-glucose meter)	DME	
RIGHTEST GM700SB GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GS250S TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS260 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GS550 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
RIGHTEST GT333 GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GT333 LEV 2 CTRL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST MAX PLUS GLUCOSE MTR (blood-glucose meter)	DME	
RITEFLO AEROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
ROBINSON CLEAR VINYL CATHETER 16 FR (catheter)	Tier 3	
RUBBER MOUTHPIECE (nebulizer accessories)	Tier 3	
SAFE-CLIP NEEDLE STORAGE DEV DEVICE (needle clipping and storage device)	DME	
SAFESNAP SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe,needle,safety 1 mL,self-contained disposal unit)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAFESNAP SYRINGE SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 GAUGE X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1" (syringe,safety needle 10 mL and self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe 3 mL with safety needle,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2" (syringe, safety needle 5 mL and self-contained disposal unit)	Tier 1	
SAFETY LANCETS 26 GAUGE (lancets)	DME	
<i>safety needles needle 18 gauge x 1 1/2"</i>	Tier 3	
SAFETY-LET LANCETS 30 GAUGE (lancets)	DME	
SAMI THE SEAL DEVICE (nebulizer and compressor)	Tier 3	
SAMI THE SEAL MASK (nebulizer accessories)	Tier 3	
SCARCINPAD TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SELF-CATHETER, FEMALE 14 FR (catheter)	Tier 3	
SIDESTREAM MASK (nebulizer accessories)	Tier 3	
SIDESTREAM PLUS (nebulizer)	Tier 3	
SILADERM TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SILASTIC FOLEY CATHETER 20 FR (catheter)	Tier 3	
SILICONE MASK - INFANT DEVICE (inhaler, assist devices, accessories)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIL-K TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SILTREX TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SINGLE-LET (lancets)	DME	
SINUSTAR NEBULIZER (nebulizer)	Tier 3	
SMART CARESENS N KIT (blood-glucose meter)	DME	
SMART SENSE LANCETS 21 GAUGE, 33 GAUGE (lancets)	DME	
SMARTDIABETES VANTAGE (lancing device)	DME	
SMARTEST CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
SMARTEST LANCET (lancets)	DME	
SMARTEST PERSONA GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PERSONA STARTER KIT (blood-glucose meter)	DME	
SMARTEST PRONTO GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PRONTO STARTER KIT (blood-glucose meter)	DME	
SMARTEST TEST STRIP (blood sugar diagnostic)	DME	
SOFIA SARS ANTIGEN FIA KIT (COVID-19 antigen immunoassay test)	Tier 3	
SOFIA2 FLU-SARS ANTIGEN FIA KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SOFT TOUCH LANCETS (lancets)	DME	
SOLUS V2 AUDIBLE METER (blood-glucose meter)	DME	
SOLUS V2 AUDIBLE METER KIT (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLUS V2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
SOLUS V2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
SOLUS V2 LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SOLUS V2 LANCING DEVICE KIT (lancing device/lancets)	DME	
SOLUS V2 TEST STRIPS STRIP (blood sugar diagnostic)	DME	
SOOTHENEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
SOOTHENEB MESH NEBULIZER (nebulizer)	Tier 3	
SPACE CHAMBER PLUS SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER WITH LARGE MASK SPACER (inhaler,assist device with large mask)	Tier 3	
SPACE CHAMBER WITH MEDIUM MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
SPACE CHAMBER WITH SMALL MASK SPACER (inhaler,assist device with small mask)	Tier 3	
SPECTRAGEL TOPICAL GEL (gel dressing)	Tier 3	
SPEEDICATH (FEMALE) 16 FR (catheter)	Tier 3	
STERILANCE TL 30 GAUGE, 32 GAUGE (lancets)	DME	
STRATACTX TOPICAL GEL (gel dressing)	Tier 3	
STRATAGRT TOPICAL GEL (gel dressing)	Tier 3	
STRATAXRT TOPICAL GEL (gel dressing)	Tier 3	
SUNRISE COMPRESSOR-NEBULIZER DEVICE (compressor, for nebulizer)	Tier 3	
SUPER THIN LANCETS (lancets)	DME	
SUPPOSITORY SHELL, SMALL DEVICE (suppository mold)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE COMFORT INS. SYR. U-100 SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
SURE COMFORT LANCETS 18 GAUGE, 21 GAUGE, 23 GAUGE, 28 GAUGE (lancets)	DME	
SURE COMFORT LANCING PEN (lancing device)	DME	
SURE COMFORT PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
SUREFLEX LANCING DEVICE (lancing device)	DME	
SURE-JECT INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE-JECT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
SURE-LANCE 26 GAUGE (lancets)	DME	
SURE-PEN LANCING DEVICE (lancing device)	DME	
SURE-T INFUSION SET (subcutaneous infusion pump accessory)	Tier 3	
SURE-TOUCH LANCET (lancets)	DME	
SURGUARD2 SAFETY NEEDLE 23 GAUGE X 1" (needles, safety)	Tier 3	
<i>syringe (disposable) syringe 20 ml, 60 ml</i>	Tier 1	
SYRINGE 3CC/20GX1" SYRINGE 3 ML 20 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1" SYRINGE 3 ML 21 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1-1/2" SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX1" SYRINGE 3 ML 22 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX3/4" SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
<i>syringe with needle syringe 3 ml 21 gauge x 1 1/2", 3 ml 23 gauge x 1 1/2"</i>	Tier 1	
<i>syringe with needle, safety syringe 1 ml 25 gauge x 5/8", 3 ml 22 gauge x 1"</i>	Tier 1	
SYRINGE WITHOUT NEEDLE SYRINGE (syringe, disposable)	Tier 1	
T.E.D. KNEE LENGTH-M-LONG (compression stocking,knee high,long length,small circumferen)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
T.E.D. KNEE LENGTH-S-REGULAR (compression stocking, knee high, regular length, small)	Tier 3	
T:FLEX SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	
T:SLIM X2 SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	
TELCARE BGM KIT (blood-glucose meter)	DME	
TELCARE BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
TELCARE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
TELCARE LANCETS 30 GAUGE (lancets)	DME	
TELCARE TEST STRIPS STRIP (blood sugar diagnostic)	DME	
TENS 502 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
TENS 504 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
TERUMO ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
TERUMO HYPODERMIC NEEDLE/SYRIN SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.3 ML 30 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TERUMO INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
TEST N'GO BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
TEST N'GO TEST STRIP (blood sugar diagnostic)	DME	
THINPRO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8", 0.3 ML 31 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8", 1 ML 31 X 3/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
THRESHOLD IMT TRAINER DEVICE (spirometers and accessories)	Tier 3	
THRESHOLD PEP DEVICE DEVICE (spirometers and accessories)	Tier 3	
TOOMEY SYRINGE SYRINGE 70 ML (syringe, disposable irrigation, 70 mL)	Tier 1	
TOPCARE CLICKFINE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPCARE ULTRA COMFORT SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TOPCARE UNIVERSAL1 LANCET 33 GAUGE (lancets)	DME	
TOUCH-TROL 10 FR (catheter)	Tier 3	
TRUE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT LANCET 30 GAUGE (lancets)	DME	
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE METRIX GLUCOSE METER KIT (blood-glucose meter)	DME	
TRUE2GO BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUECONTROL LEVEL 0 SOLUTION (blood glucose calibration control solution, high)	DME	
TRUECONTROL LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
TRUEPLUS KETONE STRIP (urine acetone test,strips)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUEPLUS LANCETS 33 GAUGE (lancets)	DME	
TRUERESULT BLOOD GLUCOSE SYSTM KIT (blood-glucose meter)	DME	
TRUETRACK BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUETRACK SMART SYSTEM KIT (blood-glucose meter)	DME	
TRUNEB NEBULIZER (nebulizer)	Tier 3	
TRUZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
<i>tuberculin-allergy syringes syringe 1 ml 26 gauge x 3/8"</i>	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 1 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 3 ML 22 X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
ULTICARE SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML (syringe, safety 3 mL)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
ULTICARE TB SAFETY SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 0.3 ML 30 X 1/2", 0.3 ML 31 X 5/16" (syringe with needle,insulin disposable,0.3 mL/empty containr)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1 ML 30 X 1/2", 1 ML 31 X 5/16" (syringe with needle, insulin,1 mL and sharps container)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1/2 ML 30 X 1/2", 1/2 ML 31 X 5/16" (syringe-needle,insulin,0.5 mL/container,empty)	Tier 1	
ULTIGUARD SAFEPAK-PEN NEEDLE NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic, remover and disposal unit)	Tier 1	
ULTI-LANCE (lancing device)	DME	
ULTI-LANCE KIT (lancing device/lancets)	DME	
ULTILET BASIC LANCETS 30 GAUGE (lancets)	DME	
ULTILET CLASSIC LANCETS 33 GAUGE (lancets)	DME	
ULTILET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE, 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTILET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTILET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTILET LANCETS 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET PEN NEEDLE NEEDLE 29 GAUGE, 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTILET SAFETY LANCETS 23 GAUGE (lancets)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA CMFT INS SYR (HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA FINE LANCETS 30 GAUGE (lancets)	DME	
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA FLO PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN II LANCETS 30 GAUGE (lancets)	DME	
ULTRA THIN LANCETS 33 GAUGE (lancets)	DME	
ULTRA THIN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN PLUS LANCETS 33 GAUGE (lancets)	DME	
ULTRACARE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRACARE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-CARE LANCETS 30 GAUGE (lancets)	DME	
ULTRACARE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRALANCE LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II (SHORT) PEN NDL NEEDLE 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INS PEN NEEDLES NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II LANCETS 28 GAUGE (lancets)	DME	
ULTRATRAK ULTIMATE (blood-glucose meter)	DME	
ULTRATRAK ULTIMATE SOLUTION (blood glucose calibration control high and low)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATRAK ULTIMATE STRIP (blood sugar diagnostic)	DME	
UNIFINE PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS NEEDLE 29 GAUGE (pen needle, diabetic)	Tier 1	
UNISTIK 3 COMFORT LANCET (lancets)	DME	
UNISTIK 3 LANCETS 21 GAUGE (lancets)	DME	
UNISTIK 3 NEONATAL DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 3 NEONATAL KIT (lancing device/lancets)	DME	
UNISTIK 3 NORMAL LANCET 23 GAUGE (lancets)	DME	
UNISTIK CZT LANCET 23 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK PRO LANCET 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK SAFETY 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTIK TOUCH LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTRIP HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
UNISTRIP LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
UNISTRIP1 TEST STRIP STRIP (blood sugar diagnostic)	DME	
VANISHPOINT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 3/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1" (syringe with needle, disposable, 1 mL)	Tier 1	
VAPRO PLUS INTERMITT CATHETER COMBO PACK 12 FR- 8", 14 FR- 8" (urinary bag/catheter)	Tier 3	
VARISOFT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VARISOFT INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARITHENA ADMINISTRATION PACK (transfer set/syringe, disposable/bandages,compression/tubing)	Tier 3	
VERASENS BLOOD GLUCOSE METER (blood-glucose meter)	DME	
VERASENS CONTROL SOLN-LEVEL 1 SOLUTION (blood glucose calibration control solution, normal)	DME	
VERASENS METER STARTER KIT KIT (blood-glucose meter)	DME	
VERIFINE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VERITOR SARS-COV-2 AND FLU A-B KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
V-GO 20 DEVICE (sub-q insulin delivery device, 20 unit,disposable)	Tier 2	
V-GO 30 DEVICE (sub-q insulin delivery device, 30 unit, disposable)	Tier 2	
V-GO 40 DEVICE (sub-q insulin delivery device, 40 unit, disposable)	Tier 2	
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
VIVAGUARD INO CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
VIVAGUARD INO CTRL SOLN-L2 SOLUTION (blood glucose calibration control solution, normal)	DME	
VIVAGUARD INO GLUCOSE METER (blood-glucose meter)	DME	
VIVAGUARD INO SMART GLUC METER (blood-glucose meter)	DME	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVAGUARD LANCET 30 GAUGE (lancets)	DME	
VIVAGUARD LANCING DEVICE (lancing device)	DME	
VIXONE NEBULIZER (nebulizer)	Tier 3	
VIXONE NEBULIZER-ADULT MASK (nebulizer)	Tier 3	
VIXONE NEBULIZER-PEDIATRIC MSK (nebulizer)	Tier 3	
VORTEX HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
VORTEX VHC FROG MASK-CHILD SPACER (inhaler,assist device with medium mask)	Tier 3	
VORTEX VHC LADYBUG MASK-TODDLR SPACER (inhaler,assist device with small mask)	Tier 3	
WAVESENSE AMP KIT (blood-glucose meter)	DME	
WAVESENSE CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, normal)	DME	
WAVESENSE PRESTO (blood-glucose meter)	DME	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM (diaphragms, wide seal)	Tier 0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM (diaphragms, wide seal)	Tier 0	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM (diaphragms, wide seal)	Tier 0	
WILLIS THE WHALE COMPRESSR NEB DEVICE (nebulizer and compressor)	Tier 3	
XEROFORM NON-OCCLUSIVE TOPICAL BANDAGE 4 X 3 "-YARD (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM DRESSING TOPICAL BANDAGE 2 X 2 ", 4 X 3 "-YARD, 4 X 4 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM OVERWRAP TOPICAL BANDAGE 1 X 8 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM TOPICAL BANDAGE 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
Metabolic Disease Enzyme Replacement Agents - Drugs For Metabolic Disease		
Metabolic Disease Enzyme Replacement, Hypophosphatasia - Drugs For Metabolic Disease		
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML (asfotase alfa)	Tier 4	PA
Metabolic Disease Enzyme Replacement, Molybdenum Cofactor Deficiency - Drugs For Metabolic Disease		
NULIBRY INTRAVENOUS RECON SOLN 9.5 MG (fosdenopterin hydrobromide)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Metabolic Dx Enzyme Replacement, Severe Combined Immune Deficiency - Drugs For Metabolic Disease		
REVCovi INTRAMUSCULAR SOLUTION 2.4 MG/1.5 ML (1.6 MG/ML) (elapegademase-lvlr)	Tier 4	PA
Metabolic Modifiers - Drugs That Alter Metabolism		
Hyperparathyroid Treatment Agents - Vitamin D Analog-Type - Drugs That Alter Metabolism		
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	Tier 1	
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	Tier 1	
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG (calcifediol)	Tier 2	QL (2 EA per 1 day)
Metabolic Modifier - Carnitine Replenisher Agents - Drugs That Alter Metabolism		
CARNITOR (SUGAR-FREE) ORAL SOLUTION 100 MG/ML (levocarnitine)	Tier 3	
<i>levocarnitine (with sugar) oral solution 100 mg/ml</i>	Tier 1	
<i>levocarnitine oral solution 100 mg/ml</i>	Tier 1	
<i>levocarnitine oral tablet 330 mg</i>	Tier 1	
Metabolic Modifier - Gaucher's Disease, Type-1, Substrate Reduction Tx - Drugs That Alter Metabolism		
CERDELGA ORAL CAPSULE 84 MG (eliglustat tartrate)	Tier 4	PA
<i>miglustat oral capsule 100 mg</i>	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Metabolic Modifier - Hereditary Orotic Aciduria Treatment Agents - Drugs That Alter Metabolism		
XURIDEN ORAL GRANULES IN PACKET 2 GRAM (uridine triacetate)	Tier 4	PA
Metabolic Modifier - Hereditary Tyrosinemia Treatment Agents - Drugs That Alter Metabolism		
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	Tier 4	PA
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG (nitisinone)	Tier 4	PA
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (nitisinone)	Tier 4	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (nitisinone)	Tier 4	PA
Metabolic Modifier - Homocystinuria Treatment Agents - Drugs That Alter Metabolism		
CYSTADANE ORAL POWDER 1 GRAM/1.7 ML (betaine)	Tier 4	
Metabolic Modifier - Urea Cycle Disorder Agents-Conjugating Agents - Drugs That Alter Metabolism		
RAVICTI ORAL LIQUID 1.1 GRAM/ML (glycerol phenylbutyrate)	Tier 4	PA
<i>sodium phenylbutyrate oral powder 0.94 gram/gram</i>	Tier 4	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	Tier 4	PA
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (Cps 1) Activator - Drugs That Alter Metabolism		
CARBAGLU ORAL TABLET, DISPERSIBLE 200 MG (carglumic acid)	Tier 4	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pharmacoenhancer - Cytochrome P450 Inhibitors - Drugs That Alter Metabolism		
TYBOST ORAL TABLET 150 MG (cobicistat)	Tier 2	
Pharmacological Chaperone Tx - Alpha-Galactosidase A Enzyme Stabilizer - Drugs That Alter Metabolism		
GALAFOLD ORAL CAPSULE 123 MG (migalastat HCl)	Tier 4	PA
Phenylketonuria(Pku) Tx Agents - Cofactor Of Phenylalanine Hydroxylase - Drugs That Alter Metabolism		
sapropterin oral powder in packet 100 mg, 500 mg	Tier 4	PA
sapropterin oral tablet,soluble 100 mg	Tier 4	PA
Phenylketonuria(Pku) Tx Agents - Phenylalanine Ammonia Lyase - Drugs That Alter Metabolism		
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML (pegvaliase-pqpz)	Tier 4	PA
Progeria Syndrome Treatment Agents - Farnyltransferase Inhibitor - Drugs That Alter Metabolism		
ZOKINVY ORAL CAPSULE 50 MG, 75 MG (lonafarnib)	Tier 4	PA
Mouth-Throat-Dental - Preparations - Drugs For The Mouth And Throat		
Dental Product - Fluoride Preparations - Drugs For The Mouth And Throat		
CLINPRO 5000 DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DENTAGEL DENTAL GEL 1.1 % (fluoride (sodium))	Tier 1	
<i>fluoride (sodium) dental cream 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental gel 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental paste 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental solution 0.2 %</i>	Tier 1	
<i>fluoride (sodium) oral drops 0.5 mg (1.1 mg sod.fluorid)/ml</i>	Tier 0	Age (Max 6 Years)
<i>fluoride (sodium) oral tablet,chewable 0.25 mg(0.55 mg sod. fluoride), 0.5 mg (1.1 mg sodium fluorid), 1 mg (2.2 mg sod. fluoride)</i>	Tier 0	Age (Max 6 Years)
FLUORIDEX DAILY DEFENSE DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 3	
PREVIDENT DENTAL SOLUTION 0.2 % (fluoride (sodium))	Tier 3	
SF 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	
SF DENTAL GEL 1.1 % (fluoride (sodium))	Tier 1	
SODIUM FLUORIDE 5000 DRY MOUTH DENTAL GEL 1.1 % (fluoride (sodium))	Tier 1	
SODIUM FLUORIDE 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	
<i>sodium fluoride-pot nitrate dental paste 1.1-5 %</i>	Tier 1	
Dental Product - Local Anesthetics - Drugs For The Mouth And Throat		
KOVANAZE NASAL NASAL SPRAY SYRINGE 6-0.1 MG/0.2 ML (tetracaine HCl/oxymetazoline HCl)	Tier 3	
ORAQIX DENTAL CARTRIDGE 2.5-2.5 % (lidocaine/prilocaine)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Mouth And Throat - Antifungals - Drugs For The Mouth And Throat		
<i>clotrimazole mucous membrane troche 10 mg</i>	Tier 1	
<i>nystatin oral suspension 100,000 unit/ml</i>	Tier 1	
Mouth And Throat - Anti-Infective Mixtures - Drugs For The Mouth And Throat		
DEBACTEROL MUCOUS MEMBRANE SOLUTION 30-50 % (sulfuric acid/sulfonated phenol)	Tier 3	
DEBACTEROL MUCOUS MEMBRANE SWAB 30-50 % (sulfuric acid/sulfonated phenol)	Tier 3	
Mouth And Throat - Antiseptics - Drugs For The Mouth And Throat		
<i>chlorhexidine gluconate mucous membrane mouthwash 0.12 %</i>	Tier 1	
chlorhexidine gluconate (Paroex Oral Rinse Mucous Membrane Mouthwash 0.12 %)	Tier 1	
chlorhexidine gluconate (Periogard Mucous Membrane Mouthwash 0.12 %)	Tier 1	
Mouth And Throat - Artificial Saliva - Drugs For The Mouth And Throat		
AQUORAL MUCOUS MEMBRANE AEROSOL, SPRAY (saliva substitute combo no.3)	Tier 3	
BOCASAL MUCOUS MEMBRANE POWDER IN PACKET 538 MG (saliva substitute combo no.5)	Tier 3	
CAPHOSOL MUCOUS MEMBRANE SOLUTION (saliva substitute combo no.2)	Tier 3	
MUCOSITISRX MUCOUS MEMBRANE POWDER IN PACKET 351 MG (saliva substitute combination no.11)	Tier 3	
NEUTRASAL MUCOUS MEMBRANE POWDER IN PACKET (saliva substitution combination no.10)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUMOISYN MUCOUS MEMBRANE LIQUID (flaxseed)	Tier 3	
NUMOISYN MUCOUS MEMBRANE LOZENGE 0.3 GRAM (sorbitol/saliva stimulant comb no. 1/malic acid/calcium phos)	Tier 3	
SALIVAMAX MUCOUS MEMBRANE POWDER IN PACKET 351 MG (saliva substitute combination no.11)	Tier 3	
XEROSTOMIA RELIEF MUCOUS MEMBRANE AEROSOL,SPRAY (saliva substitute combo no.3)	Tier 3	
Mouth And Throat - Glucocorticoids - Drugs For The Mouth And Throat		
triamcinolone acetonide (Oralene Dental Paste 0.1 %)	Tier 1	
<i>triamcinolone acetonide dental paste 0.1 %</i>	Tier 1	
Mouth And Throat - Local Anesthetic Amides - Drugs For The Mouth And Throat		
<i>lidocaine hcl mucous membrane solution 2 %, 4 % (40 mg/ml)</i>	Tier 1	
lidocaine HCl (Lidocaine Viscous Mucous Membrane Solution 2 %)	Tier 1	
Mouth And Throat - Lozenges - Drugs For The Mouth And Throat		
ELDERBERRY ZINC VIT C MUCOUS MEMBRANE LOZENGE 90-15 MG (ascorbic acid/zinc gluconate/herbal complex no.325)	Tier 3	
Mouth And Throat - Mucositis-Stomatitis Agents - Drugs For The Mouth And Throat		
EPISIL MUCOUS MEMBRANE GEL FORMING SOLUTION (oral mucositis and stomatitis anti-inflammatory agent comb 2)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GELCLAIR MUCOUS MEMBRANE GEL IN PACKET (potassium sorbate/hydroxyethylcellulose/povidone/hyaluronic)	Tier 3	
GELX MUCOUS MEMBRANE GEL (povidone/taurine/zinc gluconate/peg-40 castor oil)	Tier 3	
ORAMAGICRX MUCOUS MEMBRANE MOUTHWASH (potassium sorbate/maltodextrin/aloe vera/mann ps)	Tier 3	
ORAPEUTIC MUCOUS MEMBRANE GEL (xylitol/pectin/acemannan/sodium bicarbonate)	Tier 3	
Mouth And Throat - Protectants - Drugs For The Mouth And Throat		
GELX MUCOUS MEMBRANE GEL (povidone/taurine/zinc gluconate/peg-40 castor oil)	Tier 3	
MUGARD MUCOUS MEMBRANE SOLUTION (glycerin/carbomer homopolymer type A/potassium hydroxide)	Tier 3	
ORAFATE MUCOUS MEMBRANE PASTE 1 GRAM/10 ML (sucralfate malate, polymerized)	Tier 3	
PROTHELIAL MUCOUS MEMBRANE PASTE 1 GRAM/10 ML (sucralfate malate, polymerized)	Tier 3	
SILATRIX MUCOUS MEMBRANE GEL 1 GRAM/10 GRAM (sucralfate malate, polymerized)	Tier 3	
Mouth And Throat - Saliva Stimulants - Drugs For The Mouth And Throat		
<i>cevimeline oral capsule 30 mg</i>	Tier 1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Periodontal Product - Tetracycline Antiinfective, Local - Drugs For The Mouth And Throat		
ARESTIN DENTAL CARTRIDGE 1 MG (minocycline HCl microspheres)	Tier 4	PA
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors - Drugs For The Mouth And Throat		
<i>doxycycline hyclate oral tablet 20 mg</i>	Tier 1	
Therapy For Drooling- Primary Or Secondary Sialorrhea-Anticholinergic - Drugs For The Mouth And Throat		
CUVPOSA ORAL SOLUTION 1 MG/5 ML (0.2 MG/ML) (glycopyrrolate)	Tier 3	
Multiple Sclerosis Agents - Drugs For The Nervous System		
Multiple Sclerosis Agent - Cd20 Specific Monoclonal Antibody - Drugs For Multiple Sclerosis		
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR 20 MG/0.4 ML (ofatumumab)	Tier 4	PA
Multiple Sclerosis Agent - Interferons - Drugs For Multiple Sclerosis		
AVONEX INTRAMUSCULAR PEN INJECTOR 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA
AVONEX INTRAMUSCULAR SYRINGE 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG (interferon beta-1b)	Tier 2	PA
BETASERON SUBCUTANEOUS RECON SOLN 0.3 MG (interferon beta-1b)	Tier 2	PA
EXTAVIA SUBCUTANEOUS KIT 0.3 MG (interferon beta-1b)	Tier 2	PA
EXTAVIA SUBCUTANEOUS RECON SOLN 0.3 MG (interferon beta-1b)	Tier 2	PA
PLEGRIDY INTRAMUSCULAR SYRINGE 125 MCG/0.5 ML (peginterferon beta-1a)	Tier 4	PA
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML, 44 MCG/0.5 ML (interferon beta-1a/albumin human)	Tier 2	PA
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6) (interferon beta-1a/albumin human)	Tier 2	PA
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE 8.8MCG/0.2ML-22 MCG/0.5ML (6) (interferon beta-1a/albumin human)	Tier 2	PA
Multiple Sclerosis Agent - Others - Drugs For Multiple Sclerosis		
BAFIERTAM ORAL CAPSULE, DELAYED RELEASE(DR/EC) 95 MG (monomethyl fumarate)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML (glatiramer acetate)	Tier 2	PA
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg</i>	Tier 1	PA
<i>glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml</i>	Tier 1	PA
glatiramer acetate (Glatopa Subcutaneous Syringe 20 Mg/ML, 40 Mg/ML)	Tier 1	PA
VUMERITY ORAL CAPSULE, DELAYED RELEASE(DR/EC) 231 MG (diroximel fumarate)	Tier 4	PA
Multiple Sclerosis Agent - Potassium Channel Blocker - Drugs For Multiple Sclerosis		
<i>dalfampridine oral tablet extended release 12 hr 10 mg</i>	Tier 4	PA
FIRDAPSE ORAL TABLET 10 MG (amifampridine phosphate)	Tier 4	PA
RUZURGI ORAL TABLET 10 MG (amifampridine)	Tier 4	PA
Multiple Sclerosis Agent - Purine Nucleoside Analogs - Drugs For Multiple Sclerosis		
MAVENCLAD (10 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
MAVENCLAD (4 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
MAVENCLAD (5 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
MAVENCLAD (6 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
MAVENCLAD (7 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
MAVENCLAD (8 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (9 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 4	PA
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors - Drugs For Multiple Sclerosis		
AUBAGIO ORAL TABLET 14 MG, 7 MG (teriflunomide)	Tier 2	PA
Multiple Sclerosis Agent - Sphingosine 1-Phosphate Receptor Modulator - Drugs For Multiple Sclerosis		
GILENYA ORAL CAPSULE 0.25 MG (fingolimod HCl)	Tier 4	PA
GILENYA ORAL CAPSULE 0.5 MG (fingolimod HCl)	Tier 2	PA
MAYZENT ORAL TABLET 0.25 MG, 2 MG (siponimod)	Tier 4	PA
MAYZENT STARTER PACK ORAL TABLETS,DOSE PACK 0.25 MG (12 TABS) (siponimod)	Tier 4	PA
PONVORY 14-DAY STARTER PACK ORAL TABLETS,DOSE PACK 2 MG (2) - 10 MG (3) (ponesimod)	Tier 4	PA
PONVORY ORAL TABLET 20 MG (ponesimod)	Tier 4	PA
ZEPOSIA ORAL CAPSULE 0.92 MG (ozanimod hydrochloride)	Tier 4	PA
ZEPOSIA STARTER KIT ORAL CAPSULE,DOSE PACK 0.23-0.46-0.92 MG (ozanimod hydrochloride)	Tier 4	PA
ZEPOSIA STARTER PACK ORAL CAPSULE,DOSE PACK 0.23 MG (4)- 0.46 MG (3) (ozanimod hydrochloride)	Tier 4	PA
Ophthalmic Agents - Drugs For The Eye		
Artificial Tears And Lubricant Single Agents - Drugs For The Eye		
KLARITY (CHONDROITIN) (PF) OPHTHALMIC (EYE) DROPS 0.25 % (chondroitin sulfate A sodium/PF)	Tier 3	
LACRISERT OPHTHALMIC (EYE) INSERT 5 MG (hydroxypropyl cellulose)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Miotics - Direct Acting - Drugs For Glaucoma		
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	Tier 1	
Mydriatic And Cycloplegic Combinations - Drugs For The Eye		
CYCLOMYDRIL OPHTHALMIC (EYE) DROPS 0.2-1 % (cyclopentolate HCl/phenylephrine HCl)	Tier 3	
<i>cyclopen-tropic-phenyleph-watr ophthalmic (eye) drops 1-1-2.5 %</i>	Tier 1	
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-10 %- 0.5 %</i>	Tier 1	
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-2.5 %- 0.5 %</i>	Tier 3	
<i>cyclop-trop-propa-phen-ket-wat ophthalmic (eye) drops 1 %-1 %-0.1 %- 2.5 %-0.4 %</i>	Tier 3	
PAREMYD OPHTHALMIC (EYE) DROPS 1-0.25 % (hydroxyamphetamine hbr/tropicamide)	Tier 3	
<i>phenyleph-tropicamide in water ophthalmic (eye) drops 2.5-1 %</i>	Tier 1	
Ophth - Beta Blocker-Adrenergic-Carbonic Anhyd Inhib-Prostaglandin Analog - Drugs For Glaucoma		
<i>timol-brimon-dorzo-latanop(pf) ophthalmic (eye) drops 0.5 %-0.15 %- 2 %-0.005 %</i>	Tier 1	
Ophthalmic - Adrenergic Receptor Agonist - Drugs For The Eye		
UPNEEQ (PF) OPHTHALMIC (EYE) DROPPERETTE 0.1 % (oxymetazoline HCl/PF)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations - Drugs For Glaucoma		
<i>brimonidine-dorzolamide (pf) ophthalmic (eye) drops 0.15-2 %</i>	Tier 1	
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 % (brinzolamide/brimonidine tartrate)	Tier 2	
Ophthalmic - Agents For Corneal Collagen Cross-Linking - Drugs For The Eye		
PHOTREXA CROSS-LINKING KIT OPHTHALMIC (EYE) COMBO, DROPS AND DROPS VISCOUS 0.146 % -0.146 % (riboflavin 5-phosphate sodium in 20 % dextran)	Tier 3	
PHOTREXA OPHTHALMIC (EYE) DROPS 0.146 % (riboflavin 5-phosphate sodium (B2))	Tier 3	
PHOTREXA VISCOUS OPHTHALMIC (EYE) DROPS, VISCOUS 0.146 % (riboflavin 5-phosphate sodium in 20 % dextran)	Tier 3	
Ophthalmic - Antibacterial-Glucocorticoid Combinations - Anti-Infective/Anti-Inflammatories		
BLEPHAMIDE OPHTHALMIC (EYE) DROPS,SUSPENSION 10-0.2 % (sulfacetamide sodium/prednisolone acetate)	Tier 2	
sulfacetamide sodium/prednisolone acetate (Blephamide S.O.P. Ophthalmic (Eye) Ointment 10-0.2 %)	Tier 2	
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml</i>	Tier 1	
neomycin sulfate/bacitracin zinc/polymyxin B/hydrocortisone (Neo-Polycin Hc Ophthalmic (Eye) Ointment 3.5-400-10,000 Mg-Unit/G-1%)	Tier 1	
PRED-G OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-1 % (gentamicin sulfate/prednisolone acetate)	Tier 3	
PRED-G S.O.P. OPHTHALMIC (EYE) OINTMENT 0.3-0.6 % (gentamicin sulfate/prednisolone acetate)	Tier 3	
<i>prednisolone acet-gatifloxacin ophthalmic (eye) drops,suspension 1-0.5 %</i>	Tier 1	
<i>prednisolone sod ph-moxiflox ophthalmic (eye) drops 1-0.5 %</i>	Tier 1	
<i>prednisolone-moxifloxacin hcl ophthalmic (eye) drops,suspension 1-0.5 %</i>	Tier 1	
<i>sulfacetamide-prednisolone ophthalmic (eye) drops 10 %-0.23 % (0.25 %)</i>	Tier 1	
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 % (tobramycin/dexamethasone)	Tier 2	
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.05 % (tobramycin/dexamethasone)	Tier 3	
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %</i>	Tier 1	
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 % (tobramycin/loteprednol etabonate)	Tier 2	
Ophthalmic - Antibacterial-Glucocorticoid-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
<i>prednisol ace-gatiflox-bromfen ophthalmic (eye) drops,suspension 1-0.5-0.075 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisoln sp-gatiflox-bromfen ophthalmic (eye) drops 1-0.5-0.075 %</i>	Tier 1	
<i>prednisoln sp-moxiflox-bromfen ophthalmic (eye) drops 1-0.5-0.075 %</i>	Tier 1	
<i>prednisolone-moxiflo-nepafenac ophthalmic (eye) drops,suspension 1-0.5-0.1 %</i>	Tier 1	
<i>prednisolone-moxiflox-bromfen ophthalmic (eye) drops,suspension 1-0.5-0.075 %</i>	Tier 1	
Ophthalmic - Anticholinergics - Drugs For The Eye		
<i>atropine ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>atropine ophthalmic (eye) drops, emulsion 0.01 %</i>	Tier 1	
<i>atropine ophthalmic (eye) ointment 1 %</i>	Tier 1	
<i>cyclopentolate ophthalmic (eye) drops 0.5 %, 1 %, 2 %</i>	Tier 1	
HOMATROPAIRE OPHTHALMIC (EYE) DROPS 5 % (homatropine Hbr)	Tier 1	
<i>tropicamide ophthalmic (eye) drops 0.5 %, 1 %</i>	Tier 1	
Ophthalmic - Antifibrotic Agents - Drugs For The Eye		
MITOSOL OPHTHALMIC (EYE) KIT 0.2 MG (mitomycin)	Tier 3	
Ophthalmic - Antihistamines - Drugs For Itchy Eye		
<i>azelastine ophthalmic (eye) drops 0.05 %</i>	Tier 1	QL (12 ML per 30 days)
<i>bepotastine besilate ophthalmic (eye) drops 1.5 %</i>	Tier 1	ST: Must meet any of the following requirements: Azelastine HCL, Epinastine HCL, or Olopatadine HCL in 120 days; QL (10 ML per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEPREVE OPHTHALMIC (EYE) DROPS 1.5 % (bepotastine besilate)	Tier 3	ST: Must meet any of the following requirements: Azelastine HCL, Epinastine HCL, or Olopatadine HCL in 120 days; QL (10 ML per 30 days)
<i>epinastine ophthalmic (eye) drops 0.05 %</i>	Tier 1	QL (10 ML per 30 days)
LASTACRAFT OPHTHALMIC (EYE) DROPS 0.25 % (alcaftadine)	Tier 3	ST: Must meet any of the following requirements: Azelastine HCL, Epinastine HCL, or Olopatadine HCL in 120 days; QL (6 ML per 30 days)
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	Tier 1	
<i>olopatadine ophthalmic (eye) drops 0.2 %</i>	Tier 1	QL (3 ML per 30 days)
ZERVIAE OPHTHALMIC (EYE) DROPPERETTE 0.24 % (cetirizine HCl)	Tier 3	QL (60 EA per 30 days)
Ophthalmic - Anti-Inflammatory, Glucocorticoids - Anti-Infective/Anti-Inflammatories		
ALREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.2 % (loteprednol etabonate)	Tier 2	ST: Must meet any of the following requirements: Azelastine HCL, Epinastine HCL, or Olopatadine HCL in 120 days; QL (10 ML per 14 days)
<i>dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %</i>	Tier 1	QL (15 ML per 14 days)
DEXTENZA INTRACANALICULAR INSERT 0.4 MG (dexamethasone)	Tier 3	
<i>difluprednate ophthalmic (eye) drops 0.05 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EYSUVIS OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (loteprednol etabonate)	Tier 3	PA
FLAREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (fluorometholone acetate)	Tier 2	ST: Must meet any of the following requirements: Dexamethasone 0.1%, Fluorometholone 0.1%, or Prednisolone 1% in 120 days; QL (15 ML per 14 days)
<i>fluorometholone ophthalmic (eye) drops,suspension 0.1 %</i>	Tier 1	QL (10 ML per 14 days)
FML FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (fluorometholone)	Tier 2	ST: Must meet any of the following requirements: Dexamethasone 0.1%, Fluorometholone 0.1%, or Prednisolone 1% in 120 days; QL (10 ML per 14 days)
FML S.O.P. OPHTHALMIC (EYE) OINTMENT 0.1 % (fluorometholone)	Tier 2	ST: Must meet any of the following requirements: Dexamethasone 0.1%, Fluorometholone 0.1%, or Prednisolone 1% in 120 days; QL (3.5 GM per 14 days)
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (loteprednol etabonate)	Tier 3	ST: Must meet any of the following requirements: Lotemax and Loteprednol Etabonate in 365 days; QL (5.6 ML per 14 days)
KLARITY-B (BETAMETH-CHOND)(PF) OPHTHALMIC (EYE) DROPS 0.1-0.25 % (betamethasone sodium phos/chondroitin sulfate A sodium/PF)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLARITY-L (LOTEPRED-CHOND)(PF) OPHTHALMIC (EYE) DROPS 0.2-0.25 %, 0.5-0.25 % (loteprednol etabonate/chondroitin sulfate A sodium/PF)	Tier 3	
LOTEMAX OPHTHALMIC (EYE) OINTMENT 0.5 % (loteprednol etabonate)	Tier 2	QL (7 GM per 14 days)
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL 0.38 % (loteprednol etabonate)	Tier 2	QL (10 GM per 14 days)
<i>loteprednol etabonate ophthalmic (eye) drops,gel 0.5 %</i>	Tier 1	QL (10 GM per 14 days)
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %</i>	Tier 1	QL (20 ML per 14 days)
MAXIDEX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (dexamethasone)	Tier 3	ST: Must meet any of the following requirements: Dexamethasone 0.1%, Fluorometholone 0.1%, or Prednisolone 1% in 120 days; QL (25 ML per 14 days)
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION 0.12 % (prednisolone acetate)	Tier 2	ST: Must meet any of the following requirements: Dexamethasone 0.1%, Fluorometholone 0.1%, or Prednisolone 1% in 120 days; QL (20 ML per 14 days)
<i>prednisolone acetate (pf) ophthalmic (eye) drops,suspension 1 %</i>	Tier 1	QL (20 ML per 14 days)
<i>prednisolone acetate ophthalmic (eye) drops,suspension 1 %</i>	Tier 1	QL (20 ML per 14 days)
<i>prednisolone sodium phosphate ophthalmic (eye) drops 1 %</i>	Tier 1	QL (20 ML per 14 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Anti-Inflammatory, Immunomodulators - Anti-Infective/Anti-Inflammatories		
CEQUA OPHTHALMIC (EYE) DROPPERETTE 0.09 % (cyclosporine)	Tier 3	ST: Must meet the following requirement: Restasis or Xiidra in 120 days; QL (60 EA per 30 days)
CYCLOSPORINE IN KLARITY OPHTHALMIC (EYE) DROPS 0.1-0.25 % (cyclosporine/chondroitin sulfate A sodium)	Tier 1	
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS 0.05 % (cyclosporine)	Tier 2	QL (5.5 ML per 30 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 % (cyclosporine)	Tier 2	QL (60 EA per 30 days)
Ophthalmic - Anti-Inflammatory, Lfa-1 Antagonists - Anti-Infective/Anti-Inflammatories		
XIIDRA OPHTHALMIC (EYE) DROPPERETTE 5 % (lifitegrast)	Tier 2	QL (60 EA per 30 days)
Ophthalmic - Anti-Inflammatory, Nsaids - Anti-Infective/Anti-Inflammatories		
ACUVAIL (PF) OPHTHALMIC (EYE) DROPPERETTE 0.45 % (ketorolac tromethamine/PF)	Tier 3	ST: Must meet 2 of the following requirements: Diclofenac Sodium, Ilevro, Ketorolac Tromethamine, or Prolensa in 365 days; QL (60 EA per 15 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bromfenac ophthalmic (eye) drops 0.09 %</i>	Tier 1	ST: Must meet the following requirement: Diclofenac Sodium or Ketorolac Tromethamine in 120 days; QL (3.4 ML per 16 days)
BROMSITE OPHTHALMIC (EYE) DROPS 0.075 % (bromfenac sodium)	Tier 3	ST: Must meet 2 of the following requirements: Diclofenac Sodium, Ilevro, Ketorolac Tromethamine, or Prolensa in 365 days; QL (5 ML per 16 days)
<i>diclofenac sodium ophthalmic (eye) drops 0.1 %</i>	Tier 1	QL (10 ML per 14 days)
<i>flurbiprofen sodium ophthalmic (eye) drops 0.03 %</i>	Tier 1	
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3 % (nepafenac)	Tier 2	QL (3.4 ML per 16 days)
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	Tier 1	
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	Tier 1	QL (20 ML per 30 days)
NEVANAC OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (nepafenac)	Tier 3	ST: Must meet 2 of the following requirements: Diclofenac Sodium, Ilevro, Ketorolac Tromethamine, or Prolensa in 365 days; QL (9 ML per 16 days)
PROLENSA OPHTHALMIC (EYE) DROPS 0.07 % (bromfenac sodium)	Tier 2	QL (3 ML per 16 days)
Ophthalmic - Beta Blocker-Adrenergic-Carbonic Anhydrase Inhibitor Comb - Drugs For Glaucoma		
<i>timolol-brimonidi-dorzolam(pf) ophthalmic (eye) drops 0.5-0.15-2 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Beta Blocker-Carbonic Anhydrase Inhib-Prostaglandin Analog - Drugs For Glaucoma		
<i>timolol-dorzolamid-latanop(pf) ophthalmic (eye) drops 0.5-2-0.005 %</i>	Tier 1	
Ophthalmic - Beta Blockers-Adrenergic Combinations - Drugs For Glaucoma		
COMBIGAN OPHTHALMIC (EYE) DROPS 0.2-0.5 % (brimonidine tartrate/timolol maleate)	Tier 2	
Ophthalmic - Beta Blockers-Carbonic Anhydrase Inhibitor Combinations - Drugs For Glaucoma		
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	Tier 1	ST: Must meet the following requirement: Dorzolamide HCL/Timolol Maleate in 120 days; QL (2 EA per 1 day)
<i>dorzolamide-timolol (pf) ophthalmic (eye) drops 2-0.5 %</i>	Tier 1	
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	Tier 1	
Ophthalmic - Beta Blockers-Prostaglandin Analog Combinations - Drugs For Glaucoma		
<i>timolol-latanoprost(pf) ophthalmic (eye) drops 0.5-0.005 %</i>	Tier 1	
Ophthalmic - Carbonic Anhydrase Inhibitors - Drugs For Glaucoma		
AZOPT OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (brinzolamide)	Tier 1	
<i>dorzolamide (pf) ophthalmic (eye) drops 2 %</i>	Tier 1	
<i>dorzolamide ophthalmic (eye) drops 2 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Cystine Depleting Agents - Drugs For The Eye		
CYSTADROPS OPHTHALMIC (EYE) DROPS 0.37 % (cysteamine HCl)	Tier 4	PA
CYSTARAN OPHTHALMIC (EYE) DROPS 0.44 % (cysteamine HCl)	Tier 4	PA
Ophthalmic - Decongestants - Drugs For Itchy Eye		
<i>phenylephrine hcl ophthalmic (eye) drops 10 %, 2.5 %</i>	Tier 1	
Ophthalmic - Diagnostic Agents - Drugs For The Eye		
ALTAFLUOR BENOX OPHTHALMIC (EYE) DROPS 0.25-0.4 % (benoxinate HCl/fluorescein sodium)	Tier 1	
<i>fluorescein-benoxinate ophthalmic (eye) drops 0.3-0.4 %</i>	Tier 1	
<i>fluorescein-proparacaine ophthalmic (eye) drops 0.25-0.5 %</i>	Tier 1	
Ophthalmic - Glucocorticoid-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
<i>prednisolone acetate-bromfenac ophthalmic (eye) drops,suspension 1-0.075 %</i>	Tier 1	
<i>prednisolone acetate-nepafenac ophthalmic (eye) drops,suspension 1-0.1 %</i>	Tier 1	
Ophthalmic - Human Nerve Growth Factor (Hngf) - Drugs For The Eye		
OXERVATE OPHTHALMIC (EYE) DROPS 0.002 % (cenegermin-bkbj)	Tier 4	PA
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-Blockers - Drugs For Glaucoma		
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETIMOL OPHTHALMIC (EYE) DROPS 0.25 %, 0.5 % (timolol)	Tier 3	
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (betaxolol HCl)	Tier 3	
<i>carteolol ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>metipranolol ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>timolol maleate (pf) ophthalmic (eye) dropperette 0.5 %</i>	Tier 1	ST: Must meet the following requirement: Timolol Maleate or Timoptic Ocudose in 120 days; QL (2 EA per 1 day)
<i>timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %</i>	Tier 1	
<i>timolol maleate ophthalmic (eye) drops, once daily 0.5 %</i>	Tier 1	
<i>timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %</i>	Tier 1	
TIMOPTIC OCUDOSE (PF) OPHTHALMIC (EYE) DROPPERETTE 0.25 % (timolol maleate/PF)	Tier 3	ST: Must meet the following requirement: Timolol Maleate in 120 days; QL (2 EA per 1 day)
Ophthalmic - Local Anesthetic Combinations - Drugs For The Eye		
ALTAFLUOR BENOX OPHTHALMIC (EYE) DROPS 0.25-0.4 % (benoxinate HCl/fluorescein sodium)	Tier 1	
<i>fluorescein-benoxinate ophthalmic (eye) drops 0.3-0.4 %</i>	Tier 1	
Ophthalmic - Local Anesthetic Esters - Drugs For The Eye		
proparacaine HCl (Alcaine Ophthalmic (Eye) Drops 0.5 %)	Tier 1	
ALTACAINE OPHTHALMIC (EYE) DROPS 0.5 % (tetracaine HCl)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>proparacaine ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>tetracaine hcl (pf) ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>tetracaine hcl ophthalmic (eye) drops 0.5 %</i>	Tier 1	
Ophthalmic - Local Anesthetic, Amides - Drugs For The Eye		
AKTEN (PF) OPHTHALMIC (EYE) GEL 3.5 % (lidocaine HCl/PF)	Tier 3	
Ophthalmic - Mast Cell Stabilizers - Drugs For Itchy Eye		
ALOCRILOPHTHALMIC (EYE) DROPS 2 % (nedocromil sodium)	Tier 2	ST: Must meet the following requirement: Cromolyn 4% ophthalmic drops in 120 days; QL (20 ML per 30 days)
ALOMIDOPHTHALMIC (EYE) DROPS 0.1 % (lodoxamide tromethamine)	Tier 2	ST: Must meet the following requirement: Cromolyn 4% ophthalmic drops in 120 days; QL (40 ML per 30 days)
<i>cromolyn ophthalmic (eye) drops 4 %</i>	Tier 1	QL (50 ML per 30 days)
Ophthalmic - Mydriatic-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
MYDRIATIC4(TROP-PROP-PE-KTRLC) OPHTHALMIC (EYE) DROPS 1-0.5-2.5-0.5 % (tropicamide/proparacaine/phenylephrine/ketorolac in water)	Tier 1	
<i>tropic-proparacai-pe-ketor-wat ophthalmic (eye) drops 1-0.5-2.5-0.5 %</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Rho Kinase Inhibitor And Prostaglandin Analog Combination - Drugs For Glaucoma		
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 % (netarsudil mesylate/latanoprost)	Tier 3	ST: Must meet 2 of the following requirements: Alphagan P, Brinzolamide, Combigan, Latanoprost, Lumigan, Simbrinza, or Travoprost in 365 days; QL (2.5 ML per 25 days)
Ophthalmic - Surgical Aids Other - Drugs For The Eye		
GELFILM OPHTHALMIC (EYE) FILM (gelatin)	Tier 3	
Ophthalmic Antibacterial Mixtures - Anti-Infective/Anti-Inflammatories		
bacitracin/polymyxin B sulfate (Ak-Poly-Bac Ophthalmic (Eye) Ointment 500-10,000 Unit/Gram)	Tier 1	
<i>bacitracin-polymyxin b ophthalmic (eye) ointment 500-10,000 unit/gram</i>	Tier 1	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin ophthalmic (eye) drops 1.75 mg-10,000 unit-0.025mg/ml</i>	Tier 1	
neomycin sulfate/bacitracin/polymyxin B (Neo-Polycin Ophthalmic (Eye) Ointment 3.5-400-10,000 Mg-Unit-Unit/G)	Tier 1	
bacitracin/polymyxin B sulfate (Polycin Ophthalmic (Eye) Ointment 500-10,000 Unit/Gram)	Tier 1	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Antibiotic - Aminoglycosides - Anti-Infective/Anti-Inflammatories		
gentamicin sulfate (Gentak Ophthalmic (Eye) Ointment 0.3 % (3 Mg/Gram))	Tier 1	
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>tobramycin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
TOBREX OPHTHALMIC (EYE) OINTMENT 0.3 % (tobramycin)	Tier 2	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors - Anti-Infective/Anti-Inflammatories		
<i>bacitracin ophthalmic (eye) ointment 500 unit/gram</i>	Tier 1	
Ophthalmic Antibiotic - Fluoroquinolones - Anti-Infective/Anti-Inflammatories		
BESIVANCE OPHTHALMIC (EYE) DROPS,SUSPENSION 0.6 % (besifloxacin HCl)	Tier 2	
CILOXAN OPHTHALMIC (EYE) OINTMENT 0.3 % (ciprofloxacin HCl)	Tier 2	
<i>ciprofloxacin hcl ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>gatifloxacin ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>moxifloxacin ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>moxifloxacin ophthalmic (eye) drops, viscous 0.5 %</i>	Tier 1	
<i>ofloxacin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
Ophthalmic Antibiotic - Macrolides - Anti-Infective/Anti-Inflammatories		
AZASITE OPHTHALMIC (EYE) DROPS 1 % (azithromycin)	Tier 3	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLARITY-A (AZITHRO-CHONDR)(PF) OPHTHALMIC (EYE) DROPS 1-0.25 % (azithromycin/chondroitin sulfate A sodium/PF)	Tier 3	
Ophthalmic Antibiotic - Sulfonamides - Anti-Infective/Anti-Inflammatories		
sulfacetamide sodium (Bleph-10 Ophthalmic (Eye) Drops 10 %)	Tier 1	
<i>sulfacetamide sodium ophthalmic (eye) drops 10 %</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic (eye) ointment 10 %</i>	Tier 1	
Ophthalmic Antifungals - Anti-Infective/Anti-Inflammatories		
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 % (natamycin)	Tier 3	
Ophthalmic Antifungals - Tetraene Polyene-Type - Drugs For The Eye		
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 % (natamycin)	Tier 3	
Ophthalmic Antiseptics - Anti-Infective/Anti-Inflammatories		
BETADINE OPHTHALMIC PREP OPHTHALMIC (EYE) SOLUTION 5 % (povidone-iodine)	Tier 3	
Ophthalmic Antivirals - Anti-Infective/Anti-Inflammatories		
<i>trifluridine ophthalmic (eye) drops 1 %</i>	Tier 1	
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 % (ganciclovir)	Tier 2	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists - Drugs For Glaucoma		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 % (brimonidine tartrate)	Tier 2	
<i>apraclonidine ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	Tier 1	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE 1 % (apraclonidine HCl)	Tier 3	
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs - Drugs For Glaucoma		
<i>bimatoprost ophthalmic (eye) drops 0.03 %</i>	Tier 1	QL (1 ML per 12 days)
<i>latanoprost (pf) ophthalmic (eye) drops 0.005 %</i>	Tier 1	
<i>latanoprost ophthalmic (eye) drops 0.005 %</i>	Tier 1	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 % (bimatoprost)	Tier 2	QL (2.5 ML per 25 days)
<i>travoprost ophthalmic (eye) drops 0.004 %</i>	Tier 1	QL (2.5 ML per 25 days)
VYZULTA OPHTHALMIC (EYE) DROPS 0.024 % (latanoprostene bunod)	Tier 3	ST: Must meet 3 of the following requirements: Bimatoprost, Latanoprost, Latanoprost/pf, Lumigan, Travatan Z, or Travoprost (benzalkonium), or Travoprost in 365 days; QL (2.5 ML per 25 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XELPROS OPHTHALMIC (EYE) DROPS, EMULSION 0.005 % (latanoprost)	Tier 3	ST: Must meet 3 of the following requirements: Bimatoprost, Latanoprost, Latanoprost/pf, Lumigan, Travatan Z, or Travoprost (benzalkonium), or Travoprost in 365 days; QL (2.5 ML per 25 days)
ZIOPTAN (PF) OPHTHALMIC (EYE) DROPPERETTE 0.0015 % (tafluprost/PF)	Tier 3	ST: Must meet 3 of the following requirements: Bimatoprost, Latanoprost, Latanoprost/pf, Lumigan, Travatan Z, or Travoprost (benzalkonium), or Travoprost in 365 days; QL (1 EA per 1 day)
Ophthalmic-Intraocular Pressure Reducing Agents, Rho Kinase Inhibitors - Drugs For Glaucoma		
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 % (netarsudil mesylate)	Tier 3	ST: Must meet 2 of the following requirements: Alphagan P, Brinzolamide, Combigan, Latanoprost, Lumigan, Simbrinza, or Travoprost in 365 days; QL (2.5 ML per 30 days)
Otic (Ear) - Drugs For The Ear		
Otic (Ear) - Anti-Infective-Glucocorticoid Combinations - Anti-Infective/Anti-Inflammatories		
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 % (ciprofloxacin HCl/hydrocortisone)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	Tier 1	
CORTISPORIN-TC OTIC (EAR) DROPS,SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin sulf/colistin sul/hydrocortisone ac/thonzonium brom)	Tier 3	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	Tier 1	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	Tier 1	
Otic (Ear) - Anti-Infectives Other - Antibiotics		
<i>acetic acid otic (ear) solution 2 %</i>	Tier 1	
Otic (Ear) - Fluoroquinolones - Antibiotics		
<i>ciprofloxacin hcl otic (ear) dropperette 0.2 %</i>	Tier 1	
<i>ofloxacin otic (ear) drops 0.3 %</i>	Tier 1	
OTIPRIO INTRATYMPANIC SUSPENSION 6 % (6 MG/0.1 ML) (ciprofloxacin)	Tier 3	
Otic (Ear) - Glucocorticoids - Anti-Infective/Anti-Inflammatories		
<i>fluocinolone acetone oil otic (ear) drops 0.01 %</i>	Tier 1	
<i>hydrocortisone-acetic acid otic (ear) drops 1-2 %</i>	Tier 1	
Otic (Ear) - Pinna Combinations - Antibiotics		
CORTANE-B TOPICAL LOTION 1-1-0.1 % (hydrocortisone/pramoxine HCl/chloroxylonol)	Tier 3	
Respiratory Therapy Agents - Drugs For The Lungs		
1st Generation Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
phenylephrine HCl/promethazine HCl (Promethazine Vc Oral Syrup 6.25-5 Mg/5 Ml)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5 ml</i>	Tier 1	
1St Generation Antihistamine-Decongestant-Anticholinergic Combinations - Drugs For Cough And Cold		
RESPA-AR ORAL TABLET EXTENDED RELEASE 12 HR 8-90-0.24 MG (pseudoephedrine HCl/chlorpheniramine maleate/bellad alk)	Tier 1	
2Nd Generation Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
CLARINEX-D 12 HOUR ORAL TABLET, ER MULTIPHASE 12 HR 2.5-120 MG (desloratadine/pseudoephedrine sulfate)	Tier 3	ST: Must meet the following requirement: Desloratadine or Levocetirizine tablets in 120 days; QL (2 EA per 1 day)
<i>fexofenadine-pseudoephedrine oral tablet extended release 24 hr 180-240 mg</i>	Tier 1	
Antihistamine - 1St Generation - Alkylamines - Drugs For Allergies		
<i>dexchlorpheniramine maleate oral solution 2 mg/5 ml</i>	Tier 1	QL (236 ML per 1 FILL)
Antihistamine - 1St Generation - Ethanolamines - Drugs For Allergies		
<i>carbinoxamine maleate oral liquid 4 mg/5 ml</i>	Tier 1	Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 6 mg</i>	Tier 1	ST: Must meet the following requirements: Carbinoxamine tablet (4mg) and solution (4mg/5mL) in 365 days; QL (4 EA per 1 day); Age (Min 2 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clemastine oral syrup 0.5 mg/5 ml</i>	Tier 1	
<i>clemastine oral tablet 2.68 mg</i>	Tier 1	
diphenhydramine HCl (Diphen Oral Elixir 12.5 Mg/5 Ml)	Tier 1	
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML (carbinoxamine maleate)	Tier 3	ST: Must meet the following requirement: Carbinoxamine Maleate in 120 days; QL (960 ML per 30 days); Age (Min 2 Years)
Antihistamine - 1St Generation - Phenothiazines - Drugs For Allergies		
<i>promethazine injection solution 25 mg/ml, 50 mg/ml</i>	Tier 1	
<i>promethazine injection syringe 25 mg/ml</i>	Tier 1	
<i>promethazine oral syrup 6.25 mg/5 ml</i>	Tier 1	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg, 50 Mg)	Tier 1	
Antihistamine - 1St Generation - Piperidines - Drugs For Allergies		
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	Tier 1	
<i>cyproheptadine oral tablet 4 mg</i>	Tier 1	
Antihistamines - 1St Generation - Drugs For Allergies		
<i>carbinoxamine maleate oral liquid 4 mg/5 ml</i>	Tier 1	Age (Min 2 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbinoxamine maleate oral tablet 6 mg</i>	Tier 1	ST: Must meet the following requirements: Carbinoxamine tablet (4mg) and solution (4mg/5mL) in 365 days; QL (4 EA per 1 day); Age (Min 2 Years)
<i>clemastine oral syrup 0.5 mg/5 ml</i>	Tier 1	
<i>clemastine oral tablet 2.68 mg</i>	Tier 1	
<i>dexchlorpheniramine maleate oral solution 2 mg/5 ml</i>	Tier 1	QL (236 ML per 1 FILL)
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML (carbinoxamine maleate)	Tier 3	ST: Must meet the following requirement: Carbinoxamine Maleate in 120 days; QL (960 ML per 30 days); Age (Min 2 Years)
<i>promethazine rectal suppository 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 25 Mg)	Tier 1	
Antihistamines - 2Nd Generation - Drugs For Allergies		
<i>cetirizine oral solution 1 mg/ml</i>	Tier 1	
<i>desloratadine oral tablet 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>desloratadine oral tablet,disintegrating 2.5 mg, 5 mg</i>	Tier 1	ST: Must meet the following requirement: Desloratadine or Levocetirizine tablets in 120 days; QL (1 EA per 1 day)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levocetirizine oral solution 2.5 mg/5 ml</i>	Tier 1	ST: Must meet the following requirement: Desloratadine or Levocetirizine tablets in 120 days; QL (10 ML per 1 day)
<i>levocetirizine oral tablet 5 mg</i>	Tier 1	
Antitussives - Non-Opioid - Drugs For Allergies		
<i>benzonatate oral capsule 100 mg, 150 mg, 200 mg</i>	Tier 1	
Asthma Therapy - 5-Lipoxygenase Inhibitors - Drugs For Asthma/Copd		
<i>zileuton oral tablet, er multiphase 12 hr 600 mg</i>	Tier 1	ST: Must meet the following requirement: Montelukast Sodium and Zafirlukast in 365 days; QL (2 EA per 1 day)
ZYFLO ORAL TABLET 600 MG (zileuton)	Tier 3	ST: Must meet the following requirement: Montelukast Sodium and Zafirlukast in 365 days; QL (4 EA per 1 day)
Asthma Therapy - Alpha/Beta Adrenergic Agents - Drugs For Asthma/Copd		
<i>epinephrine injection syringe 0.1 mg/ml</i>	Tier 1	
Asthma Therapy - Inhaled Corticosteroids (Glucocorticoids) - Drugs For Asthma/Copd		
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION (ciclesonide)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (12.2 GM per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARMONAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG/ACTUATION, 232 MCG/ACTUATION, 55 MCG/ACTUATION (fluticasone propionate)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (1 EA per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION (fluticasone furoate)	Tier 2	QL (30 EA per 30 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION (mometasone furoate)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60) (mometasone furoate)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (1 EA per 30 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	Tier 1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	Tier 1	QL (60 ML per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION (fluticasone propionate)	Tier 2	QL (60 EA per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION (fluticasone propionate)	Tier 2	QL (120 EA per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION (fluticasone propionate)	Tier 2	QL (12 GM per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION (fluticasone propionate)	Tier 2	QL (24 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION (fluticasone propionate)	Tier 2	QL (21.2 GM per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION, 90 MCG/ACTUATION (budesonide)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (1 EA per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION, 80 MCG/ACTUATION (beclomethasone dipropionate)	Tier 3	ST: Must meet 2 of the following requirements: Arnuity Ellipta, Flovent Diskus, or Flovent HFA in 365 days; QL (21.2 GM per 30 days)
Asthma Therapy - Interleukin-5 (Il-5) Receptor Alpha Antagonists, Mab - Drugs For Asthma/Copd		
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML (benralizumab)	Tier 4	PA
Asthma Therapy - Leukotriene Receptor Antagonists - Drugs For Asthma/Copd		
<i>montelukast oral granules in packet 4 mg</i>	Tier 1	
<i>montelukast oral tablet 10 mg</i>	Tier 1	
<i>montelukast oral tablet, chewable 4 mg, 5 mg</i>	Tier 1	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	Tier 1	
Asthma Therapy - Mast Cell Stabilizers - Drugs For Asthma/Copd		
<i>cromolyn inhalation solution for nebulization 20 mg/2 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma Therapy - Monoclonal Antibodies To Immunoglobulin E (Ige) - Drugs For Asthma/Copd		
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML (omalizumab)	Tier 4	PA
Asthma Therapy - Xanthines - Drugs For Asthma/Copd		
theophylline anhydrous (Elixophyllin Oral Elixir 80 Mg/15 ML)	Tier 1	
THEO-24 ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG (theophylline anhydrous)	Tier 2	
THEOCHRON ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 200 MG, 300 MG (theophylline anhydrous)	Tier 1	
<i>theophylline oral elixir 80 mg/15 ml</i>	Tier 1	
<i>theophylline oral solution 80 mg/15 ml</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	Tier 1	
Asthma Therapy- Monoclonal Antibody - Interleukin-5 (IL-5) Antagonists - Drugs For Asthma/Copd		
NUCALA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML (mepolizumab)	Tier 4	PA
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML (mepolizumab)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma/Copd - Phosphodiesterase-4 (Pde4) Inhibitors - Drugs For Asthma/Copd		
DALIRESP ORAL TABLET 250 MCG, 500 MCG (roflumilast)	Tier 2	ST: Must meet any of the following requirements: Breo Ellipta, Fluticasone Propionate/salmeterol, Serevent Diskus, Spiriva Respimat, or Spiriva in 120 days; QL (1 EA per 1 day)
Asthma/Copd - Anticholinergic Agents, Inhaled Long Acting - Drugs For Asthma/Copd		
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION (umeclidinium bromide)	Tier 3	ST: Must meet any of the following requirements: Spiriva Respimat or Spiriva in 120 days; QL (30 EA per 30 days)
LONHALA MAGNAIR REFILL INHALATION SOLUTION FOR NEBULIZATION 25 MCG/ML (glycopyrrolate/nebulizer accessories)	Tier 3	QL (60 ML per 30 days)
LONHALA MAGNAIR STARTER INHALATION SOLUTION FOR NEBULIZATION 25 MCG/ML (glycopyrrolate/nebulizer and accessories)	Tier 3	QL (60 ML per 30 days)
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION (tiotropium bromide)	Tier 2	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG (tiotropium bromide)	Tier 2	QL (30 EA per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACTUATION (aclidinium bromide)	Tier 3	ST: Must meet any of the following requirements: Spiriva Respimat or Spiriva in 120 days; QL (1 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML (revefenacin)	Tier 3	ST: Must meet the following requirement: Lonhala Magnair in 120 days; QL (90 ML per 30 days)
Asthma/Copd - Anticholinergic Agents, Inhaled Short Acting - Drugs For Asthma/Copd		
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION (ipratropium bromide)	Tier 2	QL (25.8 GM per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	Tier 1	
Asthma/Copd - Beta 2-Adrenergic Agents, Inhaled, Ultra-Long Acting - Drugs For Asthma/Copd		
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION (olodaterol HCl)	Tier 2	QL (4 GM per 30 days)
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Long Acting - Drugs For Asthma/Copd		
<i>arformoterol inhalation solution for nebulization 15 mcg/2 ml</i>	Tier 1	ST: Must meet any of the following requirements: Formoterol Fumarate, Serevent Diskus, or Striverdi Respimat in 120 days; QL (120 ML per 30 days)
<i>formoterol fumarate inhalation solution for nebulization 20 mcg/2 ml</i>	Tier 1	QL (120 ML per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE (salmeterol xinafoate)	Tier 2	QL (60 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting - Drugs For Asthma/Copd		
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	Tier 1	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml</i>	Tier 1	
<i>albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 ml</i>	Tier 1	
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml</i>	Tier 1	
<i>levalbuterol tartrate inhalation hfa aerosol inhaler 45 mcg/actuation</i>	Tier 1	
PROAIR DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 90 MCG/ACTUATION (albuterol sulfate)	Tier 3	ST: Must meet the following requirement: Generic Albuterol Sulfate 90mcg HFA inhaler in 120 days
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION (albuterol sulfate)	Tier 3	ST: Must meet the following requirement: Generic Albuterol Sulfate 90mcg HFA inhaler in 120 days
Asthma/Copd Therapy - Beta Adrenergic Agents - Drugs For Asthma/Copd		
<i>albuterol sulfate oral syrup 2 mg/5 ml</i>	Tier 1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	Tier 1	
<i>albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg</i>	Tier 1	
<i>metaproterenol oral syrup 10 mg/5 ml</i>	Tier 1	
<i>terbutaline oral tablet 2.5 mg, 5 mg</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma/Copd Therapy - Beta Adrenergic-Anticholinergic Combinations - Drugs For Asthma/Copd		
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION (umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG (glycopyrrolate/formoterol fumarate)	Tier 3	ST: Must meet the following requirement: Anoro Ellipta and Stiolto Respimat in 365 days; QL (10.7 GM per 30 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION (ipratropium bromide/albuterol sulfate)	Tier 2	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION (aclidinium bromide/formoterol fumarate)	Tier 3	ST: Must meet the following requirement: Anoro Ellipta and Stiolto Respimat in 365 days; QL (1 EA per 30 days)
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	Tier 1	
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION (tiotropium bromide/olodaterol HCl)	Tier 2	QL (4 GM per 30 days)
Asthma/Copd Therapy - Beta Adrenergic-Glucocorticoid Combinations - Drugs For Asthma/Copd		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (fluticasone propionate/salmeterol xinafoate)	Tier 1	QL (60 EA per 30 days)
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION (fluticasone propionate/salmeterol xinafoate)	Tier 2	QL (12 GM per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIRDUO DIGIHALER INHALATION AERO POWDR BREATH ACT W/SENSOR 113 MCG-14 MCG/ACTUATION, 232-14 MCG/ACTUATION, 55-14 MCG/ACTUATION (fluticasone propionate/salmeterol xinafoate)	Tier 3	ST: Must meet any of the following requirements: Advair HFA, Breo Ellipta, Budesonide/Formoterol Fumarate, or Fluticasone Propionate/Salmeterol in 120 days; QL (1 EA per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE (fluticasone furoate/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION (mometasone furoate/formoterol fumarate)	Tier 3	ST: Must meet any of the following requirements: Advair HFA, Breo Ellipta, Budesonide/Formoterol Fumarate, or Fluticasone Propionate/Salmeterol in 120 days; QL (39 GM per 30 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION (mometasone furoate/formoterol fumarate)	Tier 3	ST: Must meet any of the following requirements: Advair HFA, Breo Ellipta, Budesonide/Formoterol Fumarate, or Fluticasone Propionate/Salmeterol in 120 days; QL (13 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	Tier 3	ST: Must meet any of the following requirements: Advair HFA, Breo Ellipta, Budesonide/Formoterol Fumarate, or Fluticasone Propionate/Salmeterol in 120 days; QL (1 EA per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION (budesonide/formoterol fumarate)	Tier 2	QL (30.6 GM per 30 days)
Asthma/Copd Tx - Beta-Adrenergic-Anticholinergic-Glucocorticoid Comb, - Drugs For Cystic Fibrosis		
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION (budesonide/glycopyrrolate/formoterol fumarate)	Tier 2	QL (10.7 GM per 30 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG (fluticasone furoate/umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG (fluticasone furoate/umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (2 EA per 1 day)
Corticosteroid Implant For Maintaining Sinus Patency - Drugs For The Nose		
SINUVA SINUS IMPLANT 1,350 MCG (mometasone furoate)	Tier 3	
Cystic Fibrosis - Inhaled Aminoglycosides - Drugs For Cystic Fibrosis		
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG (tobramycin)	Tier 2	PA
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml</i>	Tier 1	PA
<i>tobramycin inhalation solution for nebulization 300 mg/4 ml</i>	Tier 4	PA
<i>tobramycin with nebulizer inhalation solution for nebulization 300 mg/5 ml</i>	Tier 1	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cystic Fibrosis - Inhaled Monobactams - Drugs For Cystic Fibrosis		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML (aztreonam lysine)	Tier 2	PA
Cystic Fibrosis - Inhaled Osmotic Agents - Drugs For Cystic Fibrosis		
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE 40 MG (mannitol)	Tier 4	ST: Must meet the following requirement: Inhaled 7% Sodium Chloride solution in 120 days; QL (20 EA per 1 day); Age (Min 18 Years)
Cystic Fibrosis-Transmembrane Conductance Regulator (Cftr) Potentiator - Drugs For Cystic Fibrosis		
KALYDECO ORAL GRANULES IN PACKET 25 MG, 50 MG, 75 MG (ivacaftor)	Tier 4	PA
KALYDECO ORAL TABLET 150 MG (ivacaftor)	Tier 4	PA
Cystic Fib-Transmemb Conduct. Reg.(Cftr) Potentiator And Corrector Cmb - Drugs For Cystic Fibrosis		
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG (lumacaftor/ivacaftor)	Tier 4	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (lumacaftor/ivacaftor)	Tier 4	PA
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N) (tezacaftor/ivacaftor)	Tier 4	PA
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N) (elexacaftor/tezacaftor/ivacaftor)	Tier 4	PA

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Elastase Inhibitors - Drugs For Asthma/Copd		
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, 500 MG (alpha-1-proteinase inhibitor)	Tier 4	
PROLASTIN-C INTRAVENOUS RECON SOLN 1,000 MG (alpha-1-proteinase inhibitor)	Tier 4	
PROLASTIN-C INTRAVENOUS SOLUTION 1,000 MG (+/-)/20 ML (alpha-1-proteinase inhibitor)	Tier 4	
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG (alpha-1-proteinase inhibitor)	Tier 4	
Lung Surfactants - Drugs For The Lungs		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5 ML, 240 MG/3 ML (poractant alfa)	Tier 3	
INFASURF INTRATRACHEAL SUSPENSION 35 MG/ML (calfactant)	Tier 3	
SURVANTA INTRATRACHEAL SUSPENSION 25 MG/ML (beractant)	Tier 3	
Mucolytics - Drugs For The Lungs		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	Tier 1	
PULMOZYME INHALATION SOLUTION 1 MG/ML (dornase alfa)	Tier 4	PA
Nasal Anesthetics - Allergy		
<i>cocaine nasal solution 4 %</i>	Tier 1	
NUMBRINO NASAL SOLUTION 4 % (cocaine HCl)	Tier 1	
Nasal Anticholinergics - Allergy		
<i>ipratropium bromide nasal spray, non-aerosol 21 mcg (0.03 %), 42 mcg (0.06 %)</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nasal Antihistamine And Anti-Inflammatory Steroid Combinations - Allergy		
<i>azelastine-fluticasone nasal spray,non-aerosol 137-50 mcg/spray</i>	Tier 1	ST: Must meet the following requirement: Flunisolide (nasal formulation) or Fluticasone Propionate in 365 days; QL (23 GM per 30 days)
TICALAST NASAL KIT,SPRAY SUSPENSION AND SPRAY 137 MCG-50 MCG- 0.9 % (azelastine/fluticasone/sodium chloride/sodium bicarbonate)	Tier 3	
Nasal Antihistamines - Allergy		
<i>azelastine nasal aerosol,spray 137 mcg (0.1 %)</i>	Tier 1	QL (60 ML per 30 days)
<i>azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)</i>	Tier 1	QL (60 ML per 30 days)
<i>olopatadine nasal spray,non-aerosol 0.6 %</i>	Tier 1	QL (30.5 GM per 30 days)
Nasal Corticosteroids - Allergy		
BECONASE AQ NASAL SPRAY,NON-AEROSOL 42 MCG (0.042 %) (beclomethasone dipropionate)	Tier 3	ST: Must meet the following requirement: Flunisolide or Fluticasone Propionate in 120 days; QL (25 GM per 30 days)
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	Tier 1	QL (25 ML per 30 days)
<i>fluticasone propionate nasal spray,suspension 50 mcg/actuation</i>	Tier 1	QL (16 GM per 30 days)
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	Tier 1	QL (17 GM per 30 days)
OMNARIS NASAL SPRAY,NON-AEROSOL 50 MCG (ciclesonide)	Tier 3	ST: Must meet the following requirement: Flunisolide or Fluticasone Propionate in 120 days; QL (5 GM per 12 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION (beclomethasone dipropionate)	Tier 2	ST: Must meet any of the following requirements: Flunisolide, Fluticasone Propionate, or Qnasl in 120 days; QL (6.8 GM per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION (beclomethasone dipropionate)	Tier 2	ST: Must meet any of the following requirements: Flunisolide, Fluticasone Propionate, or Qnasl Children in 120 days; QL (10.6 GM per 30 days)
TICANASE NASAL KIT, SPRAY SUSPENSION AND SPRAY 50 MCG- 0.9 % (fluticasone propionate/sodium chloride/sodium bicarbonate)	Tier 3	
TICASPRAY NASAL KIT, SPRAY SUSPENSION AND SPRAY 50 MCG- 0.9 % (fluticasone propionate/sodium chloride/sodium bicarbonate)	Tier 3	
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION (fluticasone propionate)	Tier 2	ST: Must meet any of the following requirements: Flunisolide, Fluticasone Propionate, or Mometasone Furoate in 120 days; QL (32 ML per 30 days)
ZETONNA NASAL HFA AEROSOL INHALER 37 MCG/ACTUATION (ciclesonide)	Tier 3	ST: Must meet the following requirement: Flunisolide or Fluticasone Propionate in 120 days; QL (6.1 GM per 30 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nasal Post-Surgical Agents - Drugs For The Nose		
SINUVA SINUS IMPLANT 1,350 MCG (mometasone furoate)	Tier 3	
Nasal Preparations Other - Drugs For The Nose		
ALZAIR NASAL SPRAY, NON-AEROSOL (hypromellose)	Tier 3	
Nasal Sympathomimetic Decongestants (Intranasal) - Allergy		
<i>epinephrine hcl nasal solution 1 mg/ml</i>	Tier 1	
TYZINE NASAL DROPS 0.1 % (tetrahydrozoline HCl)	Tier 3	
TYZINE NASAL SPRAY, NON-AEROSOL 0.1 % (tetrahydrozoline HCl)	Tier 3	
Nasal Wash Combinations - Allergy		
ALKALOL NASAL WASH NASAL SOLUTION (menthol/eucal/thymol/camphor/benz/sod chloride/pot chlorate)	Tier 3	
Non-Opioid Antitussive-1st Gen. Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
brompheniramine maleate/pseudoephedrine HCl/dextromethorphan (Bromfed Dm Oral Syrup 2-30-10 Mg/5 ml)	Tier 1	
<i>brompheniramine-pseudoeph-dm oral syrup 2-30-10 mg/5 ml</i>	Tier 1	
Non-Opioid Antitussive-Antihistamine Combinations - Drugs For Cough And Cold		
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Opioid Antitussive-1st Generation Antihistamine Combinations - Drugs For Cough And Cold		
<i>hydrocodone-chlorpheniramine oral suspension, extended rel 12 hr 10-8 mg/5 ml</i>	Tier 1	QL (10 ML per 1 day); Age (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	Tier 3	QL (30 ML per 1 day); Age (Min 18 Years)
TUSSICAPS ORAL CAPSULE, EXTENDED RELEASE 12 HR 10-8 MG (hydrocodone polistirex/chlorpheniramine polistirex)	Tier 3	QL (2 EA per 1 day); Age (Min 18 Years)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HR 8-54.3 MG (chlorpheniramine maleate/codeine phosphate)	Tier 3	ST: Must meet the following requirement: Promethazine HCL/codeine in 120 days; QL (2 EA per 1 day); Age (Min 18 Years)
TUZISTRA XR ORAL SUSPENSION, EXTENDED REL 12 HR 14.7-2.8 MG/5 ML (codeine polistirex/chlorpheniramine polistirex)	Tier 3	ST: Must meet 2 of the following requirements: Montelukast Sodium, Promethazine HCL/codeine, or Zafirlukast in 365 days; QL (200 ML per 10 days); Age (Min 18 Years)
Z-TUSS AC ORAL LIQUID 2-9 MG/5 ML (chlorpheniramine maleate/codeine phosphate)	Tier 3	Age (Min 12 Years)
Opioid Antitussive-1st Generation Antihistamine-Decongestant Comb. - Drugs For Cough And Cold		
CAPCOF ORAL LIQUID 2-5-10 MG/5 ML (chlorpheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
HISTEX-AC ORAL SYRUP 2.5-10-10 MG/5 ML (triprolidine HCl/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAR-COF BP ORAL LIQUID 2-30-7.5 MG/5 ML (brompheniramine maleate/pseudoephedrine HCl/codeine phosphat)	Tier 1	Age (Min 12 Years)
MAXI-TUSS CD ORAL LIQUID 4-10-10 MG/5 ML (chlorpheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
M-END PE ORAL LIQUID 1.33-3.33-6.33 MG/5 ML (brompheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
POLY-TUSSIN AC ORAL LIQUID 4-10-10 MG/5 ML (brompheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
promethazine/phenylephrine HCl/codeine (Promethazine Vc-Codeine Oral Syrup 6.25-5-10 Mg/5 MI)	Tier 1	QL (30 ML per 1 day); Age (Min 18 Years)
<i>promethazine-phenyleph-codeine oral syrup 6.25-5-10 mg/5 ml</i>	Tier 1	QL (30 ML per 1 day); Age (Min 18 Years)
RYDEX ORAL LIQUID 1.3-10-6.3 MG/5 ML (brompheniramine maleate/pseudoephedrine HCl/codeine phosphat)	Tier 1	Age (Min 12 Years)
Opioid Antitussive-Anticholinergic Combinations - Drugs For Cough And Cold		
<i>hydrocodone-homatropine oral syrup 5-1.5 mg/5 ml</i>	Tier 3	QL (30 ML per 1 day); Age (Min 18 Years)
<i>hydrocodone-homatropine oral tablet 5-1.5 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 18 Years)
hydrocodone bitartrate/homatropine methylbromide (Hydromet Oral Syrup 5-1.5 Mg/5 MI)	Tier 3	QL (30 ML per 1 day); Age (Min 18 Years)
Opioid Antitussive-Decongestant-Expectorant Combinations - Drugs For Cough And Cold		
CODITUSSIN DAC ORAL LIQUID 30-10-200 MG/5 ML (pseudoephedrine HCl/codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML (pseudoephedrine HCl/codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
VIRTUSSIN DAC ORAL SYRUP 30-10-100 MG/5 ML (pseudoephedrine HCl/codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
Opioid Antitussive-Expectorant Combinations - Drugs For Cough And Cold		
<i>codeine-guaifenesin oral liquid 10-100 mg/5 ml</i>	Tier 1	Age (Min 12 Years)
CODITUSSIN AC ORAL LIQUID 10-200 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
G TUSSIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
GUAIATUSSIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
GUAIFENESIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
MAR-COF CG ORAL LIQUID 7.5-225 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
MAXI-TUSS AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
M-CLEAR WC ORAL LIQUID 6.3-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
NINJACOF-XG ORAL LIQUID 8-200 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
OBREDON ORAL SOLUTION 2.5-200 MG/5 ML (hydrocodone bitartrate/guaifenesin)	Tier 3	ST: Must meet the following requirement: Hydrocodone Homatropine Methylbromide in 120 days; QL (600 ML per 10 days); Age (Min 18 Years)
VIRTUSSIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pulmonary Fibrosis Treatment Agents - Antifibrotic Therapy - Drugs For The Lungs		
ESBRIET ORAL CAPSULE 267 MG (pirfenidone)	Tier 4	PA
ESBRIET ORAL TABLET 267 MG, 801 MG (pirfenidone)	Tier 4	PA
Pulmonary Fibrosis Treatment Agents - Multikinase Inhibitors - Drugs For The Lungs		
OFEV ORAL CAPSULE 100 MG, 150 MG (nintedanib esylate)	Tier 4	PA
Vaginal Products - Drugs For Women		
Vaginal Antibacterial - Lincosamides - Drugs For Infections		
CLEOCIN VAGINAL SUPPOSITORY 100 MG (clindamycin phosphate)	Tier 3	ST: Must meet 2 of the following requirements: Clindamycin HCL, Clindamycin Palmitate HCL, Clindamycin Phosphate, Metronidazole, Tinidazole, or Vandazole in 365 days; QL (3 EA per 30 days)
<i>clindamycin phosphate vaginal cream 2 %</i>	Tier 1	
CLINDESSE VAGINAL CREAM,EXTENDED RELEASE 2 % (clindamycin phosphate)	Tier 3	
Vaginal Antifungal - Imidazoles - Drugs For Infections		
GYNAZOLE-1 VAGINAL CREAM 2 % (butoconazole nitrate)	Tier 2	
MICONAZOLE-3 VAGINAL SUPPOSITORY 200 MG (miconazole nitrate)	Tier 1	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaginal Antifungal - Triazoles - Drugs For Infections		
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	Tier 1	
<i>terconazole vaginal suppository 80 mg</i>	Tier 1	
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives - Drugs For Infections		
<i>metronidazole vaginal gel 0.75 %</i>	Tier 1	
NUVESSA VAGINAL GEL 1.3 % (metronidazole)	Tier 3	
VANDAZOLE VAGINAL GEL 0.75 % (metronidazole)	Tier 2	
Vaginal Antiseptic Mixtures - Drugs For Infections		
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid/oxyquinoline sulfate)	Tier 3	
RELAGARD VAGINAL GEL 0.9-0.025 % (acetic acid/oxyquinoline sulfate)	Tier 3	
TRIMO-SAN JELLY VAGINAL GEL 0.025-0.01 % (oxyquinoline sulfate/sodium lauryl sulfate)	Tier 3	
Vaginal Estrogens - Drugs For Women		
<i>estradiol vaginal cream 0.01 % (0.1 mg/gram)</i>	Tier 1	
<i>estradiol vaginal tablet 10 mcg</i>	Tier 1	
ESTRING VAGINAL RING 2 MG (7.5 MCG /24 HOUR) (estradiol)	Tier 2	QL (1 EA per 90 days)
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR (estradiol acetate)	Tier 3	ST: Must meet any of the following requirements: Estring, Intrarosa, Osphena, or Premarin in 120 days; QL (1 EA per 84 days)

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMARIN VAGINAL CREAM 0.625 MG/GRAM (estrogens, conjugated)	Tier 2	
estradiol (Yuvaferm Vaginal Tablet 10 Mcg)	Tier 1	
Vaginal Progestins - Drugs For Women		
CRINONE VAGINAL GEL 4 % (progesterone, micronized)	Tier 3	

Tier 0 = Preventive Drugs required under the Affordable Care Act at no cost

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs

Tier 3 = Non-Preferred Generic and Brand Name Drugs | Tier 4 = Specialty Drugs

DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 11/01/2021

Index of Drugs

- 1ST TIER UNIFINE
PENTIPS..... 467
1ST TIER UNIFINE
PENTIPS PLUS..... 467
1ST TIER UNILET
COMFORTOUCH..... 434
2-IN-1 LANCET DEVICE
..... 434, 527
2TEK CONTROL (HIGH-
NORMAL)..... 434
2TEK GLUCOSE/BLOOD
PRESSURE..... 434
A-25 (VIT A PALMITATE).... 323
abacavir..... 57
abacavir-lamivudine..... 59
abacavir-lamivudine-
zidovudine..... 59
ABC COMPLETE SENIOR
WOMEN'S..... 299
ABILIFY MYCITE..... 166, 173
ABILIFY MYCITE
MAINTENANCE KIT.... 165, 173
ABILIFY MYCITE STARTER
KIT..... 166, 173
abiraterone..... 80
ABLYSINOL..... 132
ABOUTTIME PEN NEEDLE
..... 467, 527
ABSORICA..... 218
ABSORICA LD..... 218
acamprosate..... 195
acarbose..... 331
ACCRUFER..... 295
ACCUCAINE KIT..... 44, 270
ACCU-CHEK AVIVA
CONTROL SOLN..... 434, 527
ACCU-CHEK AVIVA PLUS
METER..... 434
ACCU-CHEK AVIVA PLUS
TEST STRP..... 421
ACCU-CHEK COMBO
SYSTEM..... 526, 528
ACCU-CHEK COMPACT
PLUS CARE..... 434, 528
ACCU-CHEK FASTCLIX
LANCET DRUM..... 434, 528
ACCU-CHEK FASTCLIX
LANCING DEV..... 434, 528
ACCU-CHEK GUIDE
GLUCOSE METER..... 434
ACCU-CHEK GUIDE L1-L2
CTRL SOL..... 434
ACCU-CHEK GUIDE ME
GLUCOSE MTR..... 434, 528
ACCU-CHEK GUIDE TEST
STRIPS..... 421
ACCU-CHEK LINKASSIST
INS DEV..... 511
ACCU-CHEK MULTICLIX
LANCET..... 434, 528
ACCU-CHEK RAPID-D LINK
..... 523, 528
ACCU-CHEK SAFE-T-PRO 434
ACCU-CHEK SAFE-T-PRO
PLUS..... 434, 528
ACCU-CHEK SMARTVIEW
CONTRL SOL..... 435, 528
ACCU-CHEK SMARTVIEW
TEST STRIP..... 421
ACCU-CHEK SOFT DEV
LANCETS..... 435, 528
ACCU-CHEK SOFTCLIX
LANCETS..... 435
ACCU-CHEK SPIRIT
ADAPTER..... 511, 528
ACCU-CHEK SPIRIT
CARTRIDGE SYS..... 511, 528
ACCU-CHEK SPIRIT CLIP
CASE..... 490, 511, 528
Accutane..... 218
ACCUTREND GLUCOSE
CONTROL..... 435, 528
ACCUTREND GLUCOSE
TEST STRIPS..... 421
ACD SOLUTION A..... 399
ACD-A..... 399
ACE AEROSOL CLOUD
ENHANCER..... 513, 528
acebutolol..... 125
ACESO AG..... 285
acetaminophen-caff-
dihydrocod..... 22, 23
acetaminophen-codeine..... 22
acetazolamide..... 130
acetic acid..... 391, 632
acetone..... 198
acetylcysteine..... 647
acidophilus-pectin, citrus..... 380
ACIOXIAY..... 220
ACIPHEX SPRINKLE..... 370
acitretin..... 241
ACTEMRA..... 35
ACTEMRA ACTPEN..... 34
ACTHAR..... 329
ACTICOAT 7 DRESSING.... 285
ACTICOAT DRESSING..... 285
ACTICOAT FLEX 3
DRESSING..... 285
ACTICOAT FLEX 7
DRESSING..... 285
ACTICOAT SURGICAL
DRESSING..... 285
ACTI-LANCE LANCETS..... 435
ACTIMMUNE..... 53
activated charcoal..... 373
ACTIVE-PAC..... 141, 190
ACUICYN..... 252
ACUVAIL (PF)..... 621
acyclovir..... 65, 66, 245
ACYCLOVIX..... 66
ADACEL(TDAP
ADOLESN/ADULT)(PF)..... 103
ADAINZDE..... 226
ADAINZOXIA..... 227
adapalene..... 228
adapalene-benzoyl peroxide 227
ADASUVE..... 164
ADAZIN..... 269
ADDERALL XR..... 166, 174
adefovir..... 64
ADEMPAS..... 135
adenovirus vac live type-4, 7
..... 102, 105
adenovirus vaccine live type-
4..... 102, 105
adenovirus vaccine live type-
7..... 102, 105
ADHANSIA XR..... 167
ADJUSTABLE LANCING
DEVICE..... 435
ADLYXIN..... 336
ADMELOG SOLOSTAR U-
100 INSULIN..... 355
ADMELOG U-100 INSULIN
LISPRO..... 356

ADULT 50 PLUS EYE HEALTH..... 10, 299	ADVOCATE SYRINGES 467, 468, 529	AFREZZA..... 351
ADULT ASPIRIN REGIMEN..43	ADVOCATE TEST STRIPS 421, 529	AFSTYLA.....403
ADULT LOW DOSE ASPIRIN..... 43, 413	ADYNOVATE..... 403	AFTER PILL..... 216, 217
ADULT MULTIVITAMIN GUMMIES..... 299	ADZENYS ER.....167, 174	AFTERA..... 216, 217
ADULTS 50 PLUS..... 299	ADZENYS XR-ODT 167, 175	AGAMATRIX AMP GLUC MONITOR SYS..... 436, 530
ADULTS MULTIVITAMIN... 299	AEMCOLO.....71	AGAMATRIX AMP TEST STRIPS.....421, 530
ADVAIR DISKUS.....643	AEROBIKA OSCILLATING PEP SYSTM..... 513, 530	AGAMATRIX CONTROL HIGH.....436, 530
ADVAIR HFA.....643	AEROCHAMBER MINI 513, 530	AGAMATRIX CONTROL NORM-HI.....436, 530
ADVANCE PLUS INTERMITTENT..... 524, 529	AEROCHAMBER MV.. 513, 530	AGAMATRIX CONTROL SOLN-LEVEL 2..... 436, 530
ADVANCED ALLERGY COLLECT KIT..... 252	AEROCHAMBER PLUS FLOW-VU..... 513	AGAMATRIX CONTROL SOLN-LEVEL 4..... 436, 531
ADVANCED GLUC METER TEST STRIP.....421	AEROCHAMBER PLUS FLOW-VU,L MSK..... 513	AGAMATRIX PRESTO TEST STRIPS..... 421, 531
ADVANCED GLUCOSE METER..... 435	AEROCHAMBER PLUS FLOW-VU,M MSK..... 513	AIMOVIG AUTOINJECTOR 181
ADVANCED LANCING DEVICE..... 435	AEROCHAMBER PLUS FLOW-VU,S MSK.....514	AIRDUO DIGIHALER..... 644
ADVANCED PROBIOTIC 380	AEROCHAMBER PLUS Z STAT..... 514, 530	AIRS DISPOSABLE NEBULIZER..... 492, 531
ADVANCED TRAVEL LANCETS..... 435, 529	AEROCHAMBER PLUS Z STAT LG MSK.....514, 530	AIRZONE PEAK FLOW METER.....512, 531
ADVATE..... 403	AEROCHAMBER PLUS Z STAT MD MSK..... 514, 530	AJOVY AUTOINJECTOR... 181
ADVOCATE BLOOD GLUCOSE MONITOR..... 435	AEROCHAMBER PLUS Z STAT SM MSK..... 514, 530	AJOVY SYRINGE.....181
ADVOCATE CONTROL SOLUTION HIGH..... 435, 529	AEROCHAMBER PLUS Z STAT SM MSK..... 514, 530	AKLIEF..... 228
ADVOCATE DUO 429, 435, 529	AEROCHAMBER WITH FLOW SIGNAL..... 514, 530	Ak-Poly-Bac.....627
ADVOCATE LANCET.....435	AEROCHAMBER Z-STAT PLUS-FLW SG..... 514, 530	AKTEN (PF).....626
ADVOCATE LANCING DEVICE..... 435	AEROECLIPSE II NEBULIZER..... 491, 530	AKYNZEO (NETUPITANT). 367
ADVOCATE LOW CONTROL..... 435, 529	AEROGEAR ACTION ASTHMA KIT..... 512, 530	Ala-Cort..... 252
ADVOCATE PEN NEEDLE 467, 529	AERONEB GO..... 514	ALAMAX CR..... 10
ADVOCATE RAPID-SAFE LANCING.....435, 529	AERONEB GO NEBULIZER 491	ALAMAX PROTECT..... 10
ADVOCATE REDI-CODE....421	AEROTRACH PLUS...514, 530	ALA-QUIN.....234
ADVOCATE REDI-CODE GLU MONITOR..... 435, 529	AEROVENT PLUS..... 514, 530	Ala-Scalp..... 252
ADVOCATE REDI-CODE PLUS..... 421, 436	AFINITOR.....89	<i>al bendazole</i> 50
ADVOCATE REDI-CODE+ CTRL HIGH..... 436, 529	AFINITOR DISPERZ..... 88	<i>albuterol sulfate</i> 642
ADVOCATE REDI-CODE+ CTRL LOW..... 436, 529	Afirmelle.....204	Alcaine.....625
	AFLURIA QD 2021-22(3YR UP)(PF)..... 106	<i>alclometasone</i> 252
	AFLURIA QD 2021-22(6- 35MO)(PF).....106	ALCORTIN A..... 234
	AFLURIA QUAD 2021- 2022(6MO UP)..... 106	ALDACTAZIDE..... 131
		ALECENSA..... 79
		<i>alendronate</i> 340
		ALFAMINO JUNIOR.....309
		ALFERON N..... 267
		<i>alfuzosin</i> 393
		ALGAE BASED CALCIUM.. 293
		ALINIA..... 54
		<i>aliskiren</i> 135
		ALIVE WOMEN'S 50 PLUS.299

ALIVE WOMEN'S 50 PLUS (BLEND).....	299	ALPHAGAN P	630	<i>amlodipine-valsartan</i>	111
ALKALINE BATTERIES.....	436	ALPHANATE	403	<i>amlodipine-valsartan- hcthiiazid</i>	111
ALKALOL NASAL WASH....	650	ALPHANINE SD	402	<i>ammonium lactate</i>	251
ALKA-SELTZER PM (MELATONIN).....	364	<i>alprazolam</i>	136	Amnesteem	218
ALKINDI SPRINKLE	345	ALPRAZOLAM INTENSOL	136, 171	<i>amoxapine</i>	157
ALL FLOW 1000 KIT	514	ALPROLIX	402	<i>amoxicil-clarithromy- lansopraz</i>	389
ALL FLOW 1000 PFT FILTER	514	ALREX	618	<i>amoxicillin</i>	49
ALL FLOW 3000 KIT	514	ALTABAX	234	<i>amoxicillin-pot clavulanate</i>	50
ALL FLOW 3000 PFT FILTER	514	ALTACAIN	625	<i>amphetamine</i>	167, 175
ALL FLOW 4000 KIT	514	ALTAFLUOR BENOX ..	624, 625	<i>amphetamine sulfate</i>	175
ALL FLOW 4000 PFT FILTER	514	Altavera (28)	204	<i>ampicillin</i>	49
ALL FLOW 5000 KIT	514	ALTERA NEBULIZER. 492, 531		<i>amyl nitrite</i>	47, 113
ALL FLOW 5000 PFT FILTER	514	ALTERA NEBULIZER SYSTEM	492, 531	AMZEEQ	220
ALL FLOW 6000 PFT FILTER	514	ALTERNATE SITE LANCET	436, 531	ANACAINE	281
ALLERGIST TRAY 1/2 ML 27GX3/8"	492, 531	ALTERNATE SITE LANCING DEVICE	436, 531	<i>anagrelide</i>	412
ALLERGIST TRAY INTRADERMAL BEV ...	493, 531	ALTOPREV	117	ANA-LEX KIT	46
ALLERGIST TRAY REGULAR BEVEL	493, 531	ALTRENO	228	ANALPRAM-HC	265
ALLERGY SYRINGE ...	493, 531	<i>alum, ammonium (bulk)</i>	197	ANASCORP	99
ALLEVYN	286, 531	ALUNBRIG	79	ANASTIA	279
ALLEVYN ADHESIVE DRESSING	285, 433, 531	ALVESCO	636	<i>anastrozole</i>	82
ALLEVYN AG	286	<i>alvimopan</i>	48	ANDRODERM	330
ALLEVYN AG ADHESIVE ...	285	Alyacen 1/35 (28)	204	ANGELIQ	341
ALLEVYN AG GENTLE DRESSING	285	Alyacen 7/7/7 (28)	213	<i>anise</i>	198
ALLEVYN HEEL	286, 531	Alyq	135	ANNOVERA	216
ALLEVYN LIFE DRESSING	286, 531	ALZAIR	650	ANODYNE LPT	269
<i>allopurinol</i>	398	Amabelz	342	ANORO ELLIPTA	643
Allzital	27	<i>amantadine hcl</i>	160	ANTARA	116
<i>almotriptan malate</i>	182	<i>ambrisentan</i>	135	ANTARCTIC KRILL OIL	121
ALOCRI	626	<i>amcinonide</i>	253	<i>anticoag citrate phos dextrose</i>	399
<i>alogliptin</i>	332	AMELUZ	274	ANTIOXIDANT FORMULA (SELENIUM)	11, 299
<i>alogliptin-metformin</i>	337	Amethia	202	ANTIVERT	365
<i>alogliptin-pioglitazone</i>	337	Amethyst (28)	204	ANUCORT-HC	45
ALOMIDE	626	AMIELLE VAGINAL TRAINER	490	APADAZ	24
ALORA	343	<i>amiloride</i>	131	APEXICON E	253
<i>alosetron</i>	386	<i>amiloride- hydrochlorothiazide</i>	131	APIDRA SOLOSTAR U-100 INSULIN	356
<i>alpha lipoic acid</i>	10	<i>aminocaproic acid</i>	407	APIDRA U-100 INSULIN	356
<i>alpha lipoic acid-biotin</i>	10	<i>amiodarone</i>	115	APLENZIN	157
		<i>amitriptyline</i>	157	APLIGRAF	284
		<i>amitriptyline- chlordiazepoxide</i>	156	APOGEE IC INTERMIT CATHETER	524, 531
		<i>amlodipine</i>	128	APOGEE PLUS INTERMIT CATHETER	524, 531
		<i>amlodipine-atorvastatin</i>	124	APOKYN	160
		<i>amlodipine-benazepril</i>	108	<i>apraclonidine</i>	630
		<i>amlodipine-olmesartan</i>	111	<i>aprepitant</i>	367

Apri.....	204	ASSURE 4 STRIPS.....	421	Aurovela 1.5/30 (21).....	204
APTIOM.....	143	ASSURE DOSE NORMAL		Aurovela 1/20 (21).....	204
APTIVUS.....	70	CONTROL.....	436	Aurovela 24 Fe.....	204
AQUA CARE SODIUM		ASSURE DOSE NORM-HI		Aurovela Fe 1.5/30 (28).....	205
CHLORIDE.....	292	CONTROL.....	436	Aurovela Fe 1-20 (28).....	205
AQUA CARE STERILE		ASSURE HAEMOLANCE		AURUMHEEL.....	363
WATER.....	292	PLUS.....	436	AURYXIA.....	295, 392, 393
AQUA GLYCOLIC HC.....	266	ASSURE ID INSULIN		AUSTEDO.....	186, 187
AQUA LANCE LANCING		SAFETY.....	468, 532	AUTOJECT 2 INJECTION	
DEVICE.....	436	ASSURE ID PEN NEEDLE..	468	DEVICE.....	468
AQUA-D CONCENTRATE..	326	ASSURE LANCE.....	436	AUTO-LANCET MINI...437, 532	
AQUA-K CONCENTRATE..	328	ASSURE LANCE PLUS.....	437	AUTOLET IMPRESSION	
AQUORAL.....	607	ASSURE PLATINUM		LANC DEV.....	437
ARAKODA.....	53	GLUCOSE METER.....	437	AUTOLET LANCING	
ARALAST NP.....	647	ASSURE PLATINUM TEST		DEVICE.....	437
Aranelle (28).....	214	STRIP.....	421	AUTOLET PLUS LANCING	
ARANESP (IN		ASSURE PRISM CONTROL		DEVICE.....	437
POLYSORBATE).....	401	1-2 SOLN.....	437	AUTOPEN 1 TO 21 UNITS	
ARAZLO.....	229	ASSURE PRISM MULTI		.....	468, 532
ARCALYST.....	28	METER.....	437	AUTOPEN 2 TO 42 UNITS	
ARESTIN.....	610	ASSURE PRISM MULTI		.....	468, 532
<i>arformoterol</i>	641	STRIP.....	421	AUTOSOFT 30.....	526
ARGYLE TRACHEOSTOMY		ASTAGRAF XL.....	415	AUTOSOFT 90.....	526
CARE TRAY.....	490, 532	ASTERO.....	279	AUTOSOFT XC INFUSION	
ARIKAYCE.....	49	ASTHMA CHECK METER		SET 23".....	526
<i>aripiprazole</i>	173	.....	512, 532	AUTOSOFT XC INFUSION	
<i>armodafinil</i>	187	ASTHMAPACK		SET 32".....	526, 532
ARMONAIR DIGIHALER....	637	CHILDREN'S.....	512, 532	AUTOSOFT XC INFUSION	
ARMOUR THYROID.....	362	ASTRINGYN.....	408	SET 43".....	526
ARNUITY ELLIPTA.....	637	<i>atazanavir</i>	70	AUVI-Q.....	129
ARTISS.....	278	<i>atenolol</i>	125	AVAR.....	223
Ascomp With Codeine.....	22	<i>atenolol-chlorthalidone</i>	129	AVAR LS.....	223
ASCOR.....	325	<i>atomoxetine</i>	171	AVEIDAOXIA.....	277
<i>ascorbic acid (vitamin c)</i>	325	ATOPADERM.....	248	AVENOVA.....	252
<i>ascorbic acid(vitamin</i>		<i>atorvastatin</i>	117	Aviane.....	205
<i>c)(bulk)</i>	325	<i>atovaquone</i>	54	AVIDOXY DK.....	71
<i>ascorbic acid-zinc oxide</i>	299	<i>atovaquone-proguanil</i>	53	AVITA.....	229
<i>asenapine maleate</i>	173	ATRANTIL.....	12	AVITENE.....	408
Ashlyna.....	203	ATRAPRO CP.....	249	AVITENE FLOUR.....	408
<i>ashwagandha root extract</i>	12	ATRAPRO DERMAL		AVO CREAM.....	249
ASMANEX HFA.....	637	SPRAY.....	97, 284	AVONEX.....	610, 611
ASMANEX TWISTHALER...637		ATRAPRO HYDROGEL.....	249	Ayuna.....	205
<i>aspirin</i>	43	ATROPEN.....	133	AYVAKIT.....	92
ASPIRIN CHILDRENS..	43, 413	<i>atropine</i>	617	AZADROX.....	233
ASPIRIN LOW DOSE.....	43	ATROVENT HFA.....	641	AZALGIA.....	9
<i>aspirin-dipyridamole</i>	412	AUBAGIO.....	613	Azasan.....	34, 417
<i>aspirin-omeprazole</i>	413	Aubra.....	204	AZASITE.....	628
ASPIR-TRIN.....	43, 413	Aubra Eq.....	204	<i>azathioprine</i>	417
ASSURE 4 CONTROL		AUGMENTIN.....	50	<i>azelaic acid</i>	220
SOLUTION.....	436	AURA PORTANEB.....	492, 532	<i>azelastine</i>	617, 648

<i>azelastine-fluticasone</i>	648	BD ALLERGY SYRINGE		BD MICROTAINER	
AZELEX.....	221	.....	493, 532	LANCET.....	437, 535
AZESCO.....	321	BD AUTOSHIELD DUO		BD NANO 2ND GEN PEN	
<i>azithromycin</i>	67	PEN NEEDLE.....	468, 532	NEEDLE.....	469, 535
AZO COMPLETE		BD BLUNT PLASTIC		BD POSIFLUSH NORMAL	
FEMININE BALANCE.....	380	CANNULA.....	493, 532	SALINE 0.9.....	322
AZO CRANBERRY PLUS		BD BULK SYRINGE SLIP		BD PRECISIONGLIDE	495, 535
PROBIOTIC.....	12	TIP.....	493, 533	BD PRE-FILLED NORMAL	
AZO CRANBERRY PLUS		BD ECCENTRIC TIP		SALINE.....	322
VIT C.....	12	SYRINGE.....	493, 533	BD PRE-FILLED SALINE	
AZO DUAL PROTECTION..	380	BD ECLIPSE LUER-LOK		BLUNT CAN.....	322
AZOPT.....	623	.....	468, 493, 533	BD SAFETYGLIDE	
AZSTARYS.....	167	BD FILTER NEEDLE-5		ALLERGIST TRAY.....	495, 535
Azurette (28).....	203	MICRON.....	494, 533	BD SAFETYGLIDE INSULIN	
B COMPLEX 100.....	290	BD INSULIN SYRINGE		SYRINGE.....	469, 470, 536
<i>b complex-vitamin c-folic</i>		.....	469, 533, 534	BD SAFETYGLIDE	
<i>acid</i>	290	BD INSULIN SYRINGE		SHIELDING REG.....	495, 536
B12 ACTIVE.....	324	(HALF UNIT).....	468	BD SAFETYGLIDE	
BABY COUGH.....	12	BD INSULIN SYRINGE		SYRINGE....	470, 495, 496, 536
BABY COUGH-MUCUS.....	12	MICRO-FINE.....	468, 533	BD SAFETYGLIDE TB REG	
BACICAP.....	380	BD INSULIN SYRINGE		BEVEL.....	496, 536
<i>bacitracin</i>	628	SAFETY-LOK.....	468, 533	BD SAFETYGLIDE	
<i>bacitracin-polymyxin b</i>	627	BD INSULIN SYRINGE SLIP		TUBERCULIN.....	496, 537
<i>baclofen</i>	418	TIP.....	469, 533	BD SAFETY-LOK	
BAFIERTAM.....	611	BD INSULIN SYRINGE U-		DETACHABLE NEEDL	496, 537
BALANCED B-50		500.....	469, 534	BD SAFETY-LOK	
COMPLEX (FOLIC).....	290	BD INSULIN SYRINGE		TUBERCULIN.....	496, 537
BAL-CARE DHA.....	312	ULTRA-FINE.....	469	BD SAFETY-LOK WITH	
BAL-CARE DHA		BD INSYTE AUTOGUARD		LUER-LOK.....	496, 537
ESSENTIAL.....	312	.....	489, 534	BD SAF-T-INTIMA.....	489, 537
BALCOLTRA.....	205	BD INTEGRA SYRINGE		BD SLIP TIP SYRINGE	
<i>balsalazide</i>	377	.....	494, 534	.....	496, 497, 537
<i>balsam peru (bulk)</i>	12, 197	BD INTERLINK BLUNT		B-D SLIP TIP SYRINGE	
<i>balsam peru-castor oil</i>	288	PLASTIC CAN.....	494, 534	.....	496, 537
BALVERSA.....	85	BD INTERLINK SYRINGE		BD SPECIALTY USE	
Balziva (28).....	205	.....	494, 534	NEEDLES.....	497, 538
BANZEL.....	148, 149	BD LAB ECCENTRIC NON-		BD SYRINGE.....	497, 538
BAQSIMI.....	329	STERILE.....	494, 534	BD SYRINGE CATH TIP	
BARACLUDE.....	63	BD LO-DOSE MICRO-FINE		NONSTERILE.....	497, 538
BARDEX I.C. FOLEY		IV.....	469, 534	BD SYRINGE CATHETER	
CATHETER.....	524, 532	BD LO-DOSE ULTRA-FINE		TIP.....	497, 538
BASADROX.....	233	.....	469, 534	BD SYRINGE LUER-LOK	
BASAGLAR KWIKPEN U-		BD LUER-LOK BULK		NONSTERILE.....	497, 538
100 INSULIN.....	353	SYRINGE.....	494, 534	BD SYRINGE LUER-LOK	
BAXDELA.....	63	BD LUER-LOK SYRINGE		STERILE.....	497, 538
B-COMPLEX INJECTION...	291	.....	494, 495, 534, 535	BD SYRINGE SLIP TIP	
<i>b-complex with vitamin c</i>	290	BD LUER-LOK TIP		NONSTERILE.....	497, 538
BD ALLERGIST TRAY REG		CONTROL SYRING....	495, 535	BD SYRINGE-DUAL	
BEVEL.....	493, 532	BD MAGNI-GUIDE		CANNULA.....	497, 538
		SYRINGE MAGNIFI....	437, 535		

BD TUBERCULIN SLIP-TIP 498, 538	<i>bepotastine besilate</i> 617	Blephamide S.O.P..... 615
BD TUBERCULIN SYRINGE 498, 539	BEPREVE.....618	Blisovi 24 Fe.....205
BD ULTRA FINE LANCETS 437, 539	BERINERT.....400	Blisovi Fe 1.5/30 (28).....205
BD ULTRA-FINE II LANCETS.....437	BESER KIT.....264	Blisovi Fe 1/20 (28).....205
BD ULTRA-FINE MICRO PEN NEEDLE.....470, 539	BESIVANCE.....628	<i>blood glucose contrl</i> <i>hi,normal</i> 437, 539
BD ULTRA-FINE MINI PEN NEEDLE.....470	<i>beta carotene</i> 323	<i>blood glucose control,</i> <i>normal</i> 437
BD ULTRA-FINE NANO PEN NEEDLE.....470	BETADINE OPHTHALMIC PREP.....629	<i>blood glucose ctl</i> <i>high,nml,low</i> 437, 539
BD ULTRA-FINE ORIG PEN NEEDLE.....470	BETALOAN SUIK.....345	BLOOD GLUCOSE MONITORING.....437, 539
BD ULTRA-FINE SHORT PEN NEEDLE.....470	<i>betamethasone dipropionate</i> 253	BLOOD GLUCOSE TEST...421
BD VEO INSULIN SYR (HALF UNIT).....470	<i>betamethasone valerate</i> 253, 254	<i>blood-glucose meter</i> 437
BD VEO INSULIN SYRINGE UF.....470, 471	<i>betamethasone, augmented</i> 254	<i>blunt needle, disposable</i> 498, 539
BD VERITOR SYSTEM SARS-COV-2.....430, 539	BETASERON.....611	BOCASAL.....607
BEANAID.....373	<i>betaxolol</i> 125, 624	BONJESTA.....365
BEANO.....373	<i>bethanechol chloride</i> 398	BOOST GLUCOSE CONTROL.....309
BEAU RX.....275	BETIMOL.....625	BOOSTRIX TDAP.....103
BECONASE AQ.....648	BETOPTIC S.....625	<i>bosentan</i> 135
BELBUCA.....26	BEVESPI AEROSPHERE...643	BOSULIF.....92
<i>belladonna alkaloids-opium</i> .375	<i>bexarotene</i> 95	BOYS TRAINING PANTS 4T-5T.....466, 539
BELSOMRA.....194	BEXSERO.....104	BP 10-1.....223
<i>benazepril</i> 109	<i>bicalutamide</i> 80	BPCO.....288
<i>benazepril-</i> <i>hydrochlorothiazide</i> 109	BIDIL.....136	BPO.....226
BENEFIX.....402	BIJUVA.....342	BRAFTOVI.....83
<i>benfotiamine</i> 323	BIKTARVY.....59	BRAVELLE.....345
BENLYSTA.....36	<i>bimatoprost</i> 630	BREATHERITE MDI SPACER.....514
BENSAL HP.....267	BINAXNOW COVD AG CARD HOME TST.....430, 539	BREATHERITE SPACER- MASK, NEO.....514
BENZEPRO.....226	BINAXNOW COVID-19 AG CARD.....430, 539	BREATHERITE SPACER- MASK,ADULT.....515
BENZEPRO (MICROSPHERES).....226	BINAXNOW COVID-19 AG SELF TEST.....430, 539	BREATHERITE SPACER- MASK,CHILD.....515
<i>benzhydrocodone-</i> <i>acetaminophen</i> 24	BINOSTO.....340	BREATHERITE SPACER- MASK,INFANT.....515
<i>benznidazole</i> 54	BIO C 1:1.....291	BREATHERITE SPACER- MASK,S.CHLD.....515
BENZODOX 30.....71	BIOMEPRO.....381	BREATHERITE VALVED MDI CHAMBER.....515
BENZODOX 60.....72	BIONECT.....276	BREATHERITE VALVED MDI SPACER.....515
<i>benzoin (bulk)</i> 197	BIONIME RIGHTEST GM300 SYSTEM.....437, 539	BREEZE 2 CONTROL SOLUTION, LOW.....438, 540
<i>benzonatate</i> 636	BIONIME RIGHTEST TEST STRIPS.....421, 539	BREEZE 2 CONTROL SOLUTION, NML.....438, 540
<i>benzoyl peroxide</i> 226	BIOSTEP.....286, 539	
<i>benztropine</i> 159	BIOSTEP AG.....286	
	BIOTEL CARE BGM-4 METER.....437, 539	
	<i>bisoprolol fumarate</i> 125	
	<i>bisoprolol-</i> <i>hydrochlorothiazide</i> 129	
	Bleph-10.....629	
	BLEPHAMIDE.....615	

BREEZE 2 CONTROL SOLUTION,HIGH.....	438, 540	BYSTOLIC.....	125	CAPRELSA.....	92
BREEZE 2 TEST STRIPS.....	422, 540	<i>cabergoline</i>	361	Capsfenac Pak.....	271
BREO ELLIPTA.....	644	CABLIVI.....	399	CAPSINAC.....	272
BREXAFEMME.....	51, 52	CABOMETYX.....	89	CAPSULE #1.....	198
BREZTRI AEROSPHERE...	645	CADEAU DHA.....	312	<i>captopril</i>	110
Briellyn.....	205	CADIRA COMPLIANT		<i>captopril-hydrochlorothiazide</i>	
BRILINTA.....	412	BLOOD STAT.....	525	.....	109
<i>brimonidine</i>	630	<i>caffeine citrate</i>	177	CARBAGLU.....	604
<i>brimonidine-dorzolamide (pf)</i>		<i>calc-d3-magnes-b6-zn-cu-mangan</i>	293	<i>carbamazepine</i>	143, 144
.....	615	<i>calcipotriene</i>	241, 242	<i>carbidopa</i>	159
BRIVIACT.....	147	<i>calcipotriene-betamethasone</i>		<i>carbidopa-levodopa</i>	158
Bromfed Dm.....	650	.....	230, 231	<i>carbidopa-levodopa-entacapone</i>	158
<i>bromfenac</i>	622	<i>calcitonin (salmon)</i>	341	<i>carbinoxamine maleate</i>	
<i>bromocriptine</i>	160	<i>calcitriol</i>	242, 326	.....	633, 634, 635
<i>brompheniramine-pseudoeph-dm</i>	650	<i>calcium acetate</i>	293	CARDIZEM LA.....	127
BROMSITE.....	622	<i>calcium acetate(phosphat bind)</i>	392	CARDURA XL.....	133
BRONCHITOL.....	646	<i>calcium carb-mag ox-zinc sulf</i>	293	CAREFINE PEN NEEDLE	
BRUKINSA.....	83, 92	<i>calcium carbonate</i>	293	.....	471, 540
BRYHALI.....	241	<i>calcium carbonate-vitamin d3</i>	294	CARELANCE ULT	
<i>budesonide</i>	378, 637	<i>calcium citrate</i>	293	LANCING DEVICE.....	438, 540
BULLSEYE MINI SAFETY LANCETS.....	438	<i>calcium citrate-vitamin d3</i>	294	CAREONE LANCING	
<i>bumetanide</i>	131	<i>calcium phos,dibas-vitamin d3</i>	294	DEVICE.....	438
BUNAVAIL.....	195	<i>calcium phosphate-vitamin d3</i>	294	CAREONE THIN LANCET	
BUPRENEX.....	26	CALCIUM PNV.....	306	.....	438, 540
<i>buprenorphine</i>	26	<i>calcium-magnesium-vit d3-boron</i>	293	CAREONE ULTRA THIN	
<i>buprenorphine hcl</i>	26, 195	<i>calcium-vitamin d3-vitamin k</i> 293		LANCET.....	438
<i>buprenorphine-naloxone</i>	195	CALQUENCE.....	83, 92	CAREPOINT LUER LOCK	
<i>bupropion hcl</i>	157	CAMBIA.....	40	SYRINGE.....	498, 540
<i>bupropion hcl (smoking deter)</i>	196	Camila.....	213	CAREPOINT LUER LOCK	
<i>buspirone</i>	137	CAMRESE.....	203	SYR-NEEDLE.....	498, 540
Butalbital Compound		CAMRESE LO.....	203	CAREPOINT LUER SLIP	
W/Codeine.....	22	<i>candesartan</i>	112	SYRINGE.....	498, 540
<i>butalbital-acetaminop-caf-cod</i>	22	<i>candesartan-hydrochlorothiazid</i>	111	CAREPOINT LUER SLIP	
<i>butalbital-acetaminophen</i>	27	CANDICIDAL.....	12	SYRING-NDL.....	498, 540
<i>butalbital-acetaminophen-caff</i>	27	<i>cantharidin in acetone</i>	267	CARESENS CONTROL A	
<i>butalbital-aspirin-caffeine</i>	42	CANTHARIS		AND B.....	438, 540
<i>butorphanol</i>	26	COMPOSITUM.....	363	CARESENS CONTROL A	
BUTTERFLY TOUCH		CAPCOF.....	651	NORMAL.....	438, 540
LANCET.....	438, 540	<i>capecitabine</i>	82	CARESENS LANCETS	
<i>butylated hydroxytoluene</i>	198	CAPEX.....	254	.....	438, 540
BYDUREON BCISE.....	336	CAPHOSOL.....	607	CARESENS N.....	438, 541
BYETTA.....	336	CAPLYTA.....	163	CARESENS N TEST	
BYLVAY.....	415			STRIPS.....	422

CARETOUCH INSULIN	CEQUA.....	621	<i>chlorhexidine gluconate</i>	607
SYRINGE..... 471, 541	CEQUR SIMPLICITY...523, 542		<i>chloroquine phosphate</i>	53
CARETOUCH KETONE-	CEQUR SIMPLICITY		<i>chlorpromazine</i>	164
GLUCOSE MONIT..... 429, 541	INSERTER..... 439, 542		<i>chlorthalidone</i>	132
CARETOUCH LANCING	CERACADE.....249		<i>chlorzoxazone</i>	418
DEVICE..... 438, 541	CERAMAX.....249		CHOICE DM CLARUS	
CARETOUCH PEN	CERASPORT ENDURANCE		NORM CONTROL.....439, 542	
NEEDLE..... 471, 541	297		CHOICEDM CLARUS	
CARETOUCH SAFETY	CERASPORT PLUS.....297		422, 439, 542	
LANCETS..... 438, 541	CERAVE.....248		CHOLBAM.....	367
CARETOUCH TEST STRIP 422	CERAVE AM..... 278		CHOLECAL DF.....	322
CARETOUCH TWIST	CERAVE DAILY		<i>cholecalciferol (vitamin d3)</i> ..	326
LANCET..... 438, 541	MOISTURIZING..... 247		<i>cholestyramine (with sugar)</i> ..	115
<i>carisoprodol</i>	CERAVE FOAMING FACIAL		Cholestyramine Light.....	116
<i>carisoprodol-aspirin</i>	247		<i>cholestyramine-aspartame</i> ..	116
<i>carisoprodol-aspirin-codeine</i>	CERAVE PM..... 248		<i>choline,magnesium</i>	
.....419, 420	CERAVE SA.....248		<i>salicylate</i>	43
CARNITOR (SUGAR-FREE)	CERAVE SA (WITH		<i>chorionic gonadotropin,</i>	
.....603	NIACINAMIDE).....248		<i>human</i>	350
CAROSPIR..... 110	CERDELGA.....603		<i>chromium picolinate</i>	298
CARRASYN HYDROGEL	CERTAVITE SENIOR.....300		CICASIL.....521, 542	
WOUND DRESS..... 286	CERTAVITE-ANTIOXIDANT		CICATRACE PAD..... 521, 542	
<i>carteolol</i>	306		CICLODAN KIT.....	236
Cartia Xt.....127	CERVIDIL..... 328		<i>ciclopirox</i>	236
<i>carvedilol</i> 111	CETACAINE.....270		<i>ciclopirox-ure-camph-menth-</i>	
<i>carvedilol phosphate</i> 111	CETACAINE ANESTHETIC 269		<i>euc</i>	236
CAYA CONTOURED...431, 541	<i>cetirizine</i> 635		<i>cilostazol</i>	412
CAYSTON..... 646	CETROTIDE.....360		CILOXAN.....	628
Caziant (28).....214	<i>cevimeline</i> 609		CIMDUO.....	57
<i>cefaclor</i> 61	Charlotte 24 Fe.....205		<i>cimetidine</i>	369
<i>cefadroxil</i> 61	Chateal (28).....205		<i>cimetidine hcl</i>	369
CEFALY.....490, 541	Chateal Eq (28)..... 205		CIMZIA..... 28, 29, 379	
<i>cefdinir</i> 62	CHEMET..... 48		CIMZIA POWDER FOR	
<i>cefditoren pivoxil</i> 62	CHEMSTRIP BG LOG		RECONST.....28, 29, 379	
<i>cefixime</i> 62	BOOK..... 439, 542		CIMZIA STARTER KIT	
<i>cefprozoxime</i> 62	CHENODAL.....369		28, 29, 379	
<i>cefprozil</i> 62	CHEST RUB (WITH PINE		<i>cinacalcet</i>	341
<i>cefuroxime axetil</i> 62	OIL).....282		CINRYZE.....	400
CELACYN.....249, 521	CHILDREN'S ASPIRIN.....43		CIPRO.....	63
<i>celecoxib</i> 38	CHILDRENS CHEWABLE		CIPRO HC.....	631
CELLPAD..... 521, 542	PROBIOTIC.....381		CIPRO XR..... 63, 395	
<i>cellulose (bulk)</i> 199	CHILDREN'S IRON..... 295		<i>ciprofloxacin</i>	63
CELONTIN..... 148	CHILDREN'S		<i>ciprofloxacin hcl</i> 63, 628, 632	
CEM-UREA..... 268	MULTIVITAMIN..... 310		<i>ciprofloxacin-</i>	
CENTANY AT.....233	CHILDREN'S PROBIOTIC.. 381		<i>dexamethasone</i>	632
CENTRUM ADULT 50	CHILDREN'S SLEEP		<i>citalopram</i>	152
FRESH-FRUITY..... 300	(MELATONIN)..... 180		CITRANATAL (DUAL-IRON)	
CENTRUM SILVER.....300	CHLOOXIA.....263		312	
CENTRUM WOMEN..... 306	<i>chlordiazepoxide hcl</i> 137		CITRANATAL 90 DHA	
<i>cephalexin</i> 61	<i>chlordiazepoxide-clidinium</i> .. 375		(ALGAL OIL).....	312

CITRANATAL ASSURE.....	312	CLEVER CHOICE		COAGUCHEK LANCETS	
CITRANATAL DHA (ALGAL		NEBULIZER.....	515, 542	.....	439, 543
OIL).....	312	CLEVER CHOICE PEAK		COAGUCHEK XS.....	420, 543
CITRANATAL HARMONY		FLOW METER.....	512, 542	<i>coal tar</i>	269
(IRON FUM).....	312	CLEVER CHOICE PRO		COARTEM.....	53
<i>citric acid (bulk)</i>	197	.....	422, 439, 543	<i>cocaine</i>	647
<i>citric acid anhydrous (bulk)</i> ..	197	CLEVER CHOICE TALK		<i>codeine sulfate</i>	14
<i>citric acid monohydrate</i>		GLUCOSE SYS.....	439, 543	<i>codeine-butalbital-asa-caff</i>	22
<i>(bulk)</i>	197	CLEVER CHOICE TALK		<i>codeine-guaifenesin</i>	653
Claravis.....	218	TEST.....	422, 543	CODITUSSIN AC.....	653
CLARINEX-D 12 HOUR.....	633	CLEVER CHOICE TEST		CODITUSSIN DAC.....	652
<i>clarithromycin</i>	67	STRIPS.....	422	<i>colchicine</i>	398
CLEANSING EYELID		CLEVER CHOICE VOICE+		<i>colesevelam</i>	116
MOIST PADS.....	252	TEST.....	422	COLESTID FLAVORED.....	116
CLEANSING EYELID		CLEVER CHOICE		<i>colestipol</i>	116
WIPES EXT STR.....	252	WHISPER AIRE PED..	515, 543	COLLATYL.....	286
CLEANSING WASH....	223, 277	CLICKFINE PEN NEEDLE..	471	COLOR LANCETS.....	439, 543
CLEAR FIBER.....	386	CLIMARA PRO.....	342	COMBIGAN.....	623
CLEARSHIELD SODIUM		CLINDACIN ETZ.....	222	COMBIPATCH.....	342
CHLOR FLUSH.....	322	CLINDACIN PAC.....	223	COMBIVENT RESPIMAT....	643
<i>clemastine</i>	634, 635	<i>clindamycin hcl</i>	67	COMETRIQ.....	89
CLENIA PLUS.....	223	Clindamycin Pediatric.....	67	COMFORT EZ INSULIN	
CLENPIQ.....	389	<i>clindamycin phosphate</i> 221, 654		SYRINGE.....	471, 472, 543
CLEOCIN.....	654	<i>clindamycin-benzoyl</i>		COMFORT EZ LANCETS...	439
CLEVER CHEK BLOOD		<i>peroxide</i>	223, 224	COMFORT EZ PEN	
GLUCOSE.....	439, 542	<i>clindamycin-tretinoin</i>	226	NEEDLES.....	472, 543
CLEVER CHEK BLOOD		CLINDAVIX.....	223	COMFORT LANCETS.....	439
GLUCOSE SYST.....	439	CLINDESSE.....	654	COMFORT PAC-	
CLEVER CHEK LANCETS..	439	CLINPRO 5000.....	605	CYCLOBENZAPRINE.....	419
CLEVER CHOICE BLOOD		<i>clobazam</i>	139, 140	COMFORT PAC-	
GLUC SYS.....	439	<i>clobetasol</i>	254	IBUPROFEN.....	36
CLEVER CHOICE		<i>clobetasol-emollient</i>	254	COMFORT PAC-	
CHAMBER-LRG MASK.....	515	CLOBETAVIX.....	254	MELOXICAM.....	37
CLEVER CHOICE		CLOBETEX.....	263	COMFORT PAC-	
CHAMBER-MED MASK.....	515	<i>clocortolone pivalate</i>	254	NAPROXEN.....	37
CLEVER CHOICE		CLODAN KIT.....	266	COMFORT PAC-	
CHAMBER-SM MASK.....	515	CLOFENAX.....	273	TIZANIDINE.....	419
CLEVER CHOICE		<i>clomiphene citrate</i>	344	COMFORT TOUCH PEN	
GLUCOSE MONITOR.	439, 542	<i>clomipramine</i>	157	NEEDLE.....	472, 543
CLEVER CHOICE LEVEL 1		<i>clonazepam</i>	137	COMFORT TOUCH PLUS	
CONTROL.....	439, 542	<i>clonidine</i>	130	SAFETY LANC.....	439, 544
CLEVER CHOICE LEVEL 2		<i>clonidine hcl</i>	130, 166	COMFORT TOUCH ULT	
CONTROL.....	439, 542	<i>clopidogrel</i>	413	THIN LANCETS.....	440, 544
CLEVER CHOICE LEVEL 3		<i>clorazepate dipotassium</i>	137	COMPACT SPACE	
CONTROL.....	439, 542	<i>clotrimazole</i>	237, 607	CHAMBER.....	515, 544
CLEVER CHOICE MICRO		<i>clotrimazole-betamethasone</i> 238		COMPACT SPACE	
.....	439, 542	<i>clozapine</i>	163	CHAMBER PLUS.....	515, 544
CLEVER CHOICE MICRO		C-NATE DHA.....	313	COMPACT SPACE	
TEST STRIP.....	422, 542	COAGADEX.....	406	CHAMBER-LRG MASK.....	515

COMPACT SPACE		CULTURELLE IMMUNE	
CHAMBER-MED MASK.....	515	DEFENSE.....	381
COMPACT SPACE		CULTURELLE KIDS	
CHAMBER-SM MASK.....	516	GROW-THRIVE.....	381
COMP-AIR NEBULIZER		CULTURELLE KIDS	
COMPRESSOR.....	516, 544	GUMMY.....	381
COMPLERA.....	60	CULTURELLE KIDS	
COMPLETE MV ADULT 50		IMMUNE DEFENSE.....	382
PLUS.....	300	CULTURELLE KIDS	
COMPLETE NATAL DHA.....	313	PROBIOTIC-MV.....	311
COMPLETENATE.....	313	CULTURELLE KIDS	
Compro.....	366	PROBIOTICS.....	382
CONCEPTION.....	544	CULTURELLE	
CONCERTA.....	167	METABOLISM-WT MGMT..	382
CONDYLOX.....	268	CULTURELLE PRENATAL	
CONJUPRI.....	128	PROBIOTIC.....	382
CONSENSI.....	127	CULTURELLE PROBIOTIC-	
Constulose.....	387	MULTIVIT.....	300
CONTOUR CONTROL		CULTURELLE TOTAL	
SOLUTION, HIGH.....	440, 544	BALANCE.....	382
CONTOUR CONTROL		CULTURELLE ULTIMATE..	382
SOLUTION, LOW.....	440, 544	CUPRIMINE.....	35, 47
CONTOUR CONTROL		CURAFIL GEL WOUND	
SOLUTION, NML.....	440, 544	.....	286, 545
CONTOUR METER.....	440, 544	CURITY AMD.....	433, 545
CONTOUR NEXT EZ		CURITY AMD (WITH	
METER.....	440, 544	POLYHEXAMETH).....	286, 545
CONTOUR NEXT		CURITY DRAINAGE BAG	
GLUCOSE METER.....	440, 544	.....	466, 545
CONTOUR NEXT LEV 1		CURITY IODOFORM	
CONTROL SOL.....	440, 544	PACKING STRIP.....	433, 545
CONTOUR NEXT LEV 2		CUROSURF.....	647
CONTROL SOL.....	440, 544	CUTAQUIG.....	100
CONTOUR NEXT LINK.....	440	CUVITRU.....	101
CONTOUR NEXT LINK 2.4		CUVPOSA.....	610
.....	440, 544	<i>cyanocobalamin (vitamin b-</i>	
CONTOUR NEXT METER		<i>12)</i>	324
.....	440, 544	Cyclafem 1/35 (28).....	206
CONTOUR NEXT ONE		Cyclafem 7/7/7 (28).....	214
METER.....	440, 544	CYCLINEX-2.....	310
CONTOUR NEXT TEST		<i>cyclobenzaprine</i>	418
STRIPS.....	422	CYCLOMYDRIL.....	614
CONTOUR TEST STRIPS..	422	CYCLOPAK.....	420
CONTROL AST		<i>cyclopentolate</i>	617
MONITORING SYSTEM		<i>cyclopen-tropic-phenyleph-</i>	
.....	440, 545	<i>watr</i>	614
COOL BLOOD GLUCOSE		<i>cyclopent-tropic-phen-ketr-</i>	
METER.....	440, 545	<i>wat</i>	614
COOL CONTROL A		<i>cyclophosphamide</i>	78
SOLUTION.....	440, 545		

<i>cyclop-trop-propa-phen-ket-wat</i>	614	DEBACTEROL.....	607	DERMACINRX VENEXA.....	300
<i>cycloserine</i>	60	Deblitane.....	213	DERMACINRX VENEXA FE	
CYCLOSET.....	332	Decadron.....	345	.....	300
<i>cyclosporine</i>	34, 416	<i>deferiasirox</i>	48	DERMACINRX VENTRIXYL	301
CYCLOSPORINE IN		<i>deferiprone</i>	48	DERMACINRX VENTRIXYL	
KLARITY.....	621	<i>deferoxamine</i>	48	FE.....	301
<i>cyclosporine modified</i>	415	DEKAS PLUS (FOLIC ACID)		DERMACINRX VITRANOL..	301
CYCLOTENS REFILL.....	418	.....	300	DERMACINRX VITRANOL	
CYCLOTENS STARTER.....	419	DELESTROGEN.....	343	FE.....	301
<i>cyproheptadine</i>	634	DELSTRIGO.....	60	DERMACINRX VITREXATE	301
Cyred.....	206	DELUO.....	97, 284	DERMACINRX VITREXATE	
Cyred Eq.....	206	<i>demeclocycline</i>	72	FE.....	301
CYSTADANE.....	604	DEMEROL (PF).....	14	DERMACINRX ZINTREXYL-	
CYSTADROPS.....	624	DEMSE.....	134	C.....	301
CYSTAGON.....	391	DENAVIR.....	245	DERMACINRX ZRM PAK...	281
CYSTARAN.....	624	DENTA 5000 PLUS.....	605	DERMAGRAFT.....	284
DAILY FIBER.....	386	DENTAGEL.....	606	DERMALID.....	279
DAILY FIBER (PSYLLIUM-		DEOXIA.....	222, 223	DERMAWERX SURGICAL	
ASPART).....	386	DEPO-ESTRADIOL.....	343	PLUS PAK.....	288
DAILY FIBER (PSYLLIUM-		DEPO-SUBQ PROVERA		DERMAZENE.....	238
SUCROSE).....	386	104.....	202	DERMAZYL KIT.....	281
DAILY GUMMIES.....	300	DERMACINRX		DERMELLE.....	276
DAILY-VITE (WITH FOLIC		CLORHEXACIN.....	288	DERM-SILK.....	521, 546
ACID).....	306	DERMACINRX FOLITIN-Z..	300	DERMULCERA.....	288
DAIRY DIGESTIVE.....	369	DERMACINRX		DERPIXA.....	276
DAIRY RELIEF.....	369	FOLIXAPURE.....	322	DESCOVY.....	57
<i>dalfampridine</i>	612	DERMACINRX FOLTREXYL		<i>desflurane</i>	44
DALIRESP.....	640	.....	322	<i>desipramine</i>	157
<i>danazol</i>	348	DERMACINRX LACTEROL	382	<i>desloratadine</i>	635
DANDLELION KISSES.....	291	DERMACINRX LEXITRAL..	272	<i>desmopressin</i>	331
<i>dantrolene</i>	419	DERMACINRX LIDOGEL....	279	<i>desog-e.estradiol</i> ... <i>e.estradiol</i>	203
<i>dapsone</i>	53, 221, 222	DERMACINRX PHN PAK....	281	<i>desogestrel-ethinyl estradiol</i>	206
<i>darifenacin</i>	396	DERMACINRX PRENATRIX		DESONATE.....	255
DARIO BLOOD GLUCOSE		.....	313	<i>desonide</i>	255, 256
MONITOR.....	441, 545	DERMACINRX		<i>desoximetasone</i>	256
DARIO BLOOD GLUCOSE		PRENATRYL.....	313	Desrx.....	257
TEST STRIP.....	422	DERMACINRX PRETRATE	313	<i>desvenlafaxine</i>	153
Dasetta 1/35 (28).....	206	DERMACINRX PROBITRAN		<i>desvenlafaxine succinate</i>	154
Dasetta 7/7/7 (28).....	214	.....	382	DEVILBISS DISPOSABLE	
DAURISMO.....	85	DERMACINRX PROBITROL		NEBULIZER.....	492, 546
DAVOL IRRIGATION		.....	382	DEVILBISS PULMO-AIDE	
SYRINGE.....	498, 545	DERMACINRX PROMEROL		COMPRESSR.....	516, 546
DAVOL PISTON		.....	382	DEVILBISS PULMOMATE	
IRRIGATION.....	498, 546	DERMACINRX		COMPRESSOR.....	516, 546
DAYAVITE.....	300	PUREFOLTIN.....	323	DEVILBISS PULMONEB LT	
Daysee.....	203	DERMACINRX RIBOTIN-E..	300	COMP-NEB.....	516, 546
DAYTRANA.....	168	DERMACINRX SURGICAL		DEVILBISS TRAVELER	
DAYVIGO.....	194	PHARMAPAK.....	288	COMPRESSOR.....	516
DDAVP.....	331	DERMACINRX		Dexabliss.....	345
		THERAZOLE PAK.....	238	<i>dexamethasone</i>	346

DEXAMETHASONE		DIGESTIVE ADVANTAGE	
INTENSOL.....	345	IMMUNE.....	383
<i>dexamethasone sodium</i>		DIGESTIVE ADVANTAGE	
<i>phosphate</i>	618	INTENS BOW.....	383
<i>dexchlorpheniramine</i>		DIGESTIVE ADVANTAGE	
<i>maleate</i>	633, 635	KID PROBIO.....	383
DEXCOM G4 RECEIVER....	441	DIGESTIVE ADVANTAGE	
DEXCOM G4 RECEIVER		LACTOS SUP.....	383
PEDIATRIC.....	441	DIGESTIVE ADVANTAGE	
DEXCOM G4 RECEIVER-		PROBIO-PRE.....	383
SHARE (PED).....	441	DIGESTIVE ADVANTAGE	
DEXCOM G4 RECEIVER-		PROBIOTIC.....	383
SHARE KIT.....	441	DIGESTIVE PROBIOTIC....	383
DEXCOM G4		Digitek.....	130
TRANSMITTER.....	441, 546	Digox.....	130
DEXCOM G5 RECEIVER....	441	<i>digoxin</i>	130
DEXCOM G5		<i>dihydroergotamine</i>	182
TRANSMITTER.....	441, 546	DILANTIN.....	142
DEXCOM G5-G4 SENSOR		DILAUDID (PF).....	15
.....	441, 546	<i>diltiazem hcl</i>	127
DEXCOM G6 RECEIVER		DILT-XR.....	127
.....	441, 546	DILUENT FOR ROTARIX....	292
DEXCOM G6 SENSOR		DILUTING MEDIUM FOR	
.....	441, 546	NOVOLOG.....	291
DEXCOM G6		DIMENTHO.....	272
TRANSMITTER.....	441, 546	<i>dimethyl fumarate</i>	612
DEXCOM RECEIVER. 441, 546		DIMOXIA.....	230
DEXERYL.....	249	DIOCHLOY.....	264
DEXILANT.....	370	DIPENTUM.....	377
<i>dexmethylphenidate</i>	168	Diphen.....	634
DEXONTO.....	346	<i>diphenoxylate-atropine</i>	365
DEXTENZA.....	618	<i>dipyridamole</i>	413
<i>dextroamphetamine</i>		<i>disopyramide phosphate</i>	114
.....	168, 175, 176, 188	<i>disulfiram</i>	196
<i>dextroamphetamine-</i>		DITHOL.....	272
<i>amphetamine</i>	175	DIURIL.....	132
DIACOMIT.....	149	<i>divalproex</i>	140
DIADIMAXIA.....	223	DIVIGEL.....	343
DIAOXIA.....	223	DM2.....	358
DIAPERS, UNISEX SIZE 1		DMT SUIK.....	346
.....	466, 546	<i>dofetilide</i>	115
DIAPERS, UNISEX SIZE 2		DOJOLVI.....	308
.....	466, 546	Dolishale.....	206
DIAPERS, UNISEX SIZE 3. 467		DOLOTRANZ.....	270
DIAPERS, UNISEX SIZE 4		<i>donepezil</i>	200
.....	467, 546	DONNATAL.....	375
DIAPERS, UNISEX SIZE 5. 467		DOPTLET (10 TAB PACK)414	
DIAPERS, UNISEX SIZE 6. 467		DOPTLET (15 TAB PACK)415	
DIASDIMAXIA.....	223	DOPTLET (30 TAB PACK)415	
DIASOXIA.....	223	DORYX.....	72

DORYX MPC.....72	<i>drospirenone-ethinyl</i>	EASY GLIDE DENTAL
<i>dorzolamide</i> 623	<i>estradiol</i> 206	IRRIG SYRING.....498, 548
<i>dorzolamide (pf)</i> 623	DROXIA.....414	EASY GLIDE INSULIN
<i>dorzolamide-timolol</i> 623	<i>droxidopa</i> 129	SYRINGE.....473, 548, 549
<i>dorzolamide-timolol (pf)</i> 623	DRYSOL.....240	EASY GLIDE LUER LOCK
Dotti.....343	DRYSOL DAB-O-MATIC.....240	SYRINGE.....498, 499, 549
DOVATO.....56	DSUVIA.....15	EASY GLIDE LUER SLIP
DOVER BULB SYRINGE	DUAKLIR PRESSAIR.....643	TB SYRING.....499, 549
.....498, 547	DUAVEE.....341	EASY GLIDE PEN NEEDLE
DOVER COATED LATEX	DUET DHA BALANCED.....313	473, 549
FOLEY.....524, 547	DUET DHA WITH OMEGA-3	EASY GLUCO G2.....422, 549
DOVER FOLEY CATHETER	313	EASY MINI EJECT
.....524, 547	DULERA.....644	LANCING DEVICE.....442, 549
DOVER LATEX FOLEY	<i>duloxetine</i> 154	EASY PLUS II BLOOD
CATHETER.....524, 547	DUOBRII.....230	GLUCOSE MET.....442, 549
DOVER RED RUBBER	DUODOTE.....47	EASY PLUS II HIGH
ROBINSON CATH.....524, 547	DUOPA.....158	CONTROL.....442, 549
DOVER UNIVERSAL..524, 547	DUPIXENT PEN.....232	EASY PLUS II LOW
<i>doxazosin</i> 133	DUPIXENT SYRINGE.....232	CONTROL.....442, 549
<i>doxepin</i> 157, 195, 281	DURLAZA.....43, 413	EASY PLUS II TEST..422, 549
<i>doxercalciferol</i> 603	<i>dutasteride</i> 394	EASY STEP.....422, 550
<i>doxycycline hyclate</i>	<i>dutasteride-tamsulosin</i> 390	EASY STEP BLOOD
.....72, 73, 74, 610	DUTOPROL.....129	GLUCOSE METER.....442, 549
<i>doxycycline monohydrate</i>	DUZALLO.....399	EASY STEP HIGH
.....74, 276	Dvorah.....23	CONTROL SOLN.....442, 549
<i>doxylamine-pyridoxine (vit</i>	Dxevo.....346	EASY STEP LOW
<i>b6)</i> 365	DYANAVEL XR.....169, 175	CONTROL SOLUTION442, 550
D-PENAMINE.....35, 47	E.E.S. 400.....67	EASY STEP NORMAL
DRAXACE.....224	EAR POPPER INFLATION	CONTROL SOLN.....442, 550
DRITHOCREME HP.....242	DEVICE.....525, 548	EASY TALK BLOOD
DRIXECE.....224	EASIVENT HOLDING	GLUCOSE METER.....442, 550
DRIZALMA SPRINKLE 154, 179	CHAMBER.....516	EASY TALK GLUCOSE
<i>dronabinol</i> 366	EASIVENT MASK LARGE	TEST.....422, 550
DROPLET GENTEEL	516, 548	EASY TALK HIGH
LANCING DEVICE.....442, 547	EASIVENT MASK MEDIUM	CONTROL.....442, 550
DROPLET INSULIN	516, 548	EASY TALK LOW
SYR(HALF UNIT).....472, 547	EASIVENT MASK SMALL	CONTROL.....442, 550
DROPLET INSULIN	516, 548	EASY TOUCH.....474, 501, 553
SYRINGE.....472, 547	EASY CHECK BLOOD	EASY TOUCH BLU CTRL
DROPLET LANCETS.....442	GLUCOSE.....442, 548	SOLN-L1,L3.....442, 550
DROPLET LANCING	EASY COMFORT INSULIN	EASY TOUCH BLU LINK
DEVICE.....442	SYRINGE.....473, 548	GLUC SYST.....442, 550
DROPLET MICRON PEN	EASY COMFORT	EASY TOUCH BLU LINK
NEEDLE.....472, 547	LANCETS.....442	TEST STRIP.....423, 550
DROPLET PEN NEEDLE	EASY COMFORT PEN	EASY TOUCH FLIPLOCK
.....473, 547	NEEDLES.....473, 548	INSULIN.....474, 550
DROPSAFE PEN NEEDLE	EASY FIBER.....386	EASY TOUCH FLIPLOCK
.....473, 548	EASY GLIDE CATHETER	NEEDLE.....499, 550
<i>drospirenone-e.estradiol-</i>	TIP SYRING.....498, 548	EASY TOUCH FLIPLOCK
<i>lm.fa</i> 206		SYRINGE.....499, 550, 551

EASY TOUCH FLURINGE 500, 551	EASY TOUCH UNI-SLIP 475, 501, 553	EDLUAR..... 194
EASY TOUCH FLURINGE FLIPLOCK..... 500, 551	EASY TRAK BLOOD GLUCOSE METER..... 443, 554	ED-SPAZ..... 374, 396
EASY TOUCH FLURINGE SHEATHLOCK..... 500, 551	EASY TRAK GLUCOSE TEST..... 423, 554	EDURANT..... 56
EASY TOUCH GLUCOSE MONITOR.....443	EASY TRAK HIGH CONTROL..... 443, 554	EEMT.....342
EASY TOUCH HIGH-LOW CONTROL..... 443	EASY TRAK II CTRL SOLN- NORMAL..... 443, 554	EEMT HS.....342
EASY TOUCH HYPODERMIC NEEDLE 500, 551	EASY TRAK II TEST STRIP 423, 554	<i>efavirenz</i> 56
EASY TOUCH INSULIN SAFETY SYR..... 474, 551, 552	EASY TRAK LOW CONTROL.....443, 554	<i>efavirenz-emtricitabin- tenofov</i> 60
EASY TOUCH INSULIN SYRINGE..... 474	EASY TWIST AND CAP LANCETS.....443, 554	<i>efavirenz-lamivu-tenofov disop</i> 60
EASY TOUCH LANCETS 443, 552	EASYGLUCO METER.....443	EFFACLAR ADAPALENE... 229
EASY TOUCH LANCING DEVICE..... 443, 552	EASYGLUCO MONITORING SYSTEM..... 443	EFFER-K..... 298
EASY TOUCH LUER LOCK INSULIN..... 474, 552	EASYGLUCO PLUS...423, 554	EGATEN.....50
EASY TOUCH LUER LOCK SYRINGE..... 500, 552	EASYGLUCO PLUS NORMAL CONTROL...443, 554	EGRIFTA SV..... 348
EASY TOUCH PEN NEEDLE..... 474, 552	EASYGLUCO TEST..... 423	ELDERBERRY ZINC VIT C.608
EASY TOUCH SAFETY LANCETS.....443, 552	EASYMAX..... 423	ELDERTONIC..... 292
EASY TOUCH SAFETY PEN NEEDLE.....475, 552	EASYMAX 15 LEVEL 2 443, 554	ELEMENT COMPACT GLUCOSE METER..... 444, 554
EASY TOUCH SHEATHLOCK INSULIN 475, 552	EASYMAX 15 TEST STRIPS.....423	ELEMENT COMPACT HIGH CONTROL..... 444, 554
EASY TOUCH SHEATHLOCK SYRG-NDL 500, 501, 553	EASYMAX NG.....443	ELEMENT COMPACT NORMAL CONTROL...444, 555
EASY TOUCH SHEATHLOCK SYRINGE 501, 553	EASYMAX NORMAL CONTROL..... 444	ELEMENT COMPACT TEST STRIPS.....423, 555
EASY TOUCH TEST STRIP423	EASYMAX V SPEAKING GLUCOSE SYS.....444	ELEMENT COMPACT V GLUCOSE MTR..... 444, 555
EASY TOUCH TUBERCULIN FLIPLOCK 501, 553	EASY-TOUCH BLOOD GLUCOSE METER..... 444	ELEMENT HIGH CONTROL 444, 555
EASY TOUCH TUBERCULIN SHEATHLK 501, 553	EBASE CONTROLLER 516, 554	ELEMENT LOW CONTROL 444, 555
EASY TOUCH TWIST LANCETS.....443, 553	ECEOXIA.....222	ELEMENT NORMAL CONTROL..... 444, 555
	<i>echinacea purp aerial part ext</i> 13	ELEMENT PLUS BLOOD GLUCOSE KIT 444, 555
	ECLIPSE NEEDLE..... 501, 554	ELEMENT TEST STRIPS 423, 555
	ECLIPSE SYRINGE.... 501, 554	ELEPSIA XR.....147
	EC-NAPROXEN..... 41	ELESTRIN..... 343
	<i>econazole</i> 237	<i>eletriptan</i> 183
	ECONTRA EZ..... 216	ELIGARD.....87
	ECONTRA ONE-STEP.....216	ELIGARD (3 MONTH)..... 87
	ECOTRIN..... 43	ELIGARD (4 MONTH)..... 87
	ECOZA..... 237	ELIGARD (6 MONTH)..... 87
	EDARBI..... 112	Elinest.....206
	EDARBYCLOR..... 112	ELIQUIS..... 401
		ELIQUIS DVT-PE TREAT 30D START 401
		ELITE-OB..... 301
		Elixophyllin.....639
		ELLA.....216

ELLUME COVID-19 HOME TEST.....	431, 555	<i>enalapril maleate</i>	110	<i>eplerenone</i>	110
ELLZIA PAK.....	264	<i>enalapril-hydrochlorothiazide</i>	109	EPOGEN.....	401
ELMIRON.....	391	ENBRACE HR.....	306	<i>eprosartan</i>	112
ELOCTATE.....	404	ENBREL.....	29, 30	EQUETRO.....	144, 172
Eluryng.....	216	ENBREL MINI.....	29	<i>ergocalciferol (vitamin d2)</i> ...	326
EMBRACE BLOOD GLUCOSE SYSTEM.....	423, 444, 555	ENBREL SURECLICK.....	30	<i>ergoloid</i>	201
EMBRACE EVO BLOOD GLUCOSE KIT.....	444, 555	ENDARI.....	289	ERGOMAR.....	182
EMBRACE EVO LEVEL 1.....	444, 555	ENDO AVITENE.....	408	<i>ergotamine-caffeine</i>	182
EMBRACE EVO TEST STRIPS.....	423, 555	Endocet.....	25	ERIVEDGE.....	86
EMBRACE GLUCOSE CONTROL HIGH.....	444, 555	ENDOMETRIN.....	344	ERLEADA.....	80
EMBRACE GLUCOSE CONTROL LOW.....	445, 555	ENGERIX-B (PF).....	100	<i>erlotinib</i>	77
EMBRACE LANCETS.....	445, 555	ENLITE GLUCOSE SENSOR.....	445, 556	Errin.....	213
EMBRACE LANCING DEVICE.....	445, 555	ENLITE SERTER.....	445, 556	ERTACZO.....	237
EMBRACE PRO.....	445, 556	ENLITE SYSTEM.....	445, 556	ERY PADS.....	222
EMBRACE PRO GLUCOSE METER.....	445	<i>enoxaparin</i>	411	Ery-Tab.....	67
EMBRACE PRO TEST STRIPS.....	423	Enpresse.....	214	Erythrocin (As Stearate).....	67
EMBRACE TALK BLOOD GLUCOSE SYS.....	445	Enskyce.....	206	<i>erythromycin</i>	68, 628
EMBRACE TALK CONTROL-HIGH (L2).....	445, 556	ENSPRYNG.....	416	<i>erythromycin ethylsuccinate</i>	67, 68
EMBRACE TALK CONTROL-LOW (L1).....	445, 556	ENSTILAR.....	231	<i>erythromycin with ethanol</i>	222
EMBRACE TALK GLUCOSE MONITOR.....	445	ENSURE CLEAR THERAPEUTIC.....	309	<i>erythromycin-benzoyl peroxide</i>	224
EMBRACE TALK TEST STRIPS.....	423	ENSURE RAPID HYDRATION.....	297	ESBRIET.....	654
EMCYT.....	84	<i>entacapone</i>	159	<i>escitalopram oxalate</i>	152
EMEND.....	367	<i>entecavir</i>	63	<i>esomeprazole magnesium</i>	370, 371
EMFLAZA.....	346	ENTERAL GRAVITY BAG SET-ENFIT.....	432, 556	<i>esomeprazole strontium</i>	371
EMGALITY PEN.....	181	ENTEREG.....	48	ESPEROCT.....	404
EMGALITY SYRINGE.....	136, 181	ENTRESTO.....	112	Estartylla.....	206
Emoquette.....	206	ENTTY.....	249	<i>estazolam</i>	193
EMPAVELI.....	399, 414	Enulose.....	368	<i>estradiol</i>	343, 655
EMSAM.....	152	ENVARUSUS XR.....	416	<i>estradiol valerate</i>	344
<i>emtricitabine</i>	58	ENVIVE.....	383	<i>estradiol-norethindrone acet</i>	342
<i>emtricitabine-tenofovir (tdf)</i>	57	ENZNONUTY.....	270	ESTRING.....	655
EMTRIVA.....	58	EPCLUSA.....	65	ESTROGEL.....	344
EMULSION SB.....	249	EPICERAM.....	249	<i>estrogens-methyltestosterone</i>	342
EMVERM.....	50	EPICYN.....	284	ESTROVEN CMPLT MENOPAUSE RLF.....	13
		EPIDIOLEX.....	140	ESTROVEN MENOPAUSE.....	301
		EPIDUO FORTE.....	227	<i>eszopiclone</i>	194
		EPIFIX AMNIOTIC MEMBRANE.....	282	<i>ethacrynic acid</i>	131
		EPIFOAM.....	265	<i>ethambutol</i>	61
		<i>epinastine</i>	618	<i>ethosuximide</i>	148
		<i>epinephrine</i>	129, 636	ETHOXIA.....	229
		<i>epinephrine hcl</i>	650	<i>ethyl acetate</i>	198
		EPISIL.....	608	<i>ethyl chloride</i>	271
		Epitol.....	144, 172	<i>ethynodiol diac-eth estradiol</i>	206
		EPIVIR HBV.....	63	<i>etidronate disodium</i>	340
				<i>etodolac</i>	42

<i>etonogestrel-ethinyl estradiol</i> 216	EXSERVAN.....417	<i>fenoprofen</i> 41
<i>etoposide</i> 84	EXTAVIA.....611	<i>fentanyl</i> 15
<i>etravirine</i> 56	EXTRA-VIRT PLUS DHA....313	<i>fentanyl citrate</i> 15
EUCRISA.....233	EYE.....363	<i>fentanyl citrate (pf)</i> 15
EURAX.....283	EYE HEALTH PLUS	<i>fentanyl citrate (pf)-0.9%nacl</i> .15
EUTHYROX.....362	LUTEIN.....11, 301	FENTORA.....15
EVAMIST.....344	EYE MULTIVITAMIN....11, 301	FERGON.....295
EVARREST.....409	EYE MULTIVITAMIN WITH	FERIVA 21-7.....296
EVEKEO ODT.....176	LUTEIN.....11, 301	FERIVA FA (WITH
EVENCARE.....445, 446, 556	EYSUVIS.....619	SUMALATE).....296
EVENCARE G2.....423, 445	E-Z JECT LANCETS...446, 557	FERRIPROX.....48
EVENCARE G3 CONTROL 445	E-Z JECT THIN LANCETS..446	FERRIPROX (2 TIMES A
EVENCARE G3 GLUCOSE	EZ SMART CONTROL.....446	DAY).....48
METER.....445	EZ SMART LANCETS.446, 557	<i>ferrous gluconate</i> 295
EVENCARE G3 TEST.....423	EZ SMART PLUS SYSTEM	<i>ferrous sulfate</i> 295
EVENCARE MINI	446, 557	FETZIMA.....154, 155
GLUCOSE CONTROL 445, 556	EZ SMART PLUS TEST	<i>fexofenadine-</i>
EVENCARE MINI	424, 557	<i>pseudoephedrine</i> 633
GLUCOSE TEST STR.....423	EZ SMART SYSTEM...446, 557	FIASP FLEXTOUCH U-100
EVENCARE MINI	EZ SMART TEST.....424	INSULIN.....356
MONITOR SYSTEM.....446	EZALLOR SPRINKLE.....117	FIASP PENFILL U-100
EVENCARE PROVIEW	<i>ezetimibe</i> 121	INSULIN.....356
CONTROL-L2,L3.....446, 556	<i>ezetimibe-rosuvastatin</i> 124	FIASP U-100 INSULIN.....357
EVENCARE PROVIEW	<i>ezetimibe-simvastatin</i> 124	FIBER THERAPY
TEST STRIP.....423, 556	EZ-LETS.....446, 557	(PSYLLIUM-SUCRO).....386
EVENCARE TEST.....424, 556	FABIOR.....229	FIFTY50 SAFETY SEAL
<i>everolimus (antineoplastic)</i> 89	FACTIVE.....63	LANCETS.....446
<i>everolimus</i>	Falmina (28).....206	FIFTY50 TEST STRIP.424, 557
(<i>immunosuppressive</i>).....417	<i>famciclovir</i> 66	<i>filter needles</i> 502, 557
EVERSENSE SMART	<i>famotidine</i> 369	FILTERED EXTENSION
TRANSMITTER.....446, 556	FANAPT.....162	SET.....489
EVICEL.....409	FARXIGA.....334	FINACEA.....222, 277
EVOLUTION BLOOD	FARYDAK.....86	<i>finasteride</i> 394
GLUCOSE METER....446, 556	FASENRA PEN.....638	FINE 30 UNIVERSAL
EVOLUTION NORMAL	FC2 FEMALE CONDOM	LANCETS.....446
CONTROL.....446, 556	433, 557	FINGERSTIX LANCETS
EVOLUTION TEST STRIPS	<i>febuxostat</i> 398	446, 557
.....424, 556	FEIBA NF.....400	FINTEPLA.....150
EVOTAZ.....58, 70	<i>felbamate</i> 140	Fioricet.....28
EVRYSDI.....420	<i>felodipine</i> 128	FIRDAPSE.....612
EXCEL SYRINGE.....501, 557	FEM PH.....655	FIRMAGON.....88
EXEL HYPODERMIC	FEMALE CATHETER..524, 557	FIRMAGON KIT W
NEEDLES.....501, 557	FEMCAP.....430, 557	DILUENT SYRINGE.....87
EXEL INSULIN.....475	FEMRING.....655	FIRVANQ.....63
EXEL SYRINGE.....502, 557	Femynor.....206	FISH OIL.....121, 122
EXELDERM.....237	<i>fenofibrate</i> 116	FLAREX.....619
<i>exemestane</i> 82	<i>fenofibrate micronized</i> 116	<i>flavoxate</i> 397
EXKIVITY.....77	<i>fenofibrate nanocrystallized</i> .116	<i>flecainide</i> 114
EXODERM.....236	<i>fenofibric acid</i> 117	FLEXICHAMBER.....516, 557
	<i>fenofibric acid (choline)</i> 117	

FLEXICHAMBER-LG CHILD MASK.....	516, 557	FLUOVIX.....	258	FORA G20.....	424, 447, 558
FLEXICHAMBER-SM ADULT MASK.....	516, 557	FLUOVIX PLUS.....	258	FORA G30A.....	447, 558
FLEXICHAMBER-SM CHILD MASK.....	516, 558	<i>fluoxetine</i>	152	FORA G30-PREMIUM V10 TEST STRP.....	424, 558
FLEXIPAK.....	37	<i>fluphenazine hcl</i>	164, 165	FORA GD50 BLOOD GLUCOSE SYSTEM... 447, 558	
FLEXI-SEAL SIGNAL FMS.....	466, 558	<i>flurandrenolide</i>	258, 259	FORA GD50 TEST STRIPS.....	424, 558
FLOLIPID.....	117	<i>flurazepam</i>	171, 193	FORA GTEL GLUCOSE TEST STRIP.....	424, 558
FLORAJEN WOMEN.....	383	<i>flurbiprofen</i>	41	FORA GTEL MULTI-FUNCTN MONITOR....	429, 558
FLORATUMMYS QUICK DISSOLVE.....	384	<i>flurbiprofen sodium</i>	622	FORA HIGH CONTROL.....	447, 559
FLOVENT DISKUS.....	637	<i>flutamide</i>	80	FORA LANCING DEVICE... 447	
FLOVENT HFA.....	637, 638	<i>fluticasone propionate</i> ..	259, 648	FORA LOW CONTROL.....	447, 559
FLUAD QUAD 2021-22(65Y UP)(PF).....	106	<i>fluticasone propion-salmeterol</i>	644	FORA NORMAL CONTROL 447	
FLUARIX QUAD 2021-2022 (PF).....	106	<i>fluvastatin</i>	118	FORA PREMIUM V10 GLUCOSE METER....	447, 559
FLUBLOK QUAD 2021-2022 (PF).....	106	<i>fluvoxamine</i>	152, 153	FORA TEST N'GO VOICE METER.....	447, 559
FLUCELVAX QUAD 2021-2022.....	107	FLUZONE HIGHDOSE QUAD 21-22 PF.....	107	FORA TEST STRIP.....	424
FLUCELVAX QUAD 2021-2022 (PF).....	106	FLUZONE QUAD 2021-2022.....	107	FORA TN'G ADVAN PRO TEST STRIP.....	424
<i>fluconazole</i>	52	FLUZONE QUAD 2021-2022 (PF).....	107	FORA TN'G ADVANCE PRO MONITOR.....	429, 559
<i>flucytosine</i>	51	FLUZONE QUAD SOUTH HEM2021(PF).....	107	FORA TN'G VOICE METER.....	447, 559
<i>fludrocortisone</i>	360	FLUZONE QUAD SOUTHERN HEM 2021.....	107	FORA TN'G VOICE TEST STRIPS.....	424, 559
FLULAVAL QUAD 2021-2022 (PF).....	107	FLYP NEBULIZER.....	492	FORA V10.....	424, 447, 559
FLUMIST QUAD 2021-2022.....	107	FML FORTE.....	619	FORA V10-V12-D10-D20 STRIPS.....	424
<i>flunisolide</i>	648	FML S.O.P.....	619	FORA V12 BLOOD GLUCOSE SYSTEM... 447, 559	
<i>fluocinolone</i>	257, 258	FOLET ONE.....	306, 313	FORA V12 GLUCOSE.....	424
<i>fluocinolone acetonide oil</i> ...	632	<i>folic acid</i>	327	FORA V20.....	424, 447, 559
<i>fluocinolone and shower cap</i>	257	FOLIC D3.....	323	FORA V30A.....	424, 447, 559
<i>fluocinonide</i>	258	FOLIKA PROBIOTIC.....	384	FORACARE GD20.....	425, 559
Fluocinonide-E.....	258	FOLIKA-CI.....	302	FORACARE GD20 GLUCOSE METER....	447, 559
<i>fluocinonide-emollient</i>	258	FOLIKA-MG.....	302	FORACARE GD40 TEST STRIPS.....	425, 559
FLUOPAR.....	264	FOLIKA-NC.....	290	FORACARE GD40A GLUCOSE METER....	447, 559
<i>fluorescein-benoxinate</i>	624, 625	FOLIVANE-OB.....	302	FORACARE GD40B GLUCOSE METER....	448, 560
<i>fluorescein-proparacaine</i>	624	FOLLISTIM AQ.....	345	FORACARE GDH HIGH CONTROL.....	448, 560
<i>fluoride (sodium)</i>	606	<i>fondaparinux</i>	411		
FLUORIDEX DAILY DEFENSE.....	606	FORA 6 CONNECT GLUCOSE STRIP.....	424, 558		
FLUORIDEX SENSITIVITY RELIEF.....	606	FORA 6 CONNECT MULTIFUNCTN MTR..	429, 558		
<i>fluorometholone</i>	619	FORA D10.....	429, 446, 558		
FLUOROPLEX.....	239	FORA D15 GLUCOSE-BP MONITOR.....	430, 446, 558		
<i>fluorouracil</i>	239	FORA D15G STRIPS..	424, 558		
		FORA D20.....	424, 446, 558		
		FORA D40D GLUCOSE-BP MONITOR.....	430, 447, 558		
		FORA D40-G31 TEST STRIPS.....	424, 558		

FORACARE GDH LOW CONTROL..... 448, 560	FREESTYLE LITE STRIPS..... 425	GE333 BLOOD GLUCOSE TEST STRIP..... 425
FORACARE GDH NORMAL CONTROL..... 448, 560	FREESTYLE NAVIGATOR GLUC SENS..... 449, 561	GE333 CONTROL SOLUTION NORMAL.. 449, 561
FORACARE LANCETS 448, 560	FREESTYLE PRECISION 475, 561	GEAMETDRAY..... 267
FORAXA..... 279	FREESTYLE PRECISION NEO METER..... 449	GELCLAIR..... 609
<i>formoterol fumarate</i> 641	FREESTYLE PRECISION NEO STRIPS..... 425	GELFILM..... 408, 627
FORTEO..... 339	FREESTYLE SIDEKICK II 449, 561	GEL-FLOW..... 408
FORTISCARE G1 TEST STRIP..... 425, 560	FREESTYLE SYSTEM KIT.. 449	GEL-FLOW NT..... 408
FORTISCARE GLUCOSE TEST STRIPS..... 425, 560	FREESTYLE TEST..... 425	GELFOAM..... 408
FORTISCARE HIGH... 448, 560	FREESTYLE UNISTIK 2 449, 561	GELFOAM JMI POWDER... 408
FORTISCARE LOW... 448, 560	FROTEK..... 274	GELFOAM JMI SPONGE... 408
FORTISCARE NORMAL 448, 560	<i>frovatriptan</i> 183	GELFOAM SPONGE SIZE 200..... 408
FORTISCARE T1 BLOOD GLUC SYS..... 448, 560	FULPHILA..... 406	GELNIQUE..... 397
FOSAMAX PLUS D..... 340	<i>furosemide</i> 131	GELX..... 609
<i>fosamprenavir</i> 70	FUZEON..... 55	<i>gemfibrozil</i> 117
<i>fosfomycin tromethamine</i> 51	Fyavolv..... 342	Gemmily..... 207
<i>fosinopril</i> 110	FYCOMPA..... 138, 139	GEMTESA..... 392
<i>fosinopril-</i> <i>hydrochlorothiazide</i> 109	G TUSSIN AC..... 653	GENADEK..... 311
FOSRENOL..... 392	<i>gabapentin</i> 141	GENADEK STEP 1..... 302
FOTIVDA..... 92	GALAFOLD..... 605	GENADEK STEP 2..... 302
FRAGMIN..... 411, 412	<i>galantamine</i> 200	GENADUR..... 283
FREESTYLE CONTROL.... 448	GALZIN..... 47	GENADUR (WITH LEXINAL)..... 283
FREESTYLE FLASH SYSTEM..... 448, 560	GAMMAGARD LIQUID..... 101	Generlac..... 368
FREESTYLE FREEDOM 448, 560	GAMMAKED..... 101	Gengraf..... 34, 416
FREESTYLE FREEDOM LITE..... 448	GAMUNEX-C..... 101	GENOTROPIN..... 349
FREESTYLE INSULINX 425, 448	<i>ganirelix</i> 360	GENOTROPIN MINIQUEICK 349
FREESTYLE INSULINX TEST STRIPS..... 425, 560	GARDASIL 9 (PF)..... 106	GENSTRIP TEST STRIP... 425
FREESTYLE LANCETS 448, 560	GAS RELIEF-PREVENTION 373	Gentak..... 628
FREESTYLE LIBRE 14 DAY READER..... 448, 560	<i>gatifloxacin</i> 628	<i>gentamicin</i> 233, 628
FREESTYLE LIBRE 14 DAY SENSOR..... 448, 560	GATTEX 30-VIAL..... 390	GENULTIMATE TEST STRIP..... 425
FREESTYLE LIBRE 2 READER..... 448, 561	GATTEX ONE-VIAL..... 390	GENVOYA..... 59
FREESTYLE LIBRE 2 SENSOR..... 449, 561	GAVILYTE-C..... 388	GERBER GOOD START GROW KIDS..... 384
FREESTYLE LITE METER. 449	Gavilyte-G..... 388	GERBER GOOD START GROW TODDLER..... 384
	Gavilyte-N..... 388	GERBER GROW MIGHTY.. 311
	GAVRETO..... 95	GERBER GS PRENATAL NOURISH PLS..... 302
	GDRIVE..... 449, 561	GERBER LIL BRAINIES..... 310
	GE100 BLOOD GLUCOSE SYSTEM..... 449, 561	GILENYA..... 613
	GE100 BLOOD GLUCOSE TEST STRIP..... 425	GILOTRIF..... 77
	GE100 CONTROL SOLUTION NORMAL..... 449	GIMOTI..... 374
	GE333 BLOOD GLUCOSE SYSTEM..... 449, 561	<i>ginkgo biloba leaf extract</i> 13
		GINKGO BILOBA PLUS (BACOPA)..... 13

GIRLS TRAINING PANTS	GLUCOCOM CONTROL	GONAL-F.....345
4T-5T.....467, 561	HIGH.....450, 561	GONAL-F RFF.....345
<i>glatiramer</i> 612	GLUCOCOM CONTROL	GONAL-F RFF REDI-JECT.345
Glatopa.....612	NORMAL.....450, 561	GONITRO.....113
GLEOSTINE.....79	GLUCOCOM GLUCOSE	GOODLIFE AC-302
<i>glimepiride</i> 334	426, 561	GLUCOSE METER....451, 562
<i>glipizide</i> 334	GLUCOCOM LANCETS	GOODLIFE AC-302 TEST
<i>glipizide-metformin</i> 334	450, 561	STRIP.....426, 562
GLOPERBA.....398	GLUCOSA IMMUNE	GRAFIX CORE.....282
GLUCAGON (HCL)	BOOSTER.....13	GRAFIX PRIME.....282
EMERGENCY KIT.....329	<i>glucosam-chondr-vit c-mn-</i>	GRAFIX XC.....282
Glucagon Emergency Kit	<i>boron</i> 9	GRALISE.....190
(Human).....329	<i>glucosamine hcl-hyaluronic</i> 9	<i>granisetron hcl</i> 366
GLUCERNA HUNGER	<i>glucosamine sulfate</i> 9	GRANIX.....406
SMART.....309	<i>glucosamine-chondroitin</i> 9	GRASTEK.....99
GLUCERNA SNACK BAR...309	<i>glucosamine-d3-hyaluronic</i>	<i>griseofulvin microsize</i> 52
GLUCO NAVII GLUCOSE	<i>acid</i> 9	<i>griseofulvin ultramicrosize</i> 52
MONITOR.....449, 561	<i>glucosamine-msm-chondr-</i>	<i>guaiaicol</i> 197
GLUCO NAVII TEST STRIP425	<i>d3-bosw</i> 9	GUAIIATUSSIN AC.....653
GLUCOCARD 01 HI-	<i>glucosamine-msm-hyaluron</i>	GUAIFENESIN AC.....653
NORMAL CONTROL.....449	<i>acid</i> 9	GUAIFENESIN DAC.....653
GLUCOCARD 01 METER...449	<i>glucosam-msm-chond-</i>	GUANENDRUX.....267
GLUCOCARD 01 NORMAL	<i>hrb149-hyal</i> 9	<i>guanfacine</i> 130, 166
CONTROL.....449	<i>glucose</i> 329	GUARDIAN CONNECT
GLUCOCARD 01 SENSOR	GLUCOSE CONTROL.....450	TRANSMITTER.....451
PLUS.....425	GLUCOSE KETONE	GUARDIAN LINK 3
GLUCOCARD	CONTROL SOLN.....450	TRANSMITTER.....451
EXPRESSION.....425, 449	<i>glutaraldehyde</i> 98	GUARDIAN RT CHARGER
GLUCOCARD SHINE.....450	GLUTAREX-2.....308, 309	451, 562
GLUCOCARD SHINE	<i>glutathione (bulk)</i> 11, 197	GUARDIAN RT TEST PLUG
CONNEX METER.....450	<i>glyburide</i> 335	DEVICE.....451
GLUCOCARD SHINE	<i>glyburide micronized</i> 335	GUARDIAN RT
EXPRESS METER.....450	<i>glyburide-metformin</i> 334	TRANSMITTER TAPE.451, 562
GLUCOCARD SHINE	<i>glycerin</i> 251	GUARDIAN SENSOR 3.....451
METER.....450	<i>glyceryl monostearate</i> 199	GUMMY DINOS.....310
GLUCOCARD SHINE	<i>glycine urologic solution</i> 391	GVOKE HYPOPEN 1-PACK
METER KIT.....450	<i>glycopyrrolate</i> 375	329
GLUCOCARD SHINE TEST	Glydo.....279	GVOKE HYPOPEN 2-PACK
STRIPS.....425	GLYXAMBI.....334	329
GLUCOCARD SHINE XL	GM100.....426, 450, 562	GVOKE PFS 1-PACK
METER.....450	GOCOVRI.....160	SYRINGE.....329
GLUCOCARD VITAL.....450	GOJJI BLOOD GLUCOSE	GVOKE PFS 2-PACK
GLUCOCARD VITAL	TEST STRIP.....426, 562	SYRINGE.....329
SENSOR.....425	GOJJI GLUCOSE CNTRL	GYNAZOLE-1.....654
GLUCOCARD VITAL TEST	SOL-NORMAL.....450, 562	GYNOL II.....217
STRIPS.....426	GOJJI LANCETS.....450, 562	HAEGARDA.....400
GLUCOCOM AUTOLINK	GOJJI LANCING DEVICE	Hailey.....207
.....450, 561	450, 562	Hailey 24 Fe.....207
GLUCOCOM BLOOD	GOJJI MULTI-FUNCTIONAL	Hailey Fe 1.5/30 (28).....207
GLUCOSE.....450	METER.....562	Hailey Fe 1/20 (28).....207

HAIR,SKIN AND NAILS(FA- BIOTIN).....	302	<i>heparin flush(porcine)- 0.9nacl</i>	410	HUMIRA PEN CROHNS- UC-HS START	28, 30, 379
<i>halcinonide</i>	259	HEPARIN LOCK.....	411	HUMIRA PEN PSOR- UVEITS-ADOL HS...28, 30, 379	
<i>halobetasol propionate</i> 242, 259		HEPARIN LOCK FLUSH.....	411	HUMIRA(CF).....	29, 30, 380
HALOG.....	259, 260	<i>heparin lock flush (porcine)</i> .	410	HUMIRA(CF) PEDI CROHNS STARTER	
<i>haloperidol</i>	164	HEPARIN LOCKFLUSH(PORCINE)(PF		.....	29, 30, 379
<i>haloperidol lactate</i>	164	).....	411	HUMIRA(CF) PEN.....	380
HALUCORT.....	249	<i>heparin, porcine (pf)</i>	410, 411	HUMIRA(CF) PEN CROHNS-UC-HS....	29, 30, 380
HAPRODERM.....	249	HEPLISAV-B (PF).....	100	HUMIRA(CF) PEN PEDIATRIC UC.....	29, 30, 380
HARMONY CONTROL L1,L3.....	451, 562	HETLIOZ.....	181	HUMIRA(CF) PEN PSOR- UV-ADOL HS.....	29, 30, 380
HARMONY GLUCOSE TEST STRIP.....	426, 562	HETLIOZ LQ.....	181	HUMULIN 70/30 U-100 INSULIN.....	350
HARVONI.....	65	HICON.....	94	HUMULIN 70/30 U-100 KWIKPEN.....	350
HAVRIX (PF).....	100	Hidex.....	346	HUMULIN N NPH INSULIN KWIKPEN.....	351
HAXCHLO.....	239	HIGH POTENCY MULTIVIT (W-IRON).....	302, 306	HUMULIN N NPH U-100 INSULIN.....	351
HEALTHPRO GLUCOSE MONITOR.....	451	HIGH POTENCY MULTIVITAMIN.....	306	HUMULIN R REGULAR U- 100 INSULN.....	351
HEALTHPRO HIGH-LOW CONTROL.....	451	HISTEX-AC.....	651	HUMULIN R U-500 (CONC) INSULIN.....	351
HEALTHPRO TEST STRIPS	426	HI-VOLUME PUMPING CHAMBER SET.....	490, 563	HUMULIN R U-500 (CONC) KWIKPEN.....	351
HEALTHWISE INSULIN SYRINGE.....	475, 562, 563	HIXDEFRIMA.....	236	HYCANTIN.....	96
HEALTHWISE PEN NEEDLE.....	476, 563	HIZENTRA.....	101	HYCLODEX.....	98
HEALTHY ACCENTS AUTOLET.....	451	HOMATROPAIRE.....	617	<i>hydralazine</i>	130
HEALTHY ACCENTS UNIFINE PENTIP	476, 563	HOME NEBULIZER PLUS SIDESTREAM.....	516	HYDRALYTE.....	297
HEALTHY ACCENTS UNILET LANCET	451	HOMINEX-2.....	308	HYDRO 35.....	268
Heather.....	213	HORIZANT.....	186	<i>hydrochloric acid (bulk)</i>	197
HELIDAC.....	389	HPR.....	249	<i>hydrochlorothiazide</i>	132
HEMADY.....	346	HPR PLUS.....	249	<i>hydrocodone bitartrate</i>	15, 16
HEMANGEOL.....	126	HPR PLUS HYDROGEL.....	248	<i>hydrocodone- acetaminophen</i>	24
HEMATEX.....	295	HPR PLUS-MB HYDROGEL	248	<i>hydrocodone- chlorpheniramine</i>	651
HEMATOGEN.....	296	HUMALOG JUNIOR KWIKPEN U-100.....	357	<i>hydrocodone-homatropine</i> ...652	
HEMATOGEN FORTE.....	296	HUMALOG KWIKPEN INSULIN.....	357	<i>hydrocodone-ibuprofen</i>	24
HEMLIBRA.....	406	HUMALOG MIX 50-50 INSULN U-100.....	352	<i>hydrocortisone</i>	45, 260, 261, 346, 378
HEMOFIL M HIGH.....	404	HUMALOG MIX 50-50 KWIKPEN.....	352	<i>hydrocortisone acetate</i>	45
HEMOFIL M LOW.....	404	HUMALOG MIX 75-25 KWIKPEN.....	352	<i>hydrocortisone butyrate</i>	260
HEMOFIL M MID.....	404	HUMALOG MIX 75-25(U- 100)INSULN.....	352	<i>hydrocortisone butyr- emollient</i>	260
HEMOFIL M SUPER HIGH. 404		HUMALOG U-100 INSULIN 357		<i>hydrocortisone valerate</i>	261
HEP FLUSH-10 (PF).....	410	HUMATE-P.....	404		
<i>heparin (porcine)</i>	410	HUMATROPE.....	349		
<i>heparin (porcine) in 0.9% nacl</i>	410	HUMIRA.....	28, 30, 379		
<i>heparin (porcine) in 5 % dex</i> 410		HUMIRA PEN.....	379		

<i>hydrocortisone-acetic acid</i> ...	632	Iclevia.....	207	INFINITY CONTROL	
<i>hydrocortisone-iodoquinol-</i>		ICLUSIG.....	89	SOLUTION NORM.....	452, 563
<i>aloe2</i>	234	ID NOW COVID-19 TEST		INFINITY METER KIT.....	452, 563
<i>hydrocortisone-iodoquinol</i> ...	239	KIT.....	431, 563	INFINITY STARTER KIT.....	452
<i>hydrocortisone-iodoquinol-</i>		IDELVION.....	402	INFINITY TEST STRIPS.....	426
<i>aloe</i>	234	IDHIFA.....	90	INFINITY VOICE CTRL	
<i>hydrocortisone-pramoxine</i>		IGLUCOSE BLOOD		SOLN-LVL 2.....	452, 563
.....	46, 265	GLUCOSE MONITOR.....	451	INFINITY VOICE GLUCOSE	
<i>hydrogen peroxide</i>	98	IGLUCOSE TEST STRIP...	426	MONITOR.....	452, 564
<i>hydrogen peroxide (bulk)</i>		ILEVRO.....	622	INFINITY VOICE TEST	
.....	98, 197	ILIDERM.....	270	STRIP.....	426, 564
Hydromet.....	652	<i>imatinib</i>	92	INFLAMMACIN.....	37
<i>hydromorphone</i>	16	IMBRUVICA.....	83, 84, 93	INFLAMMA-K.....	272
<i>hydromorphone (pf)-0.9 %</i>		IMIOXIA.....	236	INFLATHERM(DICLOFENA	
<i>nacl</i>	16	<i>imipramine hcl</i>	157	C-MENTHOL).....	37
<i>hydroquinone</i>	246	<i>imipramine pamoate</i>	158	INGREZZA.....	186, 187
<i>hydroxocobalamin</i>	324	<i>imiquimod</i>	266	INGREZZA INITIATION	
<i>hydroxychloroquine</i>	31, 53	IMMUNERX.....	302	PACK.....	186, 187
<i>hydroxyethyl</i>		IMPACT ADVANCED		INJECT EASE LANCETS	
<i>methacrylate,bulk</i>	197	RECOVERY.....	309	.....	452, 564
<i>hydroxypropyl cellulose</i>	199	IMPAVIDO.....	54	INLYTA.....	93
<i>hydroxyurea</i>	82	IMPEKLO.....	261	INNOPRAN XL.....	126
<i>hydroxyzine hcl</i>	136	IMPOYZ.....	242	INNOSPIRE DELUXE.....	517, 564
<i>hydroxyzine pamoate</i>	136	INAVIX.....	37	INNOSPIRE ELEGANCE.....	517
HYGEL.....	275	INBRIJA.....	159	INNOSPIRE ESSENCE.....	517
HYLAGUARD.....	250	Incassia.....	213	INNOSPIRE GO	
HYLATOPIC.....	250	IN-CHECK NASAL WITH		NEBULIZER.....	492, 564
HYLATOPICPLUS.....	250	MASK.....	512, 563	INNOSPIRE MINI.....	517
HYLAZINC.....	327	IN-CHECK ORAL FLOW		INNOSPIRE	
HYOPHEN.....	68	METER.....	512, 563	REPLACEMENT FILTER	
<i>hyoscyamine sulfate</i>	374	INCONTROL LANCING		.....	517, 564
HYOSYNE.....	374, 396	DEVICE.....	451, 563	INOVA.....	226
HYPER-SAL.....	198	INCONTROL PEN NEEDLE		INOVA 4-1.....	227
HYPERSONIQU NEBULIZER		.....	476, 563	INOVA 8-2.....	227
CARTRIDGE.....	517, 563	INCONTROL SUPER THIN		INPEN (FOR HUMALOG)...	476
HYPOCYN.....	252	LANCETS.....	451, 563	INPEN (FOR NOVOLOG	
HYPOLANCE AST		INCONTROL ULTRA THIN		OR FIASP).....	476
LANCING.....	451	LANCETS.....	451, 563	INQOVI.....	96
<i>hypromellose</i>	199	INCRELEX.....	359	INREBIC.....	86
HYQVIA.....	101	INCRUSE ELLIPTA.....	640	INSPIRACHAMBER....	517, 564
HYQVIA HY COMPONENT.....	363	<i>indapamide</i>	132	INSPIRACHAMBER WITH	
HYQVIA IG COMPONENT..	101	INDERAL XL.....	126	MASK-LARGE.....	517, 564
HYSINGLA ER.....	16	INDOCIN.....	42	INSPIRACHAMBER WITH	
<i>ibandronate</i>	340	<i>indomethacin</i>	42	MASK-MED.....	517, 564
IBRANCE.....	84	<i>indomethacin submicronized</i>	42	INSPIRACHAMBER WITH	
Ibu.....	41	INFASURF.....	647	MASK-SMALL.....	517, 564
IBUPAK.....	41	INFINITY CONTROL		INSPIRATION ELITE	
<i>ibuprofen</i>	41	SOLUTION HIGH.....	451, 563	FILTER.....	517, 564
<i>ibuprofen-famotidine</i>	36	INFINITY CONTROL		INSUFLOX.....	523, 564
<i>icatibant</i>	126	SOLUTION LOW.....	451, 563	INSUL-CAP.....	452, 564

INSUL-EZE.....	452, 564	ISENTRESS HD.....	55	JYNARQUE.....	393
<i>insulin asp prt-insulin aspart</i>	352	Isibloom.....	207	K1-1000.....	328
<i>insulin aspart u-100</i>	357, 358	I-SIGHT.....	11	Kaitlib Fe.....	208
<i>insulin syrlndl u100 half</i>		<i>isoflurane</i>	44	KALETRA.....	58
<i>mark</i>	476, 564	<i>isoniazid</i>	60	Kalliga.....	208
INSULIN SYRINGE.....	476, 565	<i>isopropyl alcohol</i>	198	KALYDECO.....	646
INSULIN SYRINGE		<i>isosorbide dinitrate</i>	113	KAMDOY.....	270
MICROFINE.....	476, 564	<i>isosorbide mononitrate</i>	113	KANGAROO 924 SAFETY	
<i>insulin syringe needleless</i>		<i>isotretinoin</i>	218	SCREW.....	432, 565
.....	476, 564	<i>isoxsuprine</i>	133	KANGAROO EPUMP SET	
<i>insulin syringe-needle u-100</i>		<i>isradipine</i>	128	.....	432, 565
.....	477, 565	ISTURISA.....	329	KANGAROO GRAVITY SET	
INSUPEN.....	477, 565	IS-ZC 50.....	298	.....	432, 565
INSYTE IV CATHETER		ITHOXIA.....	229	KAPSPARGO SPRINKLE...	125
.....	490, 565	<i>itraconazole</i>	52	KAPZIN DC.....	272
INTEGRA SYRINGE...	502, 565	I-VALEX-2.....	308	KARBINAL ER.....	634, 635
INTELENCE.....	56	<i>ivermectin</i>	50	Kariva (28).....	203
INTERLINK LEVER LOCK		IXINITY.....	402	KATARYA.....	246
CANNULA.....	511, 565	Jaimiess.....	203	KATARYAXN.....	246
INTERLINK SYRINGE AND		JAKAFI.....	86	KATERZIA.....	128
CANNULA.....	502, 565	JANSSEN COVID-19		KAXM.....	246
INTRON A.....	86	VACCINE (EUA).....	105	KEIDO.....	247
INVACARE LANCETS.	452, 565	Jantoven.....	400	KELARX.....	275
INVELTYS.....	619	JANUMET.....	337	Kelnor 1/35 (28).....	208
INVIGOFLEX AMPM.....	9	JANUMET XR.....	337	Kelnor 1-50 (28).....	208
INVIGOFLEX CS.....	9	JANUVIA.....	332	KELOTOP.....	521, 565
INVIGOFLEX D.....	9	JARDIANCE.....	334	KENDALL DISINFECTANT	
INVIGOFLEX GS.....	10	Jasmiel (28).....	207	CAP.....	511, 565
INVIRASE.....	70	JATENZO.....	330	KENGUARD FOLEY	
INVOKAMET.....	333	JAZZ WIRELESS 2 METER		CATHETER.....	524, 565
INVOKAMET XR.....	333	KIT.....	452	KERAGEL.....	286, 566
INVOKANA.....	334	JELMYTO.....	96	KERAGELT.....	286
IODOFLEX.....	98	Jencycla.....	213	KERALYT SCALP	
IODOSORB.....	98	JENTADUETO.....	337	COMPLETE.....	268
IOPIDINE.....	630	JENTADUETO XR.....	337	KERAMATRIX.....	283
I-PORT.....	511	Jinteli.....	342	KERENDIA.....	110
I-PORT ADVANCE 6 MM		JIVI.....	404	KERLIX AMD.....	286, 287
INJEC PORT.....	511, 565	JOLESSA.....	207	KESIMPTA PEN.....	610
I-PORT ADVANCE 9 MM		JORNAY PM.....	169	<i>ketamine</i>	44
INJEC PORT.....	511, 565	JUBLIA.....	238	KETARYA.....	247
<i>ipratropium bromide</i>	641, 647	Juleber.....	207	<i>ketoconazole</i>	52, 237
<i>ipratropium-albuterol</i>	643	JULUCA.....	56	Ketodan.....	237
<i>irbesartan</i>	112	Junel 1.5/30 (21).....	207	KETODAN KIT.....	237
<i>irbesartan-</i>		Junel 1/20 (21).....	207	KETONE CARE.....	525, 566
<i>hydrochlorothiazide</i>	112	Junel Fe 1.5/30 (28).....	207	KETONE URINE TEST.....	566
IRESSA.....	77	Junel Fe 1/20 (28).....	207	KETONEX-2.....	308
<i>iron bisglycinate chelate</i>	295	Junel Fe 24.....	208	<i>ketoprofen</i>	41
IRRIGATION SYRINGE		JUST 4 KIDZ MULTIVIT-		<i>ketorolac</i>	38, 622
.....	502, 565	PROBIOTIC.....	311	KETOSTIX.....	566
ISENTRESS.....	56	JUXTAPID.....	124	KEVARYA.....	247

KEVEYIS.....	417	L.E.T.(LIDO-EPINEPH BIT-TETRA).....	279	LATUDA.....	162
KEVZARA.....	35	<i>labetalol</i>	111	LAYOLIS FE.....	208
KEXM.....	246	LACRISERT.....	613	LAZANDA.....	16
KEYA.....	247	<i>lactated ringers</i>	292	LC PLUS.....	492
KINERET.....	34	<i>lactobacillus acidophilus</i>	384	LC PLUS NEBULIZER-PED	
KISQALI.....	84	<i>lactobacillus acidoph-l.bulgar</i>		MASK.....	492, 566
KISQALI FEMARA CO- PACK.....	87	.....	384	LDO PLUS.....	279
KIVIK.....	251	<i>lactulose</i>	368, 387	LEENA 28.....	214
KLARITY (CHONDROITIN) (PF).....	613	LAMICTAL XR STARTER (BLUE).....	146	<i>leflunomide</i>	35
KLARITY-A (AZITHRO- CHONDR)(PF).....	629	LAMICTAL XR STARTER (GREEN).....	146	LENVIMA.....	93
KLARITY-B (BETAMETH- CHOND)(PF).....	619	LAMICTAL XR STARTER (ORANGE).....	146	Lessina.....	208
KLARITY-L (LOTEPRED- CHOND)(PF).....	620	LAMIOFLUR.....	363	<i>letrozole</i>	82
KLISYRI.....	240	<i>lamivudine</i>	58, 63	<i>leucovorin calcium</i>	97
Klor-Con M10.....	298	<i>lamivudine-zidovudine</i>	59	LEUKERAN.....	79
Klor-Con M15.....	298	<i>lamotrigine</i>	146, 172	LEUKINE.....	407
Klor-Con M20.....	298	LAMPIT.....	54	<i>leuprolide</i>	87
KLOXXADO.....	49	<i>lancets</i>	452	<i>levabuterol hcl</i>	642
KOATE.....	404	LANCETS, SUPER THIN		<i>levabuterol tartrate</i>	642
KOGENATE FS.....	404	.....	452, 566	LEVATOL.....	125
KOMBIGLYZE XR.....	337	LANCETS, THIN.....	452, 566	LEVEMIR FLEXTOUCH U- 100 INSULN.....	353
KONSYL SUGAR-FREE.....	386	LANCETS, ULTRA THIN		LEVEMIR U-100 INSULIN...	353
KORLYM.....	332	.....	452, 566	<i>levetiracetam</i>	147
KOSELUGO.....	88	<i>lancing device</i>	452	LEVICYN ANTIPRURITIC	
KOSHER PRENATAL PLUS IRON.....	313	LANCING DEVICE WITH LANCETS.....	452	.....	282, 288
KOVALTRY.....	405	<i>lancing device with lancets</i> ..	452	LEVICYN ANTIPRURITIC SG.....	250
KOVANAZE.....	606	LANCING SYSTEM.....	452, 566	LEVICYN DERMAL.....	284
K-PHOS NO 2.....	394	LANOLIN (HPA).....	251	<i>levobunolol</i>	625
K-PHOS ORIGINAL.....	394	LANOXIN.....	130	<i>levocarnitine</i>	289, 603
KRINTAFEL.....	53	<i>lansoprazole</i>	371	<i>levocarnitine (with sugar)</i>	603
Kristalose.....	387	<i>lanthanum</i>	392	<i>levocetirizine</i>	636
KRISTALOSE.....	387	LANTUS SOLOSTAR U-100 INSULIN.....	353	<i>levofloxacin</i>	63, 628
Kurvelo (28).....	208	LANTUS U-100 INSULIN....	353	Levonest (28).....	214
KUTARYAXM.....	247	LANZO LANCING DEVICE		<i>levonorgestrel</i>	216
KUTARYAXMPA.....	247	.....	452, 566	<i>levonorgestrel-ethinyl estrad</i>	209
KUTEA.....	246	<i>lapatinib</i>	77	<i>levonorg-eth estrad triphasic</i>	
KUVARYA.....	247	Larin 1.5/30 (21).....	208	.....	214
KUVARYE.....	247	Larin 1/20 (21).....	208	Levora-28.....	209
KUXM.....	246	Larin 24 Fe.....	208	<i>levorphanol tartrate</i>	16, 17
KYLEENA.....	202	Larin Fe 1.5/30 (28).....	208	<i>levothyroxine</i>	362
KYNMOBI.....	160	Larin Fe 1/20 (28).....	208	LEVULAN.....	274
<i>l norgest/e.estradiol-e.estrad</i>		Larissia.....	208	LEXETTE.....	243
.....	203, 213	LASTACFT.....	618	LEXIVA.....	70
L.E.T. (LIDO-EPINEPH- TETRA).....	279	<i>latanoprost</i>	630	LEXIXRYL.....	274
		<i>latanoprost (pf)</i>	630	LIALDA.....	378

<i>lidocaine</i>	45, 279	LITETOUCH-SMALL MASK		LUER SLIP TIP SYRINGE	
<i>lidocaine hcl</i>	44, 279, 608	.....	517, 567	TRAY.....	502, 567
<i>lidocaine hcl-hydrocortison</i>		<i>lithium carbonate</i>	174	LUER-LOK TIP.....	502, 567
<i>ac</i>	46, 265	LITHOLYTE.....	394	LUGOLS.....	98, 294
Lidocaine Viscous.....	608	LITHOSTAT.....	394	<i>luliconazole</i>	237
<i>lidocaine-hydrocortisone-</i>		LIVALO.....	118	LUMAKRAS.....	87
<i>aloe</i>	46	LIVER PROTECT.....	11	LUMIGAN.....	630
<i>lidocaine-prilocaine</i>	270	LIVMARLI.....	415	LUPANETA PACK (1	
<i>lidocaine-racepinep-</i>		LMR PLUS.....	270	MONTH).....	359
<i>tetracaine</i>	279	LO LOESTRIN FE.....	203	LUPANETA PACK (3	
<i>lidocaine-tetracaine</i>	279	LO-DOSE ASPIRIN.....	43, 413	MONTH).....	359
LIDOMARK 1-5.....	45	LOFRIC.....	524, 567	LUPKYNIS.....	416
LIDOMARK 2-5.....	45	LOFRIC ORIGO.....	524, 567	<i>lutein</i>	11
LIDOPAC.....	279	LOFRIC PRIMO NELATON		<i>lutein-zeaxanthin</i>	11
LIDOPIN.....	279	CATHETER.....	524	<i>lutein-zeaxanthin-bilberry ext.</i>	11
LIDOPURE PATCH.....	280	LOFRIC SENSE NELATON		Lutera (28).....	209
LIDORX.....	280	CATHETER.....	524, 567	LUVIRA.....	122
LIDORXKIT.....	270	Lojaimiess.....	203	LUXAMEND.....	250
LIDOTRANS 5 PAK.....	280	LOKELMA.....	292	LYBALVI.....	173
LIDOTREX.....	280	LONHALA MAGNAIR		Lyleq.....	213
LIDOTREX (WITH VITAMIN		REFILL.....	640	Lyllana.....	344
E).....	280	LONHALA MAGNAIR		LYNPARZA.....	91
LIDOVEX.....	280	STARTER.....	640	LYRICA.....	141, 179
LIDTOPIC MAX.....	280	LONSURF.....	82	LYRICA CR	
LILETTA.....	202	<i>loperamide</i>	364	.....	178, 179, 189, 190, 191
Lillow (28).....	209	<i>lopinavir-ritonavir</i>	58	<i>lysine hcl</i>	290
<i>lindane</i>	283	LOPROX KIT.....	236, 237	LYSODREN.....	80
<i>linezolid</i>	69	<i>lorazepam</i>	137	LYUMJEV KWIKPEN U-100	
LINZESS.....	377	Lorazepam Intensol....	137, 172	INSULIN.....	358
<i>liothyronine</i>	362	LORBRENA.....	79	LYUMJEV KWIKPEN U-200	
LIPOCHOL PLUS.....	122	LOREEV XR.....	137, 172	INSULIN.....	358
LIQUID C.....	325	LORMATE.....	324	LYUMJEV U-100 INSULIN..	358
<i>lisinopril</i>	110	LORTAB ELIXIR.....	24, 25	Lyza.....	213
<i>lisinopril-hydrochlorothiazide</i>		Loryna (28).....	209	<i>mafenide acetate</i>	245
.....	109	<i>losartan</i>	112	<i>mag citrate-potassium citrate</i>	
LITE TOUCH INSULIN PEN		<i>losartan-hydrochlorothiazide</i>	112	.....	297
NEEDLES.....	477, 566	LOTEMAX.....	620	MAGELLAN INSULIN	
LITE TOUCH INSULIN		LOTEMAX SM.....	620	SAFETY SYRNG.....	478, 567
SYRINGE.....	477, 566	<i>loteprednol etabonate</i>	620	MAGELLAN SAFETY	
LITE TOUCH LANCETS		LOUTREX.....	244, 250	NEEDLE.....	502, 567
.....	452, 566	<i>lovastatin</i>	119	MAGELLAN SAFETY	
LITE TOUCH LANCING		Low-Ogestrel (28).....	209	SYRINGE.....	502, 567
DEVICE.....	452, 566	<i>loxapine succinate</i>	164	MAGELLAN SYRINGE	
LITE TOUCH-MEDIUM		LOYON.....	250	.....	478, 502, 567, 568
MASK.....	517, 566	Lo-Zumandimine (28).....	209	MAGIC3 INTERMITTENT	
LITEAIRE MDI CHAMBER		<i>lubiprostone</i>	376, 386	CATHETER.....	525, 568
.....	517, 566	LUCEMYRA.....	195	<i>magnesium chloride</i>	296
LITETOUCH-LARGE MASK		LUER LOCK SYRINGE		<i>magnesium citrate</i>	296
.....	517, 566	.....	502, 567	MAGNESIUM COMPLEX....	296

<i>magnesium glycinate-mag</i>	<i>meclizine</i>	<i>memantine</i>
<i>oxide</i>	<i>meclofenamate</i>	MEN 50 PLUS
<i>magnesium oxide</i>	<i>mecobalamin (vitamin b12)</i>	MULTIVITAMIN.....
<i>malathion</i>	MEDCAPS MENOPAUSE.....	MENACTRA (PF).....
<i>maprotiline</i>	MEDIHONEY (CAL	M-END PE.....
MAR-COF BP.....	ALGINATE-HONEY)....	MENEST.....
MAR-COF CG.....	MEDIHONEY (HONEY).....	MENOFEM.....
Marlissa (28).....	MEDIHONEY	MENOPUR.....
MARNATAL-F.....	(HYDROCOLLOID-HONEY)	MENOSTAR.....
MARPLAN.....	.....	MENQUADFI (PF).....
MARVONA SUIK (PF).....	MEDISENSE.....	MEN'S 50 PLUS
MATRISTEM.....	MEDISENSE CONTROLS	MULTIVITAMIN.....
MATRISTEM	1-HI 1-LO.....	MEN'S MULTIVITAMIN
MICROMATRIX.....	MEDISENSE GLUCOSE	GUMMIES.....
MATULANE.....	KETONE.....	MEN'S ONE DAILY.....
Matzim La.....	MEDISENSE MID	MENTAX.....
MAVENCLAD (10 TABLET	CONTROL.....	MENTHO-CAINE.....
PACK).....	MEDISENSE THIN	MENVEO A-C-Y-W-135-DIP
MAVENCLAD (4 TABLET	LANCETS.....	(PF).....
PACK).....	MEDLANCE PLUS	<i>meperidine</i>
MAVENCLAD (5 TABLET	LANCETS.....	<i>meperidine (pf)</i>
PACK).....	MEDLANCE PLUS	<i>meprobamate</i>
MAVENCLAD (6 TABLET	SPECIAL BLADE.....	<i>mercaptopurine</i>
PACK).....	MEDPOINT NORMAL	Merzee.....
MAVENCLAD (7 TABLET	CONTROL.....	<i>mesalamine</i>
PACK).....	MEDROL.....	<i>mesalamine with cleansing</i>
MAVENCLAD (8 TABLET	MEDROLOAN II SUIK.....	<i>wipe</i>
PACK).....	MEDROLOAN SUIK.....	MESNEX.....
MAVENCLAD (9 TABLET	<i>medroxyprogesterone</i> ..	Metadate Er.....
PACK).....	MEDTRONIC REMOTE	<i>metaproterenol</i>
MAVYRET.....	CONTROL.....	<i>metaxalone</i>
MAXICOMFORT II PEN	<i>mefenamic acid</i>	METER-CHECK.....
NEEDLE.....	<i>mefloquine</i>	<i>metformin</i>
MAXICOMFORT INSULIN	MEGARED ADV TOTAL	<i>methadone</i>
SYRINGE.....	BODY REFRESH.....	Methadone Intensol.....
MAXI-COMFORT INSULIN	MEGARED ADVANCED 4-	Methadose.....
SYRINGE.....	IN-1.....	<i>methamphetamine</i>
MAXICOMFORT SAFETY	MEGARED ADVANCED	<i>methazolamide</i>
PEN NEEDLE.....	TOTAL BODY.....	<i>methenamine hippurate</i>
MAXIDEX.....	MEGARED OMEGA-3	<i>methenamine mandelate</i>
MAXI-TUSS AC.....	KRILL OIL.....	<i>methen-sod phos-meth blue-</i>
MAXI-TUSS CD.....	<i>megestrol</i>	<i>hyos</i>
MAYZENT.....	MEKINIST.....	<i>me-thfolate glucos-</i>
MAYZENT STARTER PACK	MEKTOVI.....	<i>mecobalamin</i>
.....	<i>melatonin</i>	<i>methimazole</i>
MB HYDROGEL.....	<i>melatonin-pyridoxine hcl (b6)</i>	METHITEST.....
MB HYDROGEL	.....	<i>methocarbamol</i>
(CYCLOMETHICONE).....	<i>meloxicam</i>	METHOCEL E 4 M.....
M-CLEAR WC.....	<i>meloxicam submicronized</i>	<i>methotrexate sodium</i>
MCT OIL.....	<i>melphalan</i>	<i>methotrexate sodium (pf)</i>

<i>methoxsalen</i>	241	Microgestin Fe 1.5/30 (28)...	210	MINIMED SILHOUETTE 32"	
<i>methscopolamine</i>	374	Microgestin Fe 1/20 (28).....	210	.....	527
<i>methyl salicylate</i>	282	MICROLET 2 LANCING		MINIMED SILHOUETTE 43"	
<i>methyl dopa</i>	130	DEVICE.....	453, 569	.....	527
<i>methyl dopa-</i>		MICROLET LANCET.....	453	MINIMED SURE T 18".....	527, 569
<i>hydrochlorothiazide</i>	130	MICROLET NEXT LANCING		MINIMED SURE T 23".....	527
<i>methyl ergonovine</i>	360	DEVICE.....	453, 569	MINIMED SURE T 32".....	527
<i>methylphenidate hcl</i>		MICROLIFE PEAK FLOW		MINIMED SYRINGE	
.....	169, 170, 188	METER.....	513, 569	RESERVOIR.....	479, 570
<i>methylprednisolone</i>	347	MICROSPACER.....	517	Minitran.....	113
<i>methyltestosterone</i>	330	<i>midazolam</i>	44, 193	<i>minocycline</i>	74, 75, 219
<i>methyltetrahydrofolate</i>		<i>midazolam (pf)</i>	44	MINOLIRA ER.....	75, 219
<i>glucosa</i>	327	<i>midodrine</i>	129	<i>minoxidil</i>	130
<i>metipranolol</i>	625	MIFEPREX.....	328	MIRCERA.....	401
<i>metoclopramide hcl</i>	374	<i>mifepristone</i>	328	MIRENA.....	202
<i>metolazone</i>	132	MIGERGOT.....	182	<i>mirtazapine</i>	151
<i>metoprolol succinate</i>	125	<i>miglitol</i>	332	MIRVASO.....	277
<i>metoprolol ta-</i>		<i>miglustat</i>	603	<i>misoprostol</i>	373
<i>hydrochlorothiaz</i>	129	MIGRANOW.....	183	MISTASSIST.....	517, 570
<i>metoprolol tartrate</i>	125	Mili.....	210	MISTASSIST KIT.....	518, 570
<i>metronidazole</i>	54, 277, 655	MILLIPRED.....	347	MITOSOL.....	617
<i>metyrosine</i>	134	MILLIPRED DP.....	347	MKO (MIDAZOLAM-	
<i>mexiletine</i>	114	Mimvey.....	342	KETAMINE-ONDAN).....	44
Mibelas 24 Fe.....	209	MINERIN CREME.....	250	M-M-R II (PF).....	108
<i>miconazole nitrate-zinc ox-</i>		MINI LANCING DEVICE		M-NATAL PLUS.....	314
<i>pet</i>	238	.....	453, 569	<i>modafinil</i>	187
MICONAZOLE-3.....	654	MINI PLUS NEBULIZER		MODERNA COVID-19	
MICRO BLOOD GLUCOSE		.....	492, 569	VACCINE (EUA).....	105
.....	426, 568	MINI ULTRA-THIN II....	478, 569	<i>moexipril</i>	110
MICRO THIN LANCETS.....	453	MINI WRIGHT PEAK FLOW		<i>molindone</i>	164
MICROAIR MESH		METER.....	513	<i>mometasone</i>	261, 648
NEBULIZER.....	492	MINIMED 770G INSULIN		Mondoxylene NI.....	75
MICROBORE EXTENSION		PUMP.....	523	MONO-FLO DRAINAGE	
SET.....	490, 568	MINIMED MIO ADVANCE		BAG.....	466, 570
MICROCHAMBER.....	517	INF SET23".....	526	MONOJECT 140CC	
MICROCYN.....	98, 285	MINIMED MIO ADVANCE		PISTON SYRINGE.....	503
MICRODOT BLOOD		INF SET43".....	526	MONOJECT 35CC	
GLUCOSE SYSTEM		MINIMED QUICK SET 18"		SYRINGE CATH TIP... 503, 570	
.....	426, 453, 569	.....	526, 569	MONOJECT 3CC SYR	
MICRODOT HIGH-LOW		MINIMED QUICK SET 23"..	526	25GX1".....	503, 570
CONTROL.....	453, 569	MINIMED QUICK SET 32"..	526	MONOJECT ALLERGY	
MICRODOT INSULIN PEN		MINIMED QUICK SET 43"..	526	TRAY.....	503, 570
NEEDLE.....	478, 569	MINIMED QUICK-SERTER-		MONOJECT ALLERGY	
MICRODOT NORMAL		MMT 395.....	454, 569	TRAY DETACH.....	503, 570
CONTROL.....	453, 569	MINIMED SILHOUETTE 18"		MONOJECT BLOOD	
MICRODOT XTRA BLOOD		.....	526, 569	COLLECTION.....	420, 570
GLUCOSE.....	426, 569	MINIMED SILHOUETTE 23"		MONOJECT CONTROL	
Microgestin 1.5/30 (21).....	209	.....	526	SYRINGE LUER.....	503, 570
Microgestin 1/20 (21).....	209			MONOJECT DISPOSABLE	
Microgestin 24 Fe.....	209			SYRINGE.....	503

MONOJECT ECCENTRIC NON-STERILE..... 503, 570	MONOLET THIN LANCETS 454, 574	MYALEPT.....359
MONOJECT HYPODERMIC NEEDLES.....503, 571	Mono-Linyah.....210	MYCAPSSA.....361
MONOJECT INSULIN SAFETY SYRINGE.....479, 571	MONONINE.....402	<i>mycophenolate mofetil</i> 416
MONOJECT INSULIN SYRINGE..... 479, 571	MONSEL'S..... 408	<i>mycophenolate sodium</i> 416
MONOJECT LUER ADAPTER.....511, 571	<i>montelukast</i> 638	MYDAYIS..... 170, 175
MONOJECT LUER-LOCK TIP.....503, 571	MORGIDOX 1X 50..... 75	MYDRIATIC4(TROP-PROP- PE-KTRLC).....626
MONOJECT MAGELLAN SYRINGE.... 503, 504, 571, 572	MORGIDOX 1X100..... 75	<i>myelogram tray</i> 511, 574
MONOJECT PHARMACY TRAY LUER..... 504, 572	MORGIDOX 2X100..... 76	MYFEMBREE.....360
MONOJECT PHARMACY TRAY REG TIP.....504	<i>morphine</i> 17, 18	MYGLUCOHEALTH 426, 454, 574, 575
MONOJECT REG TIP NON- STERILE.....504, 572	<i>morphine (pf)</i> 17	MYGLUCOHEALTH CONTROL SOLUTION454, 574
MONOJECT REGULAR LUER.....504, 572	<i>morphine concentrate</i> 17	MYGLUCOHEALTH LANCETS..... 454, 575
MONOJECT SAFETY LUER LOCK TIP..... 505, 572	<i>morphine in 0.9 % sodium chlor</i> 17	MYLERAN..... 78
MONOJECT SAFETY SYRINGES..... 505, 572, 573	MOTTEGRITY..... 373	MYNATAL.....314
MONOJECT SMARTIP CANNULA..... 505, 573	MOTOFEN.....365	MYNATAL ADVANCE..... 314
MONOJECT SYRINGE 479, 506, 573, 574	MOVANTIK.....48	MYNATAL PLUS..... 314
MONOJECT SYRINGE ECCENTRI LUER.....505, 573	MOVE FREE JOINT HEALTH..... 10	MYNATAL-Z..... 314
MONOJECT SYRINGE LUER LOK.....505, 573	MOVE FREE PLUS MSM.....10	MYNATE 90 PLUS..... 314
MONOJECT SYRINGE REGULAR LUER.....505, 573	MOVE FREE PLUS MSM- VIT D3..... 10	MYNEPHRON.....290
MONOJECT SYRINGE TOOMEY TYPE.....506, 574	MOVE FREE ULTRA FASTER COMFORT..... 294	Myorisan.....218
MONOJECT TB.....506, 574	MOVE FREE ULTRA TURMERIC-TAMAR..... 13	MYRBETRIQ..... 392
MONOJECT TB LUER LOK 506, 574	MOXATAG.....49	MYTESI..... 364
MONOJECT TB REGULAR LUER TIP..... 506, 574	<i>moxifloxacin</i> 63, 628	MYXREDLIN.....351
MONOJECT TB SAFETY SYRINGE..... 506, 574	MUCOSITISRX.....607	N.O.MAX ER..... 290
MONOJECT TUBERCULIN SYRINGE..... 506, 507, 574	MUGARD.....609	<i>nabumetone</i> 38
MONOJECT ULTRA COMFORT INSULIN... 479, 574	MULPLETA.....415	<i>nadolol</i> 126
MONOLET LANCETS..... 454	MULTAQ.....115	<i>nadolol-bendroflumethiazide</i> 133
	MULTI FOR HIM (NO IRON) 303	<i>naftifine</i> 235
	MULTI PRO.....303	NAFTIN.....235
	MULTI-LANCET DEVICE 2 454, 574	<i>nalbuphine</i> 26
	<i>multivitamin</i> 306	Nalocet..... 25
	MULTIVITAMIN GUMMIES.303	<i>naloxone</i> 49
	MULTIVITAMIN WOMEN 50 PLUS..... 303	<i>naltrexone</i> 49
	MULTIVITAMIN-ZINC- STRESS..... 290	NAMENDA XR.....201
	<i>multivit-min-ferrous fumarate</i> 303	NAMZARIC.....201
	<i>mupirocin</i> 233	NAPRELAN CR.....41
	<i>mupirocin calcium</i> 233	<i>naproxen</i> 41
	MURI-LUBE.....198	<i>naproxen sodium</i> 41, 42
	MY CHOICE..... 216, 217	<i>naproxen-esomeprazole</i> 36
	MY WAY..... 216, 217	<i>naratriptan</i> 183
		NARCAN..... 49
		NASCOBAL..... 325
		NATACHEW (FE BIS- GLYCINATE)..... 314
		NATACYN..... 629
		NATAZIA..... 213
		<i>nateglinide</i> 333

NATESTO.....	330	NEVANAC.....	622	NOCTIVA.....	331
NATPARA.....	361	<i>nevirapine</i>	56, 57	NOOTROPIC COFFEE-PS... 13	
NAYZILAM.....	140	NEW DAY.....	216, 217	NOPIOID-LMC KIT.....	420
<i>nebivolol</i>	125	NEWGEN.....	314	NORA-BE.....	213
<i>nebulizer and compressor</i>	518, 575	NEXA PLUS.....	315	NORDITROPIN FLEXPPO..	349
NEBUPENT.....	68	NEXAVAR.....	89	<i>noreth-ethinyl estradiol-iron</i> ..	210
NEBUSAL.....	199	NEXAVIR.....	269	<i>norethindrone</i> (<i>contraceptive</i>).....	213
Necon 0.5/35 (28).....	210	NEXIUM PACKET.....	371	<i>norethindrone acetate</i>	361
<i>nefazodone</i>	153	NEXIVA.....	490, 575	<i>norethindrone ac-eth</i> <i>estradiol</i>	210, 342
<i>neomycin</i>	49	NEXLETOL.....	115	<i>norethindrone-e.estradiol-</i> <i>iron</i>	210
<i>neomycin-bacitracin-poly-hc</i>	615	NEXLIZET.....	123	Norgesic Forte.....	418
<i>neomycin-bacitracin-</i> <i>polymyxin</i>	627	NEXPLANON.....	202	<i>norgestimate-ethinyl</i> <i>estradiol</i>	210, 214
<i>neomycin-polymyxin b gu</i>	391	NEXTSTELLIS.....	210	NORITATE.....	277
<i>neomycin-polymyxin b-</i> <i>dexameth</i>	615	<i>niacin</i>	120, 325	Norlyda.....	213
<i>neomycin-polymyxin-</i> <i>gramicidin</i>	627	<i>niacin (inositol niacinate)</i>	325	NORMAL SALINE FLUSH...322	
<i>neomycin-polymyxin-hc</i>	616, 632	<i>niacinamide</i>	325	NORM-JECT.....	507, 575
NEONATAL COMPLETE... 314		Niacor.....	120	NORM-JECT TUBERKULIN	507, 575
NEONATAL FE.....	295	<i>nicardipine</i>	128	NORMLGEL AG.....	233
NEONATAL PLUS VITAMIN	314	NICOTINAMIDE (WITH CHROMIUM).....	303	NORPACE CR.....	114
NEONATAL-DHA.....	314	<i>nicotine</i>	196	Nortrel 0.5/35 (28).....	210
Neo-Polycin.....	627	<i>nicotine (polacrilex)</i>	196	Nortrel 1/35 (21).....	211
Neo-Polycin Hc.....	616	NICOTROL.....	196	Nortrel 1/35 (28).....	211
NEOSALUS.....	250	NICOTROL NS.....	196	Nortrel 7/7/7 (28).....	214
NEO-SYNALAR.....	235	<i>nifedipine</i>	128	<i>nortriptyline</i>	158
NEO-SYNALAR KIT.....	235	NIGHTTIME UNDERPANTS L-XL.....	466, 575	NORVIR.....	70
NEOVITE.....	303	Nikki (28).....	210	NOSE CLIP.....	518, 575
NEPHRON FA.....	290	<i>nilutamide</i>	80	NOURIANZ.....	159
NERLYNX.....	78	<i>nimodipine</i>	128	NOVA MAX GLUCOSE CONTROL.....	454, 575
NESTABS ABC.....	314	<i>nitazoxanide</i>	54	NOVA MAX GLUCOSE TEST.....	426
NESTABS DHA.....	314	<i>nitisinone</i>	604	NOVA MAX PLUS GLUC- KETON METER.....	429, 575
NESTABS ONE.....	306	Nitro-Bid.....	113	NOVA SAFETY LANCETS..	454
Neuac.....	224	NITRO-DUR.....	113	NOVA SUREFLEX LANCETS.....	454, 575
NEUAC KIT.....	224	<i>nitrofurantoin</i>	395	NOVACORT.....	265
NEULASTA.....	406	<i>nitrofurantoin macrocrystal</i> ..	395	NOVAMAX PLUS GLU-KET	454, 575
NEULASTA ONPRO.....	406	<i>nitrofurantoin monohydr/m-</i> <i>cryst</i>	395	NOVAREL.....	350
NEUPOGEN.....	406, 407	<i>nitroglycerin</i>	113	NOVOEIGHT.....	405
NEUPRO.....	161	NITROMIST.....	113	NOVOFINE 32.....	479, 575
NEURAPTINE.....	271	NITRO-TIME.....	113	NOVOFINE AUTOCOVER	479, 575
NEURCAINE.....	281	NITYR.....	604	NOVOFINE PLUS.....	480, 575
NEURIVA DE-STRESS.....	13	NIVATOPIC PLUS.....	250		
NEURIVA ORIGINAL.....	13	NIVESTYM.....	407		
NEUTEK 2TEK TEST STRIPS.....	426	<i>nizatidine</i>	369		
NEUTRASAL.....	607	NOC DURNA (MEN).....	331		
		NOC DURNA (WOMEN).....	331		

NOVOLIN 70/30 U-100 INSULIN..... 350	NUSURGEPAK SURGICAL PREP.....288	ODEFSEY..... 60
NOVOLIN 70-30 FLEXPEN U-100.....350	NUTRASEB.....250	ODOMZO..... 86
NOVOLIN N FLEXPEN..... 351	NUTROPIN AQ NUSPIN.....349	OFEV.....93, 654
NOVOLIN N NPH U-100 INSULIN..... 351	NUVA III.....522, 576	<i>ofloxacin</i> 63, 628, 632
NOVOLIN R FLEXPEN..... 352	NUVAGEL..... 522, 576	<i>olanzapine</i> 173
NOVOLIN R REGULAR U- 100 INSULN..... 352	NUVAIL.....276	<i>olanzapine-fluoxetine</i> 173
NOVOLOG FLEXPEN U- 100 INSULIN..... 358	NUVAZIL II..... 522, 576	<i>olive oil</i> 198
NOVOLOG MIX 70-30 U- 100 INSULN..... 353	NUVESSA..... 655	<i>olmesartan</i> 113
NOVOLOG MIX 70- 30FLEXPEN U-100..... 353	NUWIQ..... 405	<i>olmesartan-amlodipin- hcthiiazid</i> 111
NOVOPEN ECHO..... 480, 575	NUZYRA.....76	<i>olmesartan- hydrochlorothiazide</i> 112
NOVOSEVEN RT..... 403	Nyamyc.....235	<i>olopatadine</i> 618, 648
NOVOTWIST.....480, 576	Nylia 7/7/7 (28)..... 214	OLUMIANT.....35
NOXAFIL..... 52	NYMALIZE.....128	OMBRA COMPRESSOR SYSTEM.....518, 576
NOXIPAK.....264	Nymyo..... 211	OMECLAMOX-PAK.....390
NP THYROID..... 362	<i>nystatin</i> 51, 235, 236, 607	<i>omega 3-dha-epa-fish oil</i> 122
NRF2 ACTIVATOR.....13	<i>nystatin-triamcinolone</i> 239	<i>omega 3-dha-epa-fish oil- krill</i> 122
NUBEQA..... 80	Nystop..... 236	OMEGA MONOPURE DHA EC.....122
NUCALA.....639	NYVEPRIA..... 407	OMEGA MONOPURE EPA EC.....122
NUCARACLINPAK.....222	OASIS ULTRA FENESTRATED..... 284, 576	OMEGA-3 2100..... 123
NUCARARXPAK.....224	OASIS WOUND MATRIX FENESTRATED..... 284, 576	<i>omega-3 acid ethyl esters</i> ... 120
NUCORT..... 264	OASIS WOUND MATRIX MESHED..... 284, 576	<i>omega-3 fatty acids-fish oil</i> .. 123
NUCYNTA..... 18	OB COMPLETE.....303	OMEGA-3 KRILL OIL..... 123
NUCYNTA ER..... 18	OB COMPLETE ONE.....315	OMEGAPURE 600 EC..... 123
NUDERMRXPAK.....243	OB COMPLETE PETITE.....315	OMEGAPURE 780 EC..... 123
NUDICLO SOLUPAK..... 273	OB COMPLETE PREMIER.315	OMEGAPURE 900 EC..... 123
NUDICLO TABPAK..... 37	OB COMPLETE WITH DHA315	<i>omeprazole</i> 371
NUDROXIPAK.....38	OBAGI ELASTIDERM..... 246	<i>omeprazole-sodium bicarbonate</i> 372, 373
NUDROXIPAK DSDR-50..... 37	OBAGI NU-DERM.....246	OMNARIS.....648
NUDROXIPAK DSDR-75..... 37	OBAGI NU-DERM CLEAR..246	OMNIPOD DASH 5 PACK POD.....491, 576
NUDROXIPAK E-400..... 37	OBAGI NU-DERM.....247	OMNIPOD DASH PDM KIT 480, 576
NUDROXIPAK I-800.....37	SUNFADER.....247	OMNIPOD INSULIN MANAGEMENT.....523, 576
NUDROXIPAK N-500..... 37	OBAGI-C CLARIFYING SERUM.....247	OMNIPOD INSULIN REFILL 491, 576
NUDEXTA..... 193	OBAGI-C THERAPY NIGHT 247	OMNITROPE.....349
NUFOLA.....323	OBIZUR.....405	ON CALL EXPRESS CONTROL.....454, 576
NU-IRON.....295	OBREDON..... 653	ON CALL EXPRESS METER.....454, 576
NULIBRY.....602	OBSTETRIX DHA.....315	ON CALL EXPRESS TEST STRIP.....426, 577
NULYTELY LEMON-LIME...388	OBSTETRIX EC..... 315	
NUMAQUA VITAMIN...11, 303	OBSTETRIX ONE..... 306	
NUMBONEX.....280	O-CAL PRENATAL.....315	
NUMBRINO..... 647	OCALIVA.....415	
NUMOISYN..... 14, 608	OCELLA..... 211	
NUPLAZID.....165	<i>octreotide acetate</i> 361	
NURTEC ODT..... 181	ODACTRA..... 99	

ON CALL LANCET..... 454, 577	ONETOUCH DELICA	OPTIFAST..... 304
ON CALL LANCING	SAFETY LANCET..... 455, 577	OPTION-2..... 217
DEVICE..... 454, 577	ONETOUCH SURESOFT	OPTIUM EZ..... 427
ON CALL PLUS CONTROL	LANCING DEV..... 455, 577	OPTIUM TEST..... 427
..... 454, 577	ONETOUCH ULTRA	OPTUMRX..... 427, 456, 578
ON CALL PLUS LANCET	CONTROL..... 455	OPZELURA..... 217
..... 454, 577	ONETOUCH ULTRA TEST..... 427	ORACIT..... 394
ON CALL PLUS LANCING	ONETOUCH ULTRA2	ORAFATE..... 609
DEVICE..... 454, 577	METER..... 455	ORALAIR..... 99
ON CALL PLUS METER	ONETOUCH ULTRAMINI..... 455	Oralone..... 608
..... 454, 577	ONETOUCH ULTRASOFT	ORALYTE..... 297
ON CALL PLUS TEST	LANCETS..... 455, 577	ORAMAGICRX..... 609
STRIP..... 426, 577	ONETOUCH VERIO FLEX	ORAPEUTIC..... 609
ON CALL VIVID CONTROL	METER..... 455	ORAQIX..... 606
..... 455, 577	ONETOUCH VERIO FLEX	ORAVIG..... 52
ON CALL VIVID METER	START..... 455	ORAXINOL..... 14
..... 455, 577	ONETOUCH VERIO HIGH	ORENCIA..... 34
ON CALL VIVID PAL	CONTROL..... 455, 577	ORENCIA CLICKJECT..... 34
METER..... 455, 577	ONETOUCH VERIO IQ	ORENITRAM..... 134
ON CALL VIVID TEST	METER..... 455, 456, 577, 578	ORFADIN..... 604
STRIP..... 427	ONETOUCH VERIO	ORGOVYX..... 88
ONCOPLEX..... 14	METER..... 456, 578	ORIAHNN..... 360
ONCOPLEX ES..... 14	ONETOUCH VERIO MID	ORILISSA..... 360
<i>ondansetron</i> 366	CONTROL..... 456, 578	ORKAMBI..... 646
<i>ondansetron hcl</i> 366	ONETOUCH VERIO	ORLADEYO..... 134
ONE DAILY ESSENTIAL..... 303	REFLECT METER..... 456, 578	<i>orphenadrine citrate</i> 419
ONE DAILY MEN'S	ONETOUCH VERIO	<i>orphenadrine-asa-caffeine</i> ... 418
HEALTH..... 303	REFLECT START..... 456, 578	Orphengesic Forte..... 418
ONE DAILY MULTIVITAMIN	ONETOUCH VERIO TEST	Orsythia..... 211
..... 307	STRIPS..... 427	ORTIKOS..... 378
ONE DAILY	ONEXTON..... 224	OSCIMIN..... 374, 396
MULTIVITAMIN-IRON..... 303	ONGENTYS..... 159	OSCIMIN SL..... 374, 396
ONE DAILY WOMEN 50	ONGLYZA..... 332	OSCIMIN SR..... 374, 397
PLUS(VIT K)..... 304	ON-THE-GO LANCETS..... 456	<i>oseltamivir</i> 66
ONE DAILY WOMEN'S..... 304	ONUREG..... 82	OSMOLEX ER..... 161
ONE-A-DAY MEN'S	ONZDEOXIA..... 224	OSMOPREP..... 388
COMPLETE..... 304	ONZETRA XSAIL..... 183	OSSOPAN-1100..... 293
ONE-A-DAY PRENATAL-1..... 315	OPCICON ONE-STEP..... 217	OSTEOBLOX CF..... 326
ONE-A-DAY WOMEN'S	<i>opium tincture</i> 364	OTEZLA..... 35
COMPLETE..... 304	OPSUMIT..... 135	OTEZLA STARTER..... 35, 244
ONE-DAILY MULTI..... 304	OPTICHAMBER ADULT	OTIPRIO..... 632
ONETOUCH DELICA LANC	MASK-LARGE..... 518, 578	OTREXUP (PF)..... 31
DEVICE..... 455, 577	OPTICHAMBER DIAMOND	OVACE PLUS..... 244
ONETOUCH DELICA	LG MASK..... 518, 578	OVACE PLUS SHAMPOO.. 244
LANCETS..... 455, 577	OPTICHAMBER DIAMOND	OVAL TAPE..... 456, 578
ONETOUCH DELICA PLUS	VHC..... 518, 578	OVIDREL..... 350
LANC DEV..... 455, 577	OPTICHAMBER DIAMOND-	<i>oxandrolone</i> 330
ONETOUCH DELICA PLUS	MED MSK..... 518, 578	<i>oxaprozin</i> 42
LANCET..... 455, 577	OPTICHAMBER DIAMOND-	OXAYDO..... 19
	SML MASK..... 518, 578	<i>oxazepam</i> 137

OXBRYTA.....	414	PANXYME PH.....	368	PEDIATRIC FROG	
<i>oxcarbazepine</i>	144	<i>papaverine</i>	134	NEBULIZER.....	519, 579
OXERVATE.....	624	PARADIGM RESERVOIR		<i>pediatric multivitamin no.171</i>	
OXIANUJO.....	246	.....	480, 578	.....	311
OXIANUJO (WITH		PARADIGM SILHOUETTE		PEDIATRIC POLY-VITE.....	311
HYALURONATE).....	246	INFUS SET.....	511	PEDIATRIC POLY-VITE	
OXIATAR.....	227	PARAGARD T 380A.....	202	WITH IRON.....	311
OXIAVARRY.....	227	PAREMYD.....	614	PEDIATRIC TRI-VITE.....	311
OXIAZAR.....	227	PARI BABY CONV KIT -		PEDIZOL PAK.....	238
<i>oxiconazole</i>	238	SIZE 1.....	518, 578	<i>peg 3350-electrolytes</i>	388
OXISTAT.....	238	PARI BABY CONV KIT -		<i>peg3350-sod sul-nacl-kcl-</i>	
OXTELLAR XR.....	144, 145	SIZE 2.....	518, 578	<i>asb-c</i>	388
<i>oxybutynin chloride</i>	397	PARI BABY CONV KIT -		PEGASYS.....	64
<i>oxycodone</i>	19	SIZE 3.....	518, 579	<i>peg-electrolyte soln</i>	388
<i>oxycodone-acetaminophen</i> ...	25	PARI LC SPRINT		PEG-PREP.....	389
OXYCONTIN.....	19	NEBULIZER SET.....	492, 579	PEMAZYRE.....	85
<i>oxymorphone</i>	19, 20	PARI LC SPRINT SINUS		PEN NEEDLE.....	480
OXYTROL.....	397	.....	492, 579	<i>pen needle, diabetic</i>	480, 579
OYSTER SHELL CALCIUM		PARI SINUS AEROSOL		<i>penicillamine</i>	47
500.....	293	SYSTEM.....	518, 579	<i>penicillin v potassium</i>	69
OZEMPIC.....	336	PARI TREK S COMBO		PENLEN.....	250
OZOBAX.....	419	PACK.....	518, 579	PENNSAICIN.....	273
Pacerone.....	115	PARI TREK S COMPACT		PENNSAID.....	274
PACNEX HP.....	226	COMPRESSOR.....	518, 579	<i>pentamidine</i>	68
PACNEX LP.....	226	PARI TREK S PORTABLE		PENTASA.....	378
PAIN EASE MEDIUM		PWR KIT.....	518, 579	<i>pentazocine-naloxone</i>	26
STREAM SPRAY.....	271	<i>paricalcitol</i>	603	PENTIPS.....	480
PAIN EASE MIST SPRAY...	271	Paroex Oral Rinse.....	607	<i>pentoxifylline</i>	407
PAINGO KFT.....	270	<i>paromomycin</i>	49	PEPCIX.....	298
PALFORZIA (LEVEL 1).....	102	<i>paroxetine hcl</i>	153	<i>peppermint oil</i>	14
PALFORZIA (LEVEL 2).....	102	<i>paroxetine</i>		<i>perindopril erbumine</i>	110
PALFORZIA (LEVEL 3).....	102	<i>mesylate(menop.sym)</i>	360	Periogard.....	607
PALFORZIA (LEVEL 4).....	102	PASER.....	60	<i>permethrin</i>	283
PALFORZIA (LEVEL 5).....	102	PCCA ACCUPEN-15...432, 579		<i>perphenazine</i>	165
PALFORZIA (LEVEL 6).....	102	PEAK AIR PEAK FLOW		<i>perphenazine-amitriptyline</i> ..	156
PALFORZIA (LEVEL 7).....	103	METER.....	513, 579	PERSONAL BEST FULL	
PALFORZIA (LEVEL 8).....	103	<i>pedi multivit no.194-iron sulf</i> 311		RANGE.....	513, 579
PALFORZIA (LEVEL 9).....	103	PEDIA IRON.....	296	PERSONAL BEST LOW	
PALFORZIA (LEVEL 10).....	103	PEDIALYTE SPARKLING		RANGE.....	513, 579
PALFORZIA (LEVEL 11 UP-		RUSH.....	297	PERTZYE.....	368
DOSE).....	103	PEDIATRIC BEAR		<i>petrolatum, yellow (bulk)</i>	198
PALFORZIA INITIAL DOSE	103	NEBULIZER.....	518, 579	PEXEVA.....	153
PALFORZIA LEVEL 11		PEDIATRIC COMP-AIR		PFIZER COVID19 TRIS	
MAINTENANCE.....	103	COMPRES NEB.....	518, 579	VAC(UNAPP).....	105
<i>paliperidone</i>	162	PEDIATRIC DINOSAUR		PFIZER COVID-19	
PALYNZIQ.....	605	NEBULIZER.....	519, 579	VACCINE (EUA).....	105
PANCREAZE.....	368	PEDIATRIC DOG		PFLEX INSPIRATORY	
PANDEL.....	262	NEBULIZER.....	519, 579	TRAINER.....	519, 580
PANRETIN.....	240	PEDIATRIC D-VITE.....	326	PHARMABASE BARRIER...	276
<i>pantoprazole</i>	372	PEDIATRIC FE-VITE.....	296		

PHARMACIST CHOICE 427, 580	PICATO..... 240	POLY-VITA DROPS..... 311
PHARMACIST CHOICE GLUCOSE SYS.....456	PIFELTRO..... 57	POLY-VITA WITH IRON.....311
PHASEAL ASSEMBLY FIXTURE..... 511, 580	PIKO 1..... 513, 580	POMALYST..... 95
PHASEAL CONNECTOR LUER LOCK..... 512	PILLOW MASK CHILD 519, 580	PONTOCAINE.....281
PHASEAL INFUSION ADAPTER.....512, 580	<i>pilocarpine hcl</i> 609, 614	PONVORY.....613
PHASEAL INFUSION CLAMP..... 512	<i>pimecrolimus</i> 246	PONVORY 14-DAY STARTER PACK..... 613
PHASEAL INJECTOR LUER 512, 580	<i>pimozide</i> 164	POPULUS COMPOSITUM..363
PHASEAL INJECTOR LUER LOCK.....512	Pimtrea (28).....203	PORTABLE NEBULIZER SYSTEM.....519, 580
PHASEAL PROTECTOR 512, 580	<i>pindolol</i> 125	Portia 28..... 211
PHASEAL SECONDARY SET.....490, 580	<i>pioglitazone</i> 359	<i>posaconazole</i> 52
PHASEAL Y-SITE..... 490, 580	<i>pioglitazone-glimepiride</i> 335	<i>pot,sodium citrate-citric acid</i> 394
<i>phenazopyridine</i> 395	<i>pioglitazone-metformin</i> 335	POTABA.....328
<i>phenelzine</i> 152	PIP LANCET.....456, 580	<i>potassium chloride</i> 298
PHENEX-1.....291, 310	PIP PEN NEEDLE..... 480, 580	<i>potassium citrate</i> 394
PHENEX-2.....310	PIQRAY..... 90	<i>potassium citrate-citric acid</i> ..394
<i>phenobarb-hyoscy-atropine-</i> <i>scop</i> 376	Pirmella.....211, 214	<i>potassium gluconate</i> 298
<i>phenobarbital</i> 193	<i>piroxicam</i> 39	<i>potassium, sodium</i> <i>phosphates</i> 297
PHENOHYTRO..... 376	PIXEL COVID19 HOME COLLECT KIT..... 431, 580	PR BENZOYL PEROXIDE.. 226
<i>phenol</i> 98	PLANTAGO-HOMACCORD 363	PR CREAM.....275
<i>phenoxybenzamine</i> 133	PLEGRIDY..... 611	PR NATAL 400..... 316
<i>phenylephrine hcl</i> 624	PLENVU..... 388	PR NATAL 400 EC..... 316
<i>phenyleph-tropicamide in</i> <i>water</i> 614	PLEXION CLEANSING CLOTHS..... 224	PR NATAL 430..... 316
<i>phenytoin</i> 142	PNEUMOVAX-23..... 104	PR NATAL 430 EC..... 316
<i>phenytoin sodium extended</i> ..142	PNV 29-1..... 315	PRADAXA..... 414
PHEODOYO.....234	PNV TABS 20-1.....321	<i>pralidoxime</i> 46
PHEXXI..... 201	PNV-DHA..... 307	PRALUENT PEN..... 120
PHEYO.....239	PNV-DHA + DOCUSATE... 315	<i>pramipexole</i> 161
Philith.....211	PNV-FERROUS FUMARATE-DOCU-FA..... 316	PRAMOSONE..... 265, 266
PHLAG SPRAY..... 251	PNV-OMEGA.....304	<i>prasugrel</i> 413
PHOSLYRA..... 392	PNV-SELECT..... 316	<i>pravastatin</i> 119
PHOSPHASAL..... 68	POCKET CHAMBER.....519	<i>praziquantel</i> 50
PHOTREXA.....615	POCKET PEAK FLOW METER..... 513, 580	<i>prazosin</i> 133
PHOTREXA CROSS- LINKING KIT.....615	PODOCON..... 268	PRECISION.....456, 581
PHOTREXA VISCOUS.....615	<i>podofilox</i> 268	PRECISION GLUCOSE CONTROL SOLN..... 456, 581
PHYSIOLYTE..... 292	POGO AUTOMATIC BLOOD GLUC SYS....456, 580	PRECISION GLUCOSE/KETONE CONTR.....456, 581
PHYSIOSOL IRRIGATION..292	POLY HUB NEEDLE.. 507, 580	PRECISION PCX PLUS TEST..... 427
<i>phytonadione (vitamin k1)</i> ... 328	Polycin.....627	PRECISION PCX TEST..... 427
	<i>polymyxin b sulf-</i> <i>trimethoprim</i> 627	PRECISION POINT OF CARE TEST..... 427
	<i>polysaccharide iron complex</i> 296	PRECISION Q-I-D TEST.....427
	<i>polysorbate 80</i> 199	PRECISION XTRA KETONE-GLUCOSE...429, 581
	POLYTOZA..... 522, 580	
	POLY-TUSSIN AC.....652	
	POLY-VI-FLOR.....312	

PROBIOTIC (S.BOULARDII)		PRODIGY VOICE		PULMONEB LT	
.....384		GLUCOSE METER..... 457, 583		COMPRESSOR NEBUL	
PROBIOTIC (WITH		PROFILNINE..... 402		520, 583	
VITAMIN D3)..... 384		<i>progesterone</i> 361		PULMOZYME.....647	
PROBIOTIC FORMULA		<i>progesterone micronized</i> 361		PURE COMFORT	
(INULIN)..... 384		PROGRAF.....416		LANCETS.....457	
PROBIOTIC PEARLS		PROLASTIN-C..... 647		PURE COMFORT PEN	
ACIDOPHILUS..... 384		PROLATE.....26		NEEDLE..... 481, 583	
PROCARE COMPRESSOR		Prolate..... 26		PURE COMFORT SAFETY	
NEBULIZER..... 519, 582		PROLENSA.....622		LANCETS.....457, 583	
PROCARE PEDIATRIC		PROMACTA.....415		PURECOMFORT PEAK	
NEBULIZER..... 519		PROMELLA.....384		FLOW METER.....513	
PROCARE SPACER WITH		<i>promethazine</i> 366, 634, 635		PUREFE OB PLUS..... 304	
ADULT MASK.....519, 582		Promethazine Vc..... 632		PURELAN.....251	
PROCARE SPACER WITH		Promethazine Vc-Codeine...652		PURIXAN.....81	
CHILD MASK.....519, 582		<i>promethazine-codeine</i> 651		PUSH BUTTON SAFETY	
PROCEL SINGLES..... 310		<i>promethazine-dm</i> 650		LANCETS.....458, 583	
PRO-CEPTION.....491, 582		<i>promethazine-phenyleph-</i>		PYLERA..... 389	
PROCHAMBER.....519, 582		<i>codeine</i> 652		<i>pyrazinamide</i> 60	
<i>prochlorperazine</i> 366		<i>promethazine-phenylephrine</i>		<i>pyridostigmine bromide</i> 417, 418	
<i>prochlorperazine maleate</i> 165		633		<i>pyridoxine (vitamin b6)</i> 325	
PROCORT.....46		Promethegan..... 366, 634, 635		<i>pyrimethamine</i> 53	
PROCRIT..... 402		PROMISEB.....244		QBRELIS..... 110	
PROCTOFOAM HC.....46		PRONEB ULTRA II FILTER		QBREXZA..... 235	
Procto-Med Hc.....45, 262		ASSEM..... 519, 583		Q-CARE RX Q2.....431	
Procto-Pak.....45, 262		<i>propafenone</i> 114		Q-CARE RX Q4.....431	
Proctosol Hc..... 45, 262		<i>proparacaine</i> 626		QDOLO.....20	
Proctozone-Hc.....45		PROPIMEX-2..... 310		QELBREE.....171	
PROCYSBI..... 391		<i>propranolol</i> 126		QINLOCK..... 93	
PRODIGY AUTOCODE		<i>propranolol-</i>		QNASL..... 649	
METER.....457		<i>hydrochlorothiazid</i> 133		QTERN.....334	
PRODIGY AUTOCODE		<i>propylthiouracil</i> 339		QUAD-PROBIOTIC..... 384	
MONITOR SYST..... 457, 582		PROSILK..... 522, 583		QUAKE VIBRATORY PEP	
PRODIGY CONTROL		PROSILK GEL.....275		520, 583	
SOLUTION, LOW.....457		PROTHELIAL.....609		<i>quazepam</i> 193	
PRODIGY CONTROL		<i>protriptyline</i> 158		<i>quetiapine</i> 173	
SOLUTION,HIGH..... 457, 583		PROTYL AG.....287		QUICK-SET PARADIGM 43"	
PRODIGY INSULIN		PROVENT..... 519, 583		527, 583	
SYRINGE..... 481, 583		PROVENT STARTER. 520, 583		QUICKVUE AT-HOME	
PRODIGY LANCETS.. 457, 583		PROVIDA OB..... 318		COVID-19 TEST.....584	
PRODIGY LANCING		PROVIMIN.....309		QUICKVUE SARS	
DEVICE..... 457, 583		PRUCLAIR..... 250		ANTIGEN.....431, 584	
PRODIGY MINI-MIST		PRUMYX..... 251		QUIHOXVAR.....267	
NEBULIZER..... 492		PSORINOHEEL.....363		QUILLICHEW ER..... 170	
PRODIGY NO CODING..... 427		<i>psyllium husk</i> 386		QUILLIVANT XR..... 170	
PRODIGY POCKET METER		PULMICORT FLEXHALER. 638		<i>quinapril</i> 110	
.....457		PULMO-AIDE		<i>quinapril-hydrochlorothiazide</i>	
PRODIGY TWIST TOP		COMPRESSOR.....520		 109	
LANCET..... 457				<i>quinidine gluconate</i> 114	
				<i>quinidine sulfate</i> 114	

<i>quinine sulfate</i>	54	REFUAH PLUS GLUCOSE		<i>repaglinide-metformin</i>	332
QUINIXIL.....	264	CONTROL.....	458, 584	REPATHA PUSHTRONEX..	120
QUINJA.....	233	REFUAH PLUS GLUCOSE		REPATHA SURECLICK.....	121
QUINTET AC.....	427, 458, 584	MONITOR.....	458, 584	REPATHA SYRINGE.....	121
QUINTET BLOOD		REGENECARE.....	280	REPLICARE DRESSING	
GLUCOSE METER.....	458, 584	REGENECARE WITH ALOE		.....	287, 585
QUINTET GLUCOSE TEST		.....	280	REPLICARE THIN.....	287, 585
STRIPS.....	427, 584	REGIOCIT (EUA).....	399	REPLICARE ULTRA	
QUIT 2.....	196	REGRANEX.....	287	DRESSING.....	287, 585
QUIT 4.....	196, 197	REGULOID (ASPARTAME)	387	RESISTANCE FORMULA	
QULIPTA.....	181	REGULOID (PSYLLIUM		PROBIOTIC.....	385
QUTENZA.....	282	HUSK).....	387	RESPA-AR.....	633
QVAR REDIHALER.....	638	REGULOID (PSYLLIUM		RESTASIS.....	621
<i>rabeprazole</i>	372	HUSK-SUCRO).....	387	RESTASIS MULTIDOSE.....	621
RADIAGEL.....	251	RELAFEN DS.....	39	RESTORE.....	287, 433, 585
RADIAPLEXRX.....	275	RELAGARD.....	655	RESTORE CALCIUM	
RADIOGARDASE.....	47	RELENZA DISKHALER.....	66	ALGINATE.....	287
RAGWITEK.....	99	Relexxii.....	170	RETACRIT.....	402
<i>raloxifene</i>	361	RELIAMED LANCET... 458, 584		RETEVMO.....	95
<i>ramelteon</i>	181	RELIAMED MINI LANCING		RETIN-A MICRO PUMP.....	229
<i>ramipril</i>	110	DEVICE.....	458, 584	REUSABLE NEBULIZER	
RANGER READY		RELIAMED SAFETY SEAL		KIT.....	520
REPELLENT.....	267	LANCETS.....	458, 584	REVCovi.....	603
<i>ranolazine</i>	114	RELIAMED TWIST AND		REVEAL BLOOD	
RAPPORT VACUUM		CAP LANCET.....	458, 584	GLUCOSE METER.....	458
THERAPY.....	490, 584	RELION ALL-IN-ONE		REVEAL TEST STRIP.....	428
<i>rasagiline</i>	160	METER.....	458, 584	REVLIMID.....	95
RASUVO (PF).....	31, 32	RELION CONFIRM.....	458	REXULTI.....	166
RATE FLOW REGULATOR		RELION CONFIRM-MICRO	427	REYATAZ.....	70
IV SET.....	490, 584	RELION MICRO GLUCOSE		REYVOW.....	185
RAVICTI.....	604	MONITOR.....	458, 585	REZUROCK.....	14
RAYALDEE.....	603	RELION NEEDLES.....	481, 585	RHOFADE.....	277
RAYOS.....	347	RELION PEN NEEDLES		RHOPRESSA.....	631
READYLANCE SAFETY		.....	481, 585	<i>ribavirin</i>	65, 70
LANCETS.....	458, 584	RELION PRIME METER.....	458	RIDAURA.....	34
REBIF (WITH ALBUMIN)....	611	RELION PRIME TEST		<i>rifabutin</i>	61, 71
REBIF REBIDOSE.....	611	STRIPS.....	427	<i>rifampin</i>	61
REBIF TITRATION PACK... 611		RELION THIN LANCETS		RIGHTEST CONTROL	
REBINYN.....	402	.....	458, 585	SOLUTION HIGH.....	459, 585
RECEDO.....	275	RELION ULTIMA.....	427, 585	RIGHTEST CONTROL	
Reclipsen (28).....	211	RELION ULTRA THIN PLUS		SOLUTION NORM.....	459, 585
RECOMBINATE.....	405	LANCETS.....	458, 585	RIGHTEST GC250S CNTRL	
RECOMBIVAX HB (PF).....	100	RELISTOR.....	48	SOL NORM.....	459, 585
RECONSTITUTE.....	491, 584	RELIZORB.....	432, 585	RIGHTEST GC700 LEV 2	
RECOTHROM.....	408	RELTONE.....	369	CTRL SOLN.....	459, 585
RECOTHROM SPRAY KIT. 408		REMEDIENT.....	304	RIGHTEST GD500	
RECTIV.....	45	RENACIDIN.....	391	LANCING DEVICE.....	459, 585
<i>red yeast rice</i>	14	RENAMENT.....	309	RIGHTEST GL300	
REDITREX (PF).....	32, 33	RENEEL.....	363	LANCETS.....	459, 585
REFUAH PLUS.....	427, 584	<i>repaglinide</i>	333		

RIGHTEST GM250S	ROSULA.....225	SALVAX DUO PLUS.....267
GLUCOSE METER.....459, 586	ROSULA CLEANSING	SAMI THE SEAL.....520, 587
RIGHTEST GM260	CLOTHS.....225	SAMI THE SEAL MASK
GLUCOSE METER.....459, 586	<i>rosuvastatin</i> 119	520, 587
RIGHTEST GM550	ROSZET.....124	SANADERMRX.....264
SYSTEM.....459, 586	ROTARIX.....102	SANCUSO.....366
RIGHTEST GM700SB	ROTATEQ VACCINE.....102	SANDIMMUNE.....34, 416
GLUCOSE METER.....459, 586	ROZLYTREK.....93	SANTYL.....251
RIGHTEST GS250S TEST	RUBBER MOUTHPIECE	<i>sapropterin</i> 605
STRIPS.....428, 586	520, 586	SAVAYSA.....401
RIGHTEST GS260 TEST	RUBRACA.....91	SAVELLA.....155, 180
STRIPS.....428, 586	RUCONEST.....400	SCALACORT DK.....262
RIGHTEST GS550 TEST	<i>rufinamide</i> 149	SCARCARE.....276, 522
STRIPS.....428, 586	RUKOBIA.....55	SCARCIN GEL.....275
RIGHTEST GS700 TEST	RUZURGI.....612	SCARCIN ROLL-ON.....275
STRIP.....428	RYBELSUS.....336	SCARCINPAD.....522, 587
RIGHTEST GT333	RYDAPT.....93	SCARSILK.....522, 587
GLUCOSE METER.....459, 586	RYDEX.....652	SCARSILK GEL.....275
RIGHTEST GT333 LEV 2	RYLAZE.....82	<i>scopolamine base</i> 365
CTRL SOLN.....459, 586	RYNODERM.....268	SEBUDERM.....251
RIGHTEST GT333 TEST	RYTARY.....158	SECONAL SODIUM.....193
STRIP.....428	SABAL-HOMACCORD.....363	SECUADO.....162
RIGHTEST MAX PLUS	SABRIL.....142	SECURESAFE PEN
GLUCOSE MTR.....459, 586	<i>saccharin</i> 291	NEEDLE.....481
RIGHTEST MAX TEST	<i>saccharomyces boulardii</i> 385	SEGLUROMET.....333
STRIP.....428	SAF-CLENS AF DERMAL	SELECT-OB.....319
<i>riluzole</i> 417	WOUND.....278	SELECT-OB (FOLIC ACID).....319
<i>rimantadine</i> 66	SAFE-CLIP NEEDLE	SELECT-OB + DHA.....319
<i>ringer's</i> 292	STORAGE DEV.....491, 586	<i>selegiline hcl</i> 160
RINVOQ.....35	SAFESNAP INSULIN	<i>selenium sulfide</i> 244
RIOMET ER.....359	SYRINGE.....481	SELF-CATHETER, FEMALE
<i>risedronate</i> 340, 341	SAFESNAP SYRINGE	525, 587
<i>risperidone</i> 162, 163	507, 508, 586, 587	SELZENTRY.....55
RITEFLO AEROCHAMBER	SAFETY LANCETS.....459, 587	SEMGLEE PEN U-100
.....520, 586	<i>safety needles</i> 508, 587	INSULIN.....354
<i>ritonavir</i> 70	SAFETY PEN NEEDLE.....481	SEMGLEE U-100 INSULIN.....354
<i>rivastigmine</i> 200	SAFETY SEAL LANCETS.....459	SEMGLEE(INSULIN
<i>rivastigmine tartrate</i> 200	SAFETY-LET LANCETS	GLARGINE-YFGN).....354
RIVELSA.....213	459, 587	SEMGLEE(INSULIN
RIXUBIS.....403	SAIZEN.....349, 390	GLARG-YFGN)PEN.....354
<i>rizatriptan</i> 183	SAIZEN SAIZENPREP.....349	SE-NATAL 19 CHEWABLE.....319
R-NATAL OB.....318	Sajazir.....126	SE-NATAL-19.....319
ROAOXIA.....273	<i>salicylic acid</i> 268	SENOKOT-CHAMOMILE.....389
ROBINSON CLEAR VINYL	<i>salicylic acid-ceramides no.1</i>	SEREVENT DISKUS.....641
CATHETER.....525, 586	268	SERNIVO.....262
ROCKLATAN.....627	SALIMEZ FORTE.....268	SEROQUEL XR.....165
<i>ropinirole</i> 161	SALIVAMAX.....608	SEROSTIM.....349
Rosadan.....277	SALOXICIN.....14	<i>sertraline</i> 153
ROSADAN.....277	<i>salsalate</i> 43	<i>sesame oil</i> 198
ROSANIL.....224	SALVAX.....268	Setlakin.....211

<i>sevelamer carbonate</i>	392	SINUSTAR NEBULIZER		SODIUM FLUORIDE 5000	
<i>sevelamer hcl</i>	393	.....	492, 588	DRY MOUTH.....	606
SEVENFACT.....	403	SINUVA.....	645, 650	SODIUM FLUORIDE 5000	
<i>sevoflurane</i>	44	<i>sirolimus</i>	417	PLUS.....	606
SEYSARA.....	76, 219	SIRTURO.....	60	<i>sodium fluoride-pot nitrate</i> ...	606
SF.....	606	SITAVIG.....	66	<i>sodium iodide-123</i>	288
SF 5000 PLUS.....	606	SIVEXTRO.....	69	<i>sodium iodide-131</i>	288
Sharobel.....	213	SKARLITE.....	522	<i>sodium phenylbutyrate</i>	604
SHINGRIX (PF).....	107	SKYLA.....	202	<i>sodium polystyrene</i>	
SHINGRIX ADJUVANT		SKYRIZI.....	231	<i>sulfonate</i>	292
COMPONENT-PF.....	200	SLOW RELEASE IRON.....	296	<i>sodium succinate</i>	198
SHINGRIX GE ANTIGEN		SLYND.....	213	SOFIA SARS ANTIGEN FIA	
COMPONENT.....	108	SMART CARESENS N459, 588		.....	431, 588
SIDESTREAM.....	492	SMART SENSE LANCETS		SOFIA2 FLU-SARS	
SIDESTREAM MASK..	520, 587	.....	460, 588	ANTIGEN FIA.....	431, 588
SIDESTREAM NEBULIZER	492	SMART SENSE		SOFT TOUCH LANCETS	
SIDESTREAM PLUS...492, 587		MONITORING SYSTEM....	460	.....	460, 588
SIGNIFOR.....	361	SMART SENSE TEST		SOLARAVIX.....	240
SIKLOS.....	414	STRIPS.....	428	<i>solifenacin</i>	396
SILA III.....	262	SMARTDIABETES		SOLQUA 100/33.....	338
SILADERM.....	522, 587	VANTAGE.....	460, 588	SOLOSEC.....	55
SILALITE PAK.....	262	SMARTEST CONTROL		SOLOX GEL.....	233
SILASTIC FOLEY		.....	460, 588	SOLTAMOX.....	94
CATHETER.....	525, 587	SMARTEST EJECT.....	460	SOLU-CORTEF.....	347
SILATRIX.....	609	SMARTEST LANCET..	460, 588	SOLU-CORTEF ACT-O-	
<i>sildenafil</i>		SMARTEST PERSONA		VIAL (PF).....	347
(<i>pulm.hypertension</i>).....	135	GLUCOSE METER.....	460, 588	SOLUPAK.....	270
SILICONE MASK.....	520	SMARTEST PERSONA		SOLUS V2 AUDIBLE	
SILICONE MASK - INFANT		STARTER.....	460, 588	METER.....	460, 588
.....	520, 587	SMARTEST PRONTO		SOLUS V2 CONTROL	
SILIPAC.....	275	GLUCOSE METER.....	460, 588	SOLUTION, LOW.....	460, 589
SILIQ.....	232	SMARTEST PRONTO		SOLUS V2 CONTROL	
SILIVEX.....	522	STARTER.....	460, 588	SOLUTION,HIGH.....	460, 589
SIL-K.....	522, 588	SMARTEST PROTEGE.....	460	SOLUS V2 LANCETS..	460, 589
<i>silodosin</i>	393	SMARTEST SMART CODE		SOLUS V2 LANCING	
SILTREX.....	522, 588	METER.....	460	DEVICE.....	460, 589
<i>silver nitrate</i>	233	SMARTEST TALKING		SOLUS V2 TEST STRIPS	
<i>silver nitrate applicators</i>	267	METER.....	460	.....	428, 589
<i>silver sulfadiazine</i>	245	SMARTEST TEST.....	428, 588	SOMAVERT.....	348
SILVRSTAT.....	233	<i>sodium chlor 0.9%</i>		SONAFINE.....	251
SIMBRINZA.....	615	<i>bacteriostat</i>	291	SOOLANTRA.....	277
SIMILAC PROBIOTIC TRI-		<i>sodium chloride</i>		SOOTHENEB	
BLEND.....	385	.....	199, 271, 291, 293	COMPRESSOR	
Simliya (28).....	204	<i>sodium chloride 0.45 %</i>	322	NEBULIZER.....	520, 589
Simpesse.....	204	<i>sodium chloride 0.9 %</i> ..	291, 322	SOOTHENEB MESH	
SIMPLYTHICK.....	199	<i>sodium chloride 0.9 %</i>		NEBULIZER.....	492, 589
SIMPONI.....	29, 30, 380	(<i>flush</i>).....	322	SOPORDREN.....	180
SIMPONI ARIA.....	29, 30	<i>sodium citrate</i>	399, 400	<i>sorbitol</i>	387, 391
<i>simvastatin</i>	119	<i>sodium citrate in 0.9 % nacl</i> ..	399	<i>sorbitol-mannitol</i>	391
SINGLE-LET.....	459, 588	<i>sodium citrate-citric acid</i>	394	SORILUX.....	243

Sorine.....	114	STEGLUJAN.....	334	<i>sumatriptan succinate</i>	183
<i>sotalol</i>	115	STELARA.....	231, 377	<i>sumatriptan-naproxen</i>	185
Sotalol Af.....	115	STERILANCE TL.....	461, 589	SUMAXIN CP.....	225
SOTYLIZE.....	115	STERILE HYDROGEL FOR		<i>sunitinib</i>	93
SOVALDI.....	65	JELMYTO.....	291	SUNOSI.....	187
SPACE CHAMBER.....	520, 589	STIOLTO RESPIMAT.....	643	SUNRISE COMPRESSOR-	
SPACE CHAMBER PLUS		STIVARGA.....	89	NEBULIZER.....	521, 589
.....	520, 589	STOP SMOKING AID.....	197	SUPER THIN LANCETS	
SPACE CHAMBER WITH		STRATACTX.....	287, 589	.....	461, 589
LARGE MASK.....	520, 589	STRATAGRT.....	287, 589	SUPLENA CARB STEADY.	309
SPACE CHAMBER WITH		STRATAMARK.....	276	SUPPOSITORY SHELL,	
MEDIUM MASK.....	520, 589	STRATATRIZ.....	276	SMALL.....	491, 589
SPACE CHAMBER WITH		STRATAXRT.....	287, 589	SUPRANE.....	44
SMALL MASK.....	520, 589	STRAVIX.....	282	SUPRAX.....	62
SPECTRAGEL.....	287, 589	STRENSIQ.....	602	SUPREP BOWEL PREP KIT	
SPECTRAVITE ADULT.....	307	STRESSTABS ENERGY.....	290	.....	388
SPECTRAVITE ADULT 50		STRIBILD.....	59	SURE COMFORT INS.	
PLUS.....	304	STRIVERDI RESPIMAT.....	641	SYR. U-100.....	482, 590
SPECTRAVITE MEN 50		STRONG IODINE.....	98, 295	SURE COMFORT INSULIN	
PLUS.....	304	SUBSYS.....	20	SYRINGE.....	482, 590
SPECTRAVITE MEN'S.....	305	Subvenite.....	147	SURE COMFORT	
SPECTRAVITE WOMEN....	307	Subvenite Starter (Blue) Kit		LANCETS.....	461, 590
SPECTRAVITE WOMEN 50		.....	147, 172	SURE COMFORT LANCING	
PLUS.....	305	Subvenite Starter (Green)		PEN.....	461, 590
SPEEDICATH (FEMALE)		Kit.....	147, 172	SURE COMFORT PEN	
.....	525, 589	Subvenite Starter (Orange)		NEEDLE.....	482, 590
<i>spinosad</i>	284	Kit.....	147, 172	SURE COMFORT SAFETY	
SPIRIVA RESPIMAT.....	640	SUCRAID.....	369	PEN NEEDLE.....	482, 590
SPIRIVA WITH		<i>sucralfate</i>	389	SURE RESULT DSS	
HANDIHALER.....	640	<i>sulconazole</i>	238	PREMIUM PACK.....	273
<i>spironolactone</i>	110	<i>sulfacetamide sodium</i> ..	244, 629	SURE-FINE PEN NEEDLES	
<i>spironolacton-</i>		<i>sulfacetamide sodium (acne)</i>		.....	482
<i>hydrochlorothiaz</i>	131	.....	222	SUREFLEX DEVICE WITH	
SPRAVATO.....	152	<i>sulfacetamide sodium-sulfur</i>	225	LANCETS.....	461
SPRAY AND STRETCH.....	271	<i>sulfacetamide sod-sulfur-</i>		SUREFLEX LANCING	
Sprintec (28).....	211	<i>urea</i>	225, 277	DEVICE.....	461, 590
SPRITAM.....	148	<i>sulfacetamide-prednisolone</i> .	616	SURE-JECT INSULIN	
SPRIX.....	39	<i>sulfacetamide-sulfur-</i>		SYRINGE....	482, 483, 590, 591
SPRYCEL.....	93	<i>cleansr23</i>	225	SURE-LANCE.....	461, 591
Sps (With Sorbitol).....	292	SULFACLEANSE 8-4.....	225	SURE-LANCE ULTRA THIN	
SPS (WITH SORBITOL).....	292	<i>sulfadiazine</i>	71	.....	461
Sronyx.....	211	<i>sulfamethoxazole-</i>		SURE-PEN LANCING	
SSD.....	245	<i>trimethoprim</i>	51	DEVICE.....	461, 591
SSKI.....	295	SULFAMYLON.....	245	SURE-T INFUSION SET	
SSS 10-5.....	225	<i>sulfasalazine</i>	378	.....	512, 591
ST JOSEPH ASPIRIN.....	43	SULFATRIM.....	51	SURE-TEST EASYPLUS	
<i>st. john's wort</i>	10	<i>sulindac</i>	39	MINI.....	428, 461
ST. JOSEPH ASPIRIN.....	44	SUMADAN.....	225	SURE-TEST EASYPLUS	
<i>stavudine</i>	58	SUMADAN XLT.....	225, 278	MINI METER.....	461
STEGLATRO.....	334	<i>sumatriptan</i>	183		

SURE-TOUCH LANCET	SYZYGIUM COMPOSITUM 363	TARON-PREX PRENATAL-
.....461, 591	SZOSIL.....522	DHA.....307, 319
SURGIFLO.....409	T.E.D. ANTI-EMBOLISM	TAROXIA.....228
SURGUARD2 SAFETY	STOCKING.....491	TASIGNA.....94
.....508, 591	T.E.D. KNEE LENGTH-M-	TASOPROL.....263
SURVANTA.....647	LONG.....430, 591	<i>tavaborole</i> 238
SUSTIVA.....57	T.E.D. KNEE LENGTH-S-	TAVALISSE.....400
SUTAB.....388	REGULAR.....430, 592	Taysofy.....212
SUVICORT.....280	T.R.U.E. TEST ALLERGEN..99	<i>tazarotene</i> 229, 243
SWEET CHEEKS.....329	T:FLEX.....491, 592	TAZORAC.....243
Syeda.....211	T:SLIM X2.....491, 592	Taztia Xt.....127
SYMAX DUOTAB.....375, 397	T:SLIM X2 BASAL-IQ	TAZVERIK.....85
SYMBICORT.....645	INSULIN PMP.....523	TD GOLD BLOOD
SYMDEKO.....646	T:SLIM X2 CONTROL-IQ...523	GLUCOSE MONITOR.....461
SYMJEPI.....129	TAB-A-VITE.....307	TD GOLD LEVEL 1
SYMLINPEN 120.....335	TAB-A-VITE MULTIVITAMIN	CONTROL.....461
SYMLINPEN 60.....335	W-IRON.....305, 307	TD GOLD LEVEL 2
SYMPAZAN.....140	TABLOID.....81	CONTROL.....461
SYMPROIC.....49	TABRECTA.....94	TD GOLD LEVEL 3
SYMTUZA.....59	TACHOSIL.....409	CONTROL.....461
SYNALAR CREAM KIT.....264	<i>tacrolimus</i> 246, 416	TD GOLD TEST STRIP.....428
SYNALAR OINTMENT KIT.264	<i>tadalafil</i> 289	TD GOLD VOICE
SYNALAR TS.....266	<i>tadalafil (pulm. hypertension)</i>	GLUCOSE MONITOR.....461
SYNAREL.....359	135	TDVAX.....104
SYNDROS.....174, 289, 366	TAFINLAR.....83	TECHLITE INSULIN
SYNERA.....280	TAGRISSO.....78	SYRINGE.....483
SYNERDERM.....251	TAKE ACTION.....217	TECHLITE INSULN
SYNJARDY.....333	TAKHZYRO.....134	SYR(HALF UNIT).....483
SYNJARDY XR.....333	TALICIA.....390	TECHLITE LANCETS.....461
SYNOVX DJD.....10	TALTZ AUTOINJECTOR...232	TECHLITE PEN NEEDLE...483
SYNRIBO.....96	TALTZ AUTOINJECTOR (2	TECHNA NAT UNSWT
<i>syringe (disposable)</i> 508, 591	PACK).....232	TROCHE BASEG2.....197, 200
SYRINGE 3CC/20GX1"	TALTZ AUTOINJECTOR (3	TEGSEDI.....330
.....508, 591	PACK).....232	TEKTURN HCT.....136
SYRINGE 3CC/21GX1"	TALTZ SYRINGE.....232	TELCARE BGM.....461, 592
.....509, 591	TALZENNA.....91	TELCARE BLOOD
SYRINGE 3CC/21GX1-1/2"	<i>tamarind seed-turmeric</i>	GLUCOSE KIT.....462, 592
.....509, 591	<i>extract</i> 14	TELCARE CONTROL.462, 592
SYRINGE 3CC/22GX1"	<i>tamoxifen</i> 94	TELCARE LANCETS..462, 592
.....509, 591	<i>tamsulosin</i> 393	TELCARE TEST STRIPS
SYRINGE 3CC/22GX3/4"	Taperdex.....348	428, 592
.....509, 591	TAPERDEX.....348	<i>telmisartan</i> 113
SYRINGE 3CC/25GX1"	TARDEOXIA.....226	<i>telmisartan-amlodipine</i> 111
.....509, 591	TARDIMAXIA.....227	<i>telmisartan-</i>
SYRINGE AVITENE.....409	TARGRETIN.....240	<i>hydrochlorothiazid</i> 112
<i>syringe with needle</i> 509, 591	Tarina 24 Fe.....211	<i>temazepam</i> 193
<i>syringe with needle, safety</i>	Tarina Fe 1/20 (28).....212	TEMIXYS.....57
.....509, 591	Tarina Fe 1-20 Eq (28).....212	<i>temozolomide</i> 79
SYRINGE WITHOUT	TARON-C DHA.....305	Tencon.....28
NEEDLE.....509, 591		TENIVAC (PF).....104

<i>tenofovir disoproxil fumarate</i> 58	THRESHOLD IMT TRAINER..... 521, 593	TODAY CONTRACEPTIVE SPONGE..... 217
TENS 502..... 491, 592	THRESHOLD PEP DEVICE..... 521, 593	TOLAK..... 239
TENS 504..... 491, 592	THRIVITE RX..... 319	<i>tolcapone</i> 159
TEPMETKO..... 94	THROMBI-GEL..... 409	<i>tolmetin</i> 39
<i>terazosin</i> 133	THROMBIN-JMI..... 409	TOLSURA..... 52
<i>terbinafine hcl</i> 51	THROMBI-PAD..... 409	<i>tolterodine</i> 397
<i>terbutaline</i> 642	THYQUIDITY..... 363	<i>tolvaptan</i> 131
<i>terconazole</i> 655	THYROLAR-1..... 362	TOOMEY SYRINGE.... 509, 593
<i>teriparatide</i> 339	THYROLAR-1/2..... 362	TOPCARE CLICKFINE 484, 593
Terrell..... 44	THYROLAR-1/4..... 362	TOPCARE ULTRA COMFORT..... 484, 593, 594
TERSI FOAM..... 244	THYROLAR-2..... 362	TOPCARE UNIVERSAL1 LANCET..... 462, 594
TERUMO ALLERGY SYRINGE..... 509, 592	THYROLAR-3..... 362	<i>topiramate</i> 145
TERUMO HYPODERMIC NEEDLE/SYRIN..... 509, 592	Tiadylt Er..... 127	<i>toremifene</i> 95
TERUMO INSULIN SYRINGE..... 483, 592, 593	<i>tiagabine</i> 141	TORONOVA II SUIK..... 39
TERUMO SYRINGE.... 509, 593	TIBSOVO..... 90	TORONOVA SUIK..... 39
TEST N'GO BLOOD GLUCOSE SYSTEM... 462, 593	TICALAST..... 648	<i>torseamide</i> 131
TEST N'GO TEST..... 428, 593	TICANASE..... 649	TOSYMRA..... 184
<i>testosterone</i> 330, 331	TICASPRAY..... 649	TOUCH-TROL..... 525, 594
<i>testosterone cypionate</i> 330	TIGLUTIK..... 417	TOUJEO MAX U-300 SOLOSTAR..... 355
<i>testosterone enanthate</i> 330	Tilia Fe..... 214	TOUJEO SOLOSTAR U-300 INSULIN..... 355
<i>tetrabenazine</i> 186	<i>timol-brimon-dorzo-latanop(pf)</i> 614	TOVET KIT..... 264
<i>tetracaine hcl</i> 626	<i>timolol maleate</i> 126, 625	TOVIAZ..... 397
<i>tetracaine hcl (pf)</i> 626	<i>timolol maleate (pf)</i> 625	TPOXX (NATIONAL STOCKPILE)..... 76
<i>tetracycline</i> 76	<i>timolol-brimonidi-dorzolam(pf)</i> 622	TRACLEER..... 135
TETRIX..... 276	<i>timolol-dorzolamid-latanop(pf)</i> 623	TRADJENTA..... 332
TEXACORT..... 263	<i>timolol-latanoprost(pf)</i> 623	<i>tramadol</i> 20, 21
THALITONE..... 132	TIMOPTIC OCUDOSE (PF) 625	<i>tramadol-acetaminophen</i> 27
THALOMID..... 53, 96	<i>tinidazole</i> 55	<i>trandolapril</i> 110
THEO-24..... 639	<i>tiopronin</i> 392	<i>trandolapril-verapamil</i> 109
THEOCHRON..... 639	TIROSINT-SOL..... 363	<i>tranexamic acid</i> 407
<i>theophylline</i> 639	TISSEEL VHSD (APROTININ, SYN)..... 278	<i>tranylcypromine</i> 152
THERAPEUTIC MOISTURIZING CREAM.... 251	TIS-U-SOL PENTALYTE.... 293	TRANZAREL..... 280
THEREMS MULTIVITAMIN 308	TIVICAY..... 56	<i>travoprost</i> 630
<i>thiamine hcl (vitamin b1)</i> 323	TIVICAY PD..... 56	<i>trazodone</i> 153
<i>thiamine mononitrate (vit b1)</i> 323	TIVORBEX..... 42	TRECTOR..... 61
THICK AND EASY..... 199	<i>tizanidine</i> 419	TRELEGY ELLIPTA..... 645
THIN LANCETS..... 462	TOBI PODHALER..... 645	TREMFYA..... 231
THINPRO INSULIN SYRINGE..... 484, 593	TOBRADEX..... 616	<i>treprostinil sodium</i> 134
THIOLA..... 392	TOBRADEX ST..... 616	TRESIBA FLEXTOUCH U-100..... 355
THIOLA EC..... 391	<i>tobramycin</i> 628, 645	TRESIBA FLEXTOUCH U-200..... 355
<i>thioridazine</i> 165	<i>tobramycin in 0.225 % nacl</i> 645	TRESIBA U-100 INSULIN... 355
<i>thiothixene</i> 165	<i>tobramycin with nebulizer</i> 645	<i>tretinoin</i> 230
	<i>tobramycin-dexamethasone</i> 616	
	TOBREX..... 628	

<i>tretinoin (antineoplastic)</i>	94	Trivora (28).....	215	TRUETRACK TEST.....	428
<i>tretinoin microspheres</i>	230	Tri-Vylibra.....	215	TRULANCE.....	368, 377
TRETTEN.....	406	Tri-Vylibra Lo.....	215	TRULICITY.....	336
TREXALL.....	33, 81	TRIXYLITRAL.....	271	TRUMENBA.....	105
Tri Femynor.....	214	TROKENDI XR.....	145, 146	TRUNEB NEBULIZER.....	492, 595
<i>triacetin</i>	239	<i>tropicamide</i>	617	TRUSELTIQ.....	85
TRIAMAZOLE.....	239	<i>tropic-proparacai-pe-ketor-</i> <i>wat</i>	626	TRUSKIN.....	283
<i>triamcinolone acetonide</i>	263, 608	<i>trospium</i>	397	TRUSTEEL INFUSION SET 23".....	527
<i>triamterene</i>	131	TRUDHESA.....	182	TRUSTEEL INFUSION SET 32".....	527
<i>triamterene-</i> <i>hydrochlorothiazid</i>	131	TRUE COMFORT INSULIN SYRINGE.....	484, 594	TRUVADA.....	57
Trianex.....	263	TRUE COMFORT LANCET	462, 594	TRUZONE PEAK FLOW METER.....	513, 595
<i>triazolam</i>	193	TRUE COMFORT PEN NEEDLE.....	484, 594	TUBERCULIN SYRINGE	509, 510, 595
TRICARE.....	319	TRUE COMFORT PRO INS SYRINGE.....	484, 485, 594	<i>tuberculin-allergy syringes</i>	510, 595
TRI-CHLOR.....	268	TRUE METRIX AIR GLUCOSE METER.....	462	TUDORZA PRESSAIR.....	640
<i>trichloroacetic acid</i>	268	TRUE METRIX GLUCOSE METER.....	462, 594	TUKYSA.....	84
Triderm.....	263	TRUE METRIX GLUCOSE TEST STRIP.....	428	Tulana.....	213
<i>trientine</i>	47	TRUE METRIX GO GLUCOSE METER.....	462	TURALIO.....	94
Tri-Estarylla.....	214	TRUE METRIX LEVEL 1....	462	<i>turmeric root-ginger root ext..</i>	14
<i>trifluoperazine</i>	165	TRUE METRIX LEVEL 2....	462	<i>turmeric-turmeric root extract</i>	14
<i>trifluridine</i>	629	TRUE METRIX LEVEL 3....	462	TUSSICAPS.....	651
<i>trihexyphenidyl</i>	159	TRUE METRIX PRO TEST STRIP.....	428	TUXARIN ER.....	651
TRIJARDY XR.....	339	TRUE2GO BLOOD GLUCOSE SYSTEM... ..	462, 594	TUZISTRA XR.....	651
TRIKAFTA.....	646	TRUECONTROL LEVEL 0	462, 594	TWINRIX (PF).....	100
Tri-Legest Fe.....	215	TRUECONTROL LEVEL 1	462, 594	TWIRLA.....	216
Tri-Linyah.....	215	TRUEDRAW LANCING DEVICE.....	463	TWIST LANCETS.....	463
TRILOAN II SUIK.....	348	TRUEPLUS INSULIN.....	485	TYBLUME.....	212
TRILOAN SUIK.....	348	TRUEPLUS KETONE.....	594	TYBOST.....	605
TRILOCICLO.....	239	TRUEPLUS LANCETS.....	463, 595	Tydemy.....	212
Tri-Lo-Estarylla.....	215	TRUEPLUS PEN NEEDLE..	485	TYMLOS.....	339
Tri-Lo-Marzia.....	215	TRUERESULT BLOOD GLUCOSE SYSTM.....	463, 595	TYREX-2.....	310
Tri-Lo-Mili.....	215	TRUETEST TEST STRIPS..	428	TYVASO.....	134
Tri-Lo-Sprintec.....	215	TRUETRACK BLOOD GLUCOSE SYSTEM... ..	463, 595	TYVASO INSTITUTIONAL START KIT.....	134
TRI-LUMA.....	247	TRUETRACK SMART SYSTEM.....	463, 595	TYVASO REFILL KIT.....	134
<i>trimethobenzamide</i>	366			TYVASO STARTER KIT.....	135
<i>trimethoprim</i>	51			TYZINE.....	650
Tri-Mili.....	215			UBRELVY.....	181
<i>trimipramine</i>	158			UCERIS.....	379
TRIMO-SAN JELLY.....	655			UDENYCA.....	407
TRINATE.....	319			UKONIQ.....	89
TRINTELLIX.....	156			ULESFIA.....	284
Tri-Nymyo.....	215			ULTICARE.....	486, 510
TRIPLE OMEGA 3-6-9.....	123			ULTICARE INSULIN SYRINGE.....	485
Tri-Previfem (28).....	215				
Tri-Sprintec (28).....	215				
TRISTART DHA.....	319				
TRIUMEQ.....	59				
TRIVEEN-DUO DHA.....	319				
TRIVEEN-PRX RNF.....	319				

ULTICARE INSULN		ULTRA THIN LANCETS		UNILET EXCELITE	
SYR(HALF UNIT).....	485	.....	463, 597	LANCET.....	464
ULTICARE LOW DEAD		ULTRA THIN PEN NEEDLE		UNILET GP LANCET.....	464
SPACE SYRING.....	510, 595	.....	487, 597	UNILET LANCET.....	464
ULTICARE PEN NEEDLE...	485	ULTRA THIN PLUS		UNILET LANCETS.....	464
ULTICARE SAFETY PEN		LANCETS.....	463, 597	UNILET SUPER THIN	
NEEDLE.....	485, 595	ULTRA TLC LANCETS.....	463	LANCETS.....	464
ULTICARE SAFETY		ULTRACARE INSULIN		UNISPEND ANHYDROUS	
SYRINGE.....	510, 595	SYRINGE.....	488, 597, 598	SWEET.....	199
ULTICARE TB SAFETY		ULTRA-CARE LANCETS		UNISTIK 2 DEVICE.....	464
SYRINGE.....	510, 595	.....	463, 598	UNISTIK 2 EXTRA.....	464
ULTIGUARD SAFEPACK-		ULTRACARE PEN NEEDLE		UNISTIK 2 NORMAL	
INSULIN SYR.....	486, 596	.....	488, 598	LANCET,DEVICE.....	464
ULTIGUARD SAFEPACK-		ULTRAFOAM.....	409	UNISTIK 3.....	464
PEN NEEDLE.....	486, 596	ULTRALANCE LANCETS		UNISTIK 3 COMFORT	
ULTI-LANCE.....	463, 596	.....	463, 598	DEVICE.....	464
ULTILET BASIC LANCETS		ULTRASAL-ER.....	269	UNISTIK 3 COMFORT	
.....	463, 596	ULTRA-THIN II (SHORT)		LANCET.....	464, 599
ULTILET CLASSIC		INS SYR.....	488, 598	UNISTIK 3 EXTRA LANCET	
LANCETS.....	463, 596	ULTRA-THIN II (SHORT)		.....	464
ULTILET INSULIN		PEN NDL.....	488, 598	UNISTIK 3 GENTLE.....	464
SYRINGE.....	486, 596	ULTRA-THIN II INS PEN		UNISTIK 3 LANCETS..	464, 599
ULTILET LANCETS....	463, 596	NEEDLES.....	488, 598	UNISTIK 3 NEONATAL	
ULTILET PEN NEEDLE		ULTRA-THIN II INSULIN		.....	465, 599
.....	486, 596	SYRINGE.....	488, 598	UNISTIK 3 NEONATAL	
ULTILET SAFETY		ULTRA-THIN II LANCETS		DEVICE.....	464, 599
LANCETS.....	463, 596	.....	463, 598	UNISTIK 3 NORMAL	
ULTIMA MONITOR.....	463	ULTRATRAK.....	428	LANCET.....	465, 599
ULTIMA TEST STRIPS.....	428	ULTRATRAK GLUCOSE		UNISTIK COMFORT	
ULTIMATE FLORA BABY		METER.....	463, 464	LANCETS.....	465
PROBIOTIC.....	385	ULTRATRAK HIGH-LOW		UNISTIK CZT LANCET	
ULTRA B-100 COMPLEX		CONTROL.....	464	.....	465, 599
(FOODBASE).....	290	ULTRATRAK NORMAL		UNISTIK EXTRA LANCETS	465
ULTRA CMFT INS SYR		CONTROL.....	464	UNISTIK NORMAL	
(HALF UNIT).....	487, 597	ULTRATRAK ULTIMATE		LANCETS.....	465
ULTRA COMFORT INSULIN		.....	429, 464, 598, 599	UNISTIK PRO LANCET	
SYRINGE.....	487, 597	ULTRAVATE.....	243	.....	465, 599
ULTRA FINE LANCETS		UMECTA.....	269	UNISTIK SAFETY.....	465, 599
.....	463, 597	UNIFINE PEN NEEDLE		UNISTIK TOUCH LANCETS	
ULTRA FLO INSUL		.....	489, 599	.....	465, 599
SYR(HALF UNIT).....	487, 597	UNIFINE PENTIPS.....	489, 599	UNISTRIP HIGH CONTROL	
ULTRA FLO INSULIN		UNIFINE PENTIPS		.....	465, 599
SYRINGE.....	487, 597	MAXFLOW.....	489	UNISTRIP LOW CONTROL	
ULTRA FLO PEN NEEDLE		UNIFINE PENTIPS PLUS...	489	.....	465, 599
.....	487, 597	UNIFINE PENTIPS PLUS		UNISTRIP1 TEST STRIP	
ULTRA PRENATAL PLUS		MAXFLOW.....	489	.....	429, 599
DHA.....	320	UNILET COMFORTOUCH		UNIVERSAL 1 LANCETS....	465
ULTRA THIN II LANCETS		LANCET.....	464	UP4 PROBIOTICS ADULT..	385
.....	463, 597	UNILET EXCELITE II		UP4 PROBIOTICS ADULT	
		LANCET.....	464	50 PLUS.....	385

UP4 PROBIOTICS KIDS		VAPRO PLUS INTERMITT		VEREGEN.....	266
CUBES.....	385	CATHETER.....	525, 599	VERIFINE PEN NEEDLE	
UP4 PROBIOTICS PLUS		VAQTA (PF).....	100	.....	489, 600
PREBIOTIC.....	385	VARDIMAXIA.....	228	VERITOR SARS-COV-2	
UP4 PROBIOTICS ULTRA..	385	<i>varenicline</i>	197	AND FLU A-B.....	431, 600
UP4 PROBIOTICS		VARISOFT INFUSION SET		VERQUVO.....	114
WOMEN'S.....	385	23".....	527	VERSACLOZ.....	163
UP4 PROBIOTICS-		VARISOFT INFUSION SET		VERTIGOHEEL.....	364
PREBIOTICS KIDS.....	385	32".....	527, 599	VERZENIO.....	84
UPCAL D.....	294	VARISOFT INFUSION SET		VESICARE LS.....	396
UPNEEQ (PF).....	614	43".....	527, 600	Vestura (28).....	212
UPTRAVI.....	133	VARITHENA		VEXASYN.....	280
URAMAXIN.....	269	ADMINISTRATION PACK		V-GO 20.....	523, 600
URAMAXIN GT.....	267	.....	512, 600	V-GO 30.....	523, 600
<i>urea</i>	269	VARIVAX (PF).....	108	V-GO 40.....	523, 600
UREA NAIL STICK.....	269	VAROPHEN		VIBERZI.....	386
URETRON D-S.....	68, 395	(DICLOFENAC).....	273	VIBRAMYCIN.....	76
UREVAZ.....	269	VAROXIA.....	228	Vicodin Hp.....	24, 25
URIMAR-T.....	68, 395	VARUBI.....	367	VICTOZA 2-PAK.....	336
URO-458.....	69, 395	VASCEPA.....	120	VICTOZA 3-PAK.....	336
UROGESIC-BLUE.....	69	VASELINE WHITE		VIEKIRA PAK.....	65
URO-MP.....	69, 395	PETROLEUM.....	276	Vienna.....	212
UROQID-ACID NO.2.....	68, 395	VASHE WOUND THERAPY	285	<i>vigabatrin</i>	142
<i>ursodiol</i>	369	VCF CONTRACEPTIVE		Vigadrone.....	142
USTELL.....	69, 396	FILM.....	217	VIIBRYD.....	155, 156
VAGINAL		VCF CONTRACEPTIVE		VIMPAT.....	141
CONTRACEPTIVE FILM.....	217	GEL.....	217	VINATE GT.....	320
<i>valacyclovir</i>	66	VECAMYL.....	132	VINATE II.....	320
VALCHLOR.....	239	Velivet Triphasic Regimen		VINATE ULTRA.....	320
<i>valerian root extract-hops</i>	12	(28).....	215	VIOKACE.....	369
<i>valerian-flower-hops-lemon</i> ...	14	VELPHORO.....	393	Viorele (28).....	204
<i>valganciclovir</i>	62	VELTASSA.....	292	VIOS AEROSOL DELIVERY	
<i>valproic acid</i>	141	VEMLIDY.....	64	SYSTEM.....	521
<i>valproic acid (as sodium</i>		VENA-BAL DHA.....	320	VIRACEPT.....	70
<i>salt)</i>	140, 172	VENCLEXTA.....	83	VIREAD.....	58, 64
<i>valsartan</i>	113	VENCLEXTA STARTING		VIRT-C DHA.....	305
<i>valsartan-</i>		PACK.....	83	VIRT-FEFA PLUS.....	296
<i>hydrochlorothiazide</i>	112	ENELEX.....	288	VIRT-NATE DHA.....	320
VALTOCO.....	140, 172	<i>venlafaxine</i>	155	VIRT-PN DHA.....	308
Vanatol Lq.....	28	VENNGEL ONE.....	274	VIRT-PN PLUS.....	305
Vanatol S.....	28	VENTAVIS.....	135	VIRTUSSIN AC.....	653
<i>vancomycin</i>	63	<i>verapamil</i>	115, 128, 129	VIRTUSSIN DAC.....	653
VANDAZOLE.....	655	VERASENS BLOOD		VISION HEALTH.....	11
VANISHPOINT INSULIN		GLUCOSE METER....	465, 600	VISTA ADVANCED	
SYRINGE.....	489, 599	VERASENS CONTROL		AREDS2.....	12, 305
VANISHPOINT SYRINGE		SOLN-LEVEL 1.....	465, 600	VISTA MEIBO EYELID	
.....	489, 510, 511, 599	VERASENS METER		CLEANSING.....	252
VANISHPOINT		STARTER KIT.....	465, 600	VISTASEAL-FIBRIN	
TUBERCULIN SYRINGE....	511	VERASENS TEST STRIP...	429	SEALANT.....	410
VANOXIDE-HC.....	227	VERDESO.....	263	VISTOGARD.....	97

<i>vit a palmitate-vit c-vit d3</i>	311	VIXONE NEBULIZER-ADULT MASK.....	492, 601	WHYTEDERM TRILASIL PAK.....	265
VITABEX IRON.....	296	VIXONE NEBULIZER-PEDIATRIC MSK.....	492, 601	WIDE-SEAL DIAPHRAGM 60.....	431, 601
VITAFOL FE PLUS.....	320	VIZIMPRO.....	78	WIDE-SEAL DIAPHRAGM 65.....	431, 601
VITAFOL FE+ (WITH DOCUSATE).....	320	VOCABRIA.....	56	WIDE-SEAL DIAPHRAGM 70.....	432, 601
VITAFOL GUMMIES.....	320	Volnea (28).....	204	WIDE-SEAL DIAPHRAGM 75.....	432, 601
VITAFOL NANO.....	320	VONVENDI.....	407	WIDE-SEAL DIAPHRAGM 80.....	432, 601
VITAFOL ULTRA.....	320	<i>voriconazole</i>	52	WIDE-SEAL DIAPHRAGM 85.....	432, 601
VITAFOL-OB.....	320	VORTEX HOLDING CHAMBER.....	521, 601	WIDE-SEAL DIAPHRAGM 90.....	432, 601
VITAFOL-OB+DHA.....	321	VORTEX VHC FROG MASK-CHILD.....	521, 601	WIDE-SEAL DIAPHRAGM 95.....	432, 602
VITAFOL-ONE.....	321	VORTEX VHC LADYBUG MASK-TODDLR.....	521, 601	WILATE.....	405
VITAJOY ADULT MULTI.....	305	VOSEVI.....	64	WILLIS THE WHALE COMPRESSR NEB.....	521, 602
VITAL AF 1.2 CAL.....	309	VOTRIENT.....	94	WILZIN.....	47
VITAMED MD ONE RX.....	321	VP-CH PLUS.....	321	WINLEVI.....	220
<i>vitamin a</i>	323	VP-CH-PNV.....	321	WINTERGREEN OIL.....	282
VITAMIN B-12.....	325	VP-PNV-DHA.....	321	WOMEN'S 50 PLUS MULTIVITAMIN.....	305
<i>vitamin b12-folic acid</i>	324	VRAYLAR.....	166, 174	WOMEN'S MULTIVITAMIN COLLAGEN.....	305
VITAMIN C FIZZY DRINK...	322	Vtol Lq.....	28	WOMEN'S PROBIOTIC.....	386
VITAMIN C WITH ROSE HIPS.....	325	VUMERITY.....	612	WOUNDGELHA MATRIX...	275
Vitamin D2.....	327	Vyfemla (28).....	212	WPR PLUS.....	270
<i>vitamin d3-vitamin k2</i>	326	Vylibra.....	212	Wymzya Fe.....	212
<i>vitamin e (dl, acetate)</i>	327	VYNDAMAX.....	330	WYNZORA.....	231
<i>vitamin e acetate (bulk)</i> 197,	327	VYND AQEL.....	330	XADAGO.....	160
<i>vitamin e mixed</i>	327	VYVANSE.....	170	XALIX.....	269
Vitamin K.....	328	VYZULTA.....	630	XALKORI.....	80
Vitamin K1.....	328	WAKIX.....	187	XARELTO.....	401
<i>vitamin k2</i>	328	<i>warfarin</i>	400	XARELTO DVT-PE TREAT 30D START.....	401
VITRAKVI.....	96	<i>water for irrigation, sterile</i>	293	XATMEP.....	33
VITREXYL.....	305	WAVESENSE AMP.....	466, 601	XCLAIR.....	251
VITREXYL PLUS IRON.....	305	WAVESENSE CONTROL SOLUTION.....	466, 601	XCOPRI.....	150, 151
VIVA DHA.....	321	WAVESENSE JAZZ.....	429	XCOPRI MAINTENANCE PACK.....	150
VIVAGUARD INO CTRL SOLN-L1,2,3.....	465, 600	WAVESENSE PRESTO.....	429, 466, 601	XCOPRI TITRATION PACK 151	
VIVAGUARD INO CTRL SOLN-L1,L3.....	465, 600	WEEKLY-D.....	327	XELITRAL.....	273
VIVAGUARD INO CTRL SOLN-L2.....	465, 600	WELIREG.....	76	XELJANZ.....	35, 379
VIVAGUARD INO GLUCOSE METER.....	466, 600	Wera (28).....	212	XELJANZ XR.....	35, 379
VIVAGUARD INO SMART GLUC METER.....	466, 600	WESTAB MAX.....	323, 327	XELPROS.....	631
VIVAGUARD INO TEST STRIP.....	429	WESTAB MINI.....	323, 327	XEMBIFY.....	102
VIVAGUARD LANCET.....	466, 601	WESTAB ONE.....	323, 327		
VIVAGUARD LANCING DEVICE.....	466, 601	WESTAB PLUS.....	321		
VIVLODEX.....	40	WESTGEL DHA.....	321		
VIXONE NEBULIZER..	492, 601	WESTHROID.....	362		
		WHITE WAX (BEESWAX)...	198		
		WHYTEDERM SURGIPAK.....	288		
		WHYTEDERM TDDPAK.....	265		

XENAFLAMM.....	37	Zarah.....	212	ZOMACTON.....	349
XENLETA.....	69	ZARXIO.....	407	<i>zonisamide</i>	148
XEPI.....	234	ZATEAN-PN DHA.....	308	ZONTIVITY.....	414
XERESE.....	245	ZATEAN-PN PLUS.....	306	ZORTRESS.....	417
XERMELO.....	365	ZCORT.....	348	ZORVOLEX.....	41
XEROFORM.....	433, 602	Zebutal.....	28	ZOSTAVAX (PF).....	108
XEROFORM NON- OCCLUSIVE.....	433, 602	ZEGALOGUE AUTOINJECTOR.....	329	Zovia 1/35E (28).....	212
XEROFORM PETROLATUM DRESSING	433, 602	ZEGALOGUE SYRINGE.....	329	Zovia 1-35 (28).....	212
XEROFORM PETROLATUM OVERWRAP.....	433, 602	ZEJULA.....	91	ZTLIDO.....	281
XEROSTOMIA RELIEF.....	608	ZELAPAR.....	160	Z-TUSS AC.....	651
XHANCE.....	649	ZELBORAF.....	83	ZUBSOLV.....	195
XIFAXAN.....	71	ZELNORM.....	377, 386	Zumandimine (28).....	212
XIGDUO XR.....	333	ZEMAIRA.....	647	ZUPLENZ.....	367
XIIDRA.....	621	ZEMBRACE SYMTOUCH...	184	ZYCLARA.....	266
XILAPAK.....	266	Zenatane.....	218	ZYDELIG.....	90, 91
XIMINO.....	220	ZENPEP.....	369	ZYFLO.....	636
XOFLUZA.....	66	Zenzedi.....	176, 177	ZYKADIA.....	80
XOLAIR.....	639	ZENZEDI.....	177	ZYLET.....	616
XOLEGEL.....	238	ZEPATIER.....	64	ZYPITAMAG.....	119
XOSPATA.....	85	ZEPOSIA.....	613	ZYPRAM.....	46
XPOVIO.....	95	ZEPOSIA STARTER KIT	613	ZYVANA.....	306
XRYLIDERM.....	280	ZEPOSIA STARTER PACK	613		
XRYLIX (DICLOFENAC- KINES TAPE).....	274	ZERViate.....	618		
XTAMPZA ER.....	21	ZETONNA.....	649		
XTANDI.....	81	ZEYOCAINE.....	280		
XULANE.....	216	ZICLOPRO.....	273		
XULTOPHY 100/3.6.....	338	<i>zidovudine</i>	58		
XURIDEN.....	604	ZIEXTENZO.....	407		
Xylon 10.....	25	ZILACaine PATCH....	280, 522		
XYNTHA.....	405	<i>zileuton</i>	636		
XYNTHA SOLOFUSE.....	405	ZILXI.....	278		
XYOSTED.....	331	<i>zinc citrate</i>	298		
XYREM.....	187	<i>zinc gluconate</i>	299		
XYWAV.....	187	<i>zinc oxide</i>	276		
YOGURT PLUS CALCIUM GUMMIES.....	294	<i>zinc stearate</i>	199		
YONSA.....	77, 81	<i>zinc sulfate</i>	299		
YOSPRALA.....	413	ZINGIBER.....	323		
YUPELRI.....	641	ZIOPTAN (PF).....	631		
Yuvaferm.....	656	<i>ziprasidone hcl</i>	174		
Zafemy.....	216	ZIPSOR.....	40		
<i>zafirlukast</i>	638	ZIRGAN.....	629		
<i>zaleplon</i>	194	ZITHRANOL.....	244		
ZALVIT.....	321	ZOHYDRO ER.....	22		
		ZOKINVY.....	605		
		ZOLINZA.....	86		
		<i>zolmitriptan</i>	184, 185		
		ZOLPAK.....	238		
		<i>zolpidem</i>	194		
		ZOLPIMIST.....	194		



KAISER PERMANENTE®

Kaiser Permanente Insurance Company Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-788-2949. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios lingüísticos sin ningún costo. Puede conseguir un intérprete. Puede conseguir que le lean los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-788-2949. Para obtener más ayuda, llame al Departamento de Seguro de CA al 1-800-927-4357. Los usuarios de la línea TTY deben llamar al 711. Spanish

免費語言服務。 您可使用口譯員。您可請人將文件唸給您聽，且您可請我們將您語言版本的部分文件寄給您。如需協助，請致電列於會員卡上的電話號碼或致電 1-800-788-2949 與我們聯絡。如需進一步協助，請致電 1-800-927-4357 與加州保險局聯絡。聽障及語障電話專線使用者請致電 711。Chinese

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-788-2949. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

T'áá jíik'e ata' hane'go saad bee háká e'elwo'. Ata' halne'í naaltsoos nich'í' yídóotah t'áá ninizaad bee. Bee níká i'doolwołgo béesh bee hodílnih koji' 1-800-788-2949 éi doodago naaltsoos bee nééhózinígíí bikáá'ígíí. CA Dept. of Insurance bich'í' hodílnih 1-800-927-4357 áká e'elyeed nínizingo. TTY chodayool'ínígíí éi 711. Navajo

Các dịch vụ trợ giúp ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và được người đọc giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Để được giúp đỡ, xin gọi chúng tôi theo số điện thoại ghi trên thẻ ID hội viên hoặc số 1-800-788-2949. Để được giúp đỡ thêm, vui lòng gọi Bộ Bảo hiểm CA theo số 1-800-927-4357. Người sử dụng TTY gọi số 711. Vietnamese

무료 언어 서비스. 원하시는 언어로 통역 및 낭독 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와 있는 전화번호 또는 1-800-788-2949 번으로 문의하십시오. 보다 자세한 사항은 캘리포니아 주 보험국, 전화번호 1-800-927-4357 번으로 문의하십시오. TTY 사용자 번호 711. Korean

Mga Libreng Serbisyo para sa Wika. Maaari kang makakuha ng tagapagsalin-wika at hinging basahin ang mga dokumento para sa iyo sa iyong sariling wika. Para humingi ng tulong, tumawag sa numerong nakasulat sa iyong ID card o 1-800-788-2949. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Mga gumagamit ng TTY, tumawag sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք օգտվել բանավոր թարգմանչի ծառայություններից և խնդրել, որ փաստաթղթերը Ձեզ համար կարդան Ձեր լեզվով: Օգնության համար զանգահարեք մեզ՝ Ձեր ID քարտի վրա նշված կամ 1-800-788-2949 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության դեպարտամենտ՝ 1-800-927-4357 հեռախոսահամարով: TTY -ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-788-2949. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Пользователи TTY, звоните по номеру 711. Russian

無料の言語サービス。 通訳サービスを利用して、日本語で書類を読んでもらうことができます。通訳サービスが必要な際は、IDカードに記載の番号、または 1-800-788-2949 にお電話ください。さらにヘルプが必要な場合は、カリフォルニア州保険庁（1-800-927-4357）にお電話ください。TTY ユーザーの方は、711 にお電話ください。Japanese

خدمات زبان به طور رایگان. می توانید از خدمات مترجم شفاهی بهره مند شده و ترتیبی بدهید تا نوشته ها به زبان خودتان برای شما خوانده شوند. برای دریافت کمک و راهنمایی، با شماره ای که روی کارت شناسایی شما قید شده یا 1-800-788-2949 تماس بگیرید. برای دریافت کمک و راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY با شماره 711 تماس حاصل نمایند. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਆਬੀਏ ਦੀ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-788-2949 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ, ਕੈਲੀਫੋਰਨੀਆਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែ និងឱ្យគេអានឯកសារជូនអ្នក ជាភាសាខ្មែរ។ សំរាប់ជំនួយ សូម ទូរស័ព្ទមកយើងតាមលេខដែលមាននៅលើប័ណ្ណ ID របស់អ្នក ឬ 1-800-788-2949។ សំរាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ អ្នកប្រើ TTY ហៅលេខ 711។ Khmer

خدمات لغوية مجانية. بإمكانك الحصول على مترجم فوري وطلب قراءة الوثائق عليك بلغتك. لطلب المساعدة، ما عليك سوى الاتصال بنا على الرقم الوارد في بطاقة الهوية الخاصة بك أو على الرقم 1-800-788-2949. للحصول على المزيد من المساعدة، يرجى الاتصال بدائرة كاليفورنيا للتأمين على الرقم 1-800-927-4357. على مستخدمي ميزة TTY طلب الرقم 711. Arabic

Cov Kev Pab Txhais Lus Dawb. Koj thov tau ib tug neeg txhais lus thiab muab tau cov ntaub ntawv nyeem rau koj ua koj hom lus. Xav tau kev pab, hu rau peb tus xov tooj ntawm koj daim yuaj ID los yog 1-800-788-2949. Xav taukev pab ntxiv, hu rau CA Tuam Tsev Tswj Kev Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu 711. Hmong

मुफ्त भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और दस्तावेज़ आपको आपकी भाषा में पढ़ कर सुनाये जा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-788-2949 पर हमें फोन करें। अधिक सहायता के लिए कैलीफ़ोर्निया डिपार्टमेंट ऑफ़ इंशोरेंस को 1-800-927-4357 पर फोन करें। TTY प्रयोक्ता 711 पर फोन करें। Hindi

บริการทางภาษาที่ไม่เสียค่าใช้จ่ายใด ๆ คุณสามารถขอใช้บริการล่ามและบริการอ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดติดต่อหมายเลขโทรศัพท์ที่ปรากฏบนบัตรประจำตัวของคุณหรือติดต่อหมายเลข 1-800-788-2949 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อกรมการประกันภัยของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 ผู้ใช้เครื่อง TTY โปรดติดต่อหมายเลข 711. Thai

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-464-4000** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator can help you.

KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-251-7052

You may also contact the California Department of Insurance regarding your complaint.

By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Electronically:
www.insurance.ca.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file the complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.