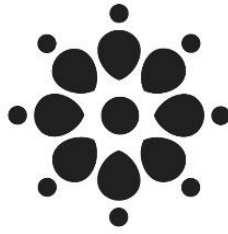


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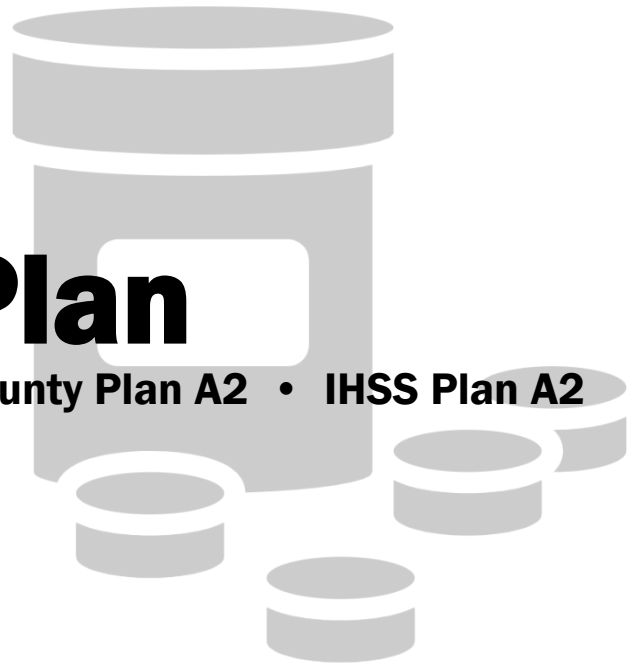


# Commercial Plan

County Plan A • County Plan B • County Plan A2 • IHSS Plan A2

# Formulary

Formulario



## Contra Costa Health Plan (CCHP)

November **2024**

noviembre 2024



- The CCHP formulary is subject to change. For the most up-to-date formulary, use the interactive formulary search tool at [cchealth.org/CCHPrx](http://cchealth.org/CCHPrx)
- For plan-specific coverage information, including cost sharing information, review your Member Handbook / Evidence of Coverage (EOC) at [cchealth.org/CCHPmaterials](http://cchealth.org/CCHPmaterials)
  
- El formulario de CCHP está sujeto a cambios. Para obtener el formulario más actualizado, utilice la herramienta de búsqueda de formulario interactiva en [cchealth.org/CCHPrx-es](http://cchealth.org/CCHPrx-es)
- Para obtener información de cobertura específica del plan, incluida información de costos compartidos, revise su Manual para Miembros / Evidencia de Cobertura (EOC) en [cchealth.org/CCHPmateriales](http://cchealth.org/CCHPmateriales)

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# **Frequently Asked Questions**

## **What is the CCHP formulary?**

The CCHP formulary (also known as the CCHP preferred drug list, or PDL) includes drugs used to treat common diseases or health problems. This formulary applies only to outpatient drugs and self-administered drugs – it does not apply to medications used in the inpatient setting or in medical offices.

The formulary is a continually reviewed and revised list of preferred medications based on safety, efficacy, and cost-effectiveness. It is updated on a monthly basis and is effective the first of every month. Updates are based on input from a team of doctors and pharmacists that meet regularly to decide which drugs should be included. These updates may include, but are not limited to the following: (i) removal or addition of drugs and/or dosage forms. (ii) changes in tier placement of a drug (iii) changes to utilization management restrictions (such as quantity limits, step therapy, etc.). Updated documents are available online at: <https://www.cchealth.org>.

## **How do I use the CCHP formulary?**

The list of formulary drugs begins on Page 1. To locate a drug on the formulary, simply look for the name of the drug in the index at the end of this booklet - the index lists all of the drugs on the formulary, including brand name and generic name. Once you have located the name of the drug in the index, you will see the page number where you can find more information about your drug listed next to it.

Instead of using the index, the formulary can also be searched by using ctrl+F to find a specific medication by brand name, generic name, or therapeutic class.

A mobile-enabled version of the CCHP formulary is also available using the ePocrates application. After you have downloaded the application to your mobile device, simply choose the “Contra Costa Health Plan-Commercial” formulary to display the formulary status of drugs within the application. If you have any questions about the installation or use of the Epocrates application, please contact Epocrates Customer Support at (800)230-2150 or [goldsupport@epocrates.com](mailto:goldsupport@epocrates.com).



The presence of a prescription drug on the CCHP formulary does not guarantee that a member will be prescribed that medication by his or her prescribing provider for a particular medical condition. The absence of a drug on the CCHP means that the drug

is not on the formulary, and will require prior authorization to be covered (specific information about the CCHP prior authorization process is located below in the section titled “What if the drug that I need isn’t listed on the CCHP formulary?”)

**How are drugs listed on the formulary?**

Drugs are listed alphabetically by brand and generic name within the therapeutic category and class to which they belong. Brand name drugs will appear in all CAPITAL letters, with the generic name listed in parentheses after the brand name in all ***bold and italicized lowercase letters***. If a generic drug is available, it will be listed separately from the brand name drug, and will always be listed in ***bold and italicized lowercase letters***. If a generic equivalent of a brand name drug is not available, then the generic drug will not be listed separately from the brand name drug. In situations where an FDA approved generic equivalent is available, brand names are listed for reference purposes only, and do not denote coverage for the brand, unless specifically noted.

An example listing from the CCHP formulary is below:

Therapeutic Class ↓		Drug Tier ↓	
<b>Insulins - Drugs For Diabetes</b>			
LANTUS SOLOSTAR U-100 INSULIN ( <i>insulin glargine</i> )		T2	QL (30mL per 30 days)
↑ Brand Name	↑ Generic Name	↑ Coverage Limits	

**What if the drug that I need isn’t listed on the CCHP formulary?**

If your drug isn’t listed on the CCHP formulary you can ask your doctor if there is a different drug on the formulary that will work the same way. If your doctor decides that you need a drug that is not on the formulary, they can ask CCHP to make an exception through the prior authorization process. All prior authorization requests will be evaluated by a health plan clinician (pharmacist or medical doctor) based upon CCHP prior authorization criteria that is approved by the CCHP Pharmacy and Therapeutics (P&T) committee. In instances where specific criteria do not exist, FDA indications, peer reviewed literature, other plan criteria, national treatment guidelines (such as IDSA, NCCN, AACE, etc.), and other medical compendia will be used for evaluation. Exceptions can be made for a variety of different reasons:

- Your doctor can ask CCHP to cover a drug that is listed on the formulary as requiring a prior authorization (PA): these drugs require approval prior to being dispensed at a network pharmacy. Each request will be reviewed by a health plan clinician, and if the request does not meet the guidelines established by the plan it will not be approved, and alternative therapy may be recommended.

- Your doctor can ask CCHP to cover a drug that isn't listed on the formulary: any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn't an alternate agent on the formulary.
- Your doctor can ask CCHP to make an exception to limits on a drug. For example, if a drug has a limit of 1 tablet per day, your doctor can ask us to cover more. If quantities exceeding the limit are necessary, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists without compromising safety.
- Your doctor can ask CCHP to make an exception to Step Therapy (ST) requirements: these drugs require one or more first step drugs to be tried before progressing to the second step drug (for example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first). If there is a medical need to use a second step drug without trying a first step drug, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists. If you have already tried and failed the preferred drug(s), or if you are already taking a drug that is subject to step therapy when you switch to CCHP, you will not have to try the preferred drugs again. Your doctor can simply request an approval through the plan for continuation of therapy.

To start the CCHP prior authorization process or to ask for an exception, your doctor must fax a prior authorization request to CCHP at **1-866-428-7369** for urgent requests, or **1-866-205-8014** for standard requests. Your doctor may also be able to submit the request electronically to CCHP using the electronic medical record. If the request is approved, you will be able to get your medication filled at a pharmacy that works with CCHP. If we deny the request we will send you and your doctor a letter and will tell you how to file an appeal or a grievance. An "appeal" is when you want a decision to be reviewed again by the health plan (usually with additional information), and a "grievance" is a complaint or concern regarding the health plan.

CCHP will make a decision to deny or approve all urgent prior authorization and exception requests within 24 hours of receiving the request and will make a decision to deny or approve all standard prior authorization and exception requests within 72 hours of receiving the request. If CCHP fails to respond to a prior authorization or step therapy request within 72 hours of receiving a non-urgent request or 24 hours of receiving a request based on exigent circumstances, the request shall be deemed approved. CCHP will notify the member or the member's designee and the prescribing provider within 24 hours of CCHP's coverage determination.

CCHP will provide coverage pursuant to a prior authorization or exception request for the duration of the prescription, including refills. CCHP will not limit or exclude coverage for a medication if the health plan previously approved coverage for the medication for the member's medical condition.

If you would like to download the CCHP prior authorization form, it is available at: [https://cchealth.org/healthplan/pdf/performrx\\_medication\\_prior\\_auth\\_form.pdf](https://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf)

### **What if I need my medication urgently – do pharmacies have the ability to fill emergency supplies of medication?**

Yes. To ensure that CCHP members have access to a sufficient supply of medications in emergency situations, CCHP has established an Emergency Supply Policy that allows pharmacists to use their clinical judgement to override claims that deny at the point of sale. When a pharmacist determines that a medication is medically necessary, they may enter an authorization code that allows them to fill a 5-day emergency supply of medication for any CCHP member. CCHP promotes the use of the Emergency Supply Policy through point-of-sale messaging.

Instead of using the 5-day Emergency Supply Policy, pharmacies may also choose to call the PerformRx provider call center at 877-234-4269 – representatives are available 24 hours per day, 365 days per year. Staff at the call center have the ability to override prescriptions based on guidance provided by CCHP.

### **What if I'm a new CCHP member?**

If you are a new CCHP member you may be taking drugs that are not on our formulary, or you may be taking drugs that are on our formulary but have limits. If possible, you should talk to your doctor to see if you can change to a preferred drug on the CCHP formulary. If you cannot switch to a preferred drug, then your doctor will need to ask CCHP for an exception to cover a drug you have been taking (known as continuation of therapy). See the section above titled “What if the drug that I need isn’t listed on the CCHP formulary?” for more information.

### **Does CCHP cover generic and brand name medications?**

CCHP covers brand and generic drugs, but when a generic drug is available CCHP requires that it be used. All drugs that become available generically are subject to review by the CCHP Pharmacy & Therapeutics committee.

A prescriber may request a brand name product in lieu of an approved generic if the prescriber determines that there is a documented medical need for the brand equivalent. This type of request for coverage may be made through the CCHP prior authorization process described above in the section titled “What if the drug that I need isn’t listed on the CCHP formulary.”

### **Are there drugs that are excluded from coverage?**

For the CCHP Commercial pharmacy benefit, there are no prescription medications that are excluded for coverage. Your doctor can ask CCHP to cover a drug that isn’t listed on the formulary: any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn’t an alternate agent on the formulary.

If CCHP's coverage is amended to exclude a drug that we have been covering and providing to you under your current coverage, we will continue to provide the drug if a plan physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

### **Can I go to any pharmacy for my medication?**

No, members must use a pharmacy that is in the CCHP network. To find a network pharmacy, visit the CCHP website or call the health plan directly to have one of our member services or pharmacy staff help you locate a pharmacy near you (see section below titled "How do I find a pharmacy?").

### **How do I find a pharmacy?**

To find a pharmacy near you, visit the CCHP website at <https://cchealth.org/healthplan/>. Once you have navigated to the CCHP website, follow the directions below:

- (1) Scroll down and click on the "Search Doctors/Clinics/Pharmacies in My Area" button
- (2) Click on the red "Begin Your Search Here" button (a new window will pop up)
- (3) Click on the "Facility" tab, and choose "Pharmacy" as the facility type
- (4) Choose how you want to search (by zip code, distance, etc.)
- (5) Click "Find a Facility" - results will immediately show up (as a map and a list)

Be sure to show your CCHP Member ID card when you fill your prescriptions at the pharmacy.

Note: some medications are subject to limited distribution by the U.S. Food and Drug Administration. These types of drugs are called "specialty medications" because they require special handling, provider coordination, or special education that may not be



provided at your local pharmacy. CCHP has a contract with Walgreens to provide these types of medications. If you have specific questions about these types of drugs please contact the CCHP pharmacy unit directly. Additionally, CCHP has a contract with Walgreens for mail order prescriptions. If you have specific questions about how to obtain medications via mail order, please contact the CCHP pharmacy unit directly or visit the CCHP website at <https://cchealth.org/healthplan/member-pdl.php>.

### **What drugs are covered by CCHP?**

You can get the following drugs and other items when they are prescribed by your doctor and are medically necessary:

- Prescription drugs listed on the CCHP formulary
- Non-prescription drugs or over-the-counter drugs (such as cough/cold syrups, cough drops or aspirin) listed on the CCHP formulary
- Formulary diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, pen delivery systems, and blood glucose monitors
- FDA-approved birth control and contraceptives listed on the CCHP formulary
- Emergency contraception
- Epi-Pens, peak flow meters and spacers

### **Are intravenous (IV) and injectable drugs covered by CCHP?**

Yes, the CCHP formulary lists certain injectable products that are covered as a pharmacy benefit. CCHP also covers most other intravenous medications through the medical benefit. Medications that are generally covered through the medical benefit are those that are given in a doctor's office, clinic, or hospital setting. Requests for coverage of a medication through the medical benefit should be directed to the CCHP Utilization Management Department by downloading the medical referral form at <https://cchealth.org/healthplan/providers/> and faxing to (925) 313-6058 for routine requests or (925) 313-6458 for urgent requests.

Coverage of intravenous and injectable drugs through the pharmacy benefit are outlined below:

- **Simple intravenous solutions:** simple intravenous solutions are typically used for hydration therapy. Included are commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10% in Water) and Lactated Ringer's Solution; commercially prepared solutions of potassium chloride in such solutions are also included in this definition. Simple intravenous solutions should be billed using the product's National Drug Code (NDC) number.
- **Parenteral nutrition solutions (TPN or hyperalimentation):** restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period. (Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin &/or mineral supplements and trace elements.) Adjuncts to

parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

- Separately administered intravenous lipids: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period. Intravenous lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.
- Intravenous solutions of unlisted antibiotics: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same antibiotic was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.
- Intravenous solutions of other unlisted drugs: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same drug was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

### **How Much I Will Pay for My Drugs?**

CCHP commercial members (plans such as commercial plan A, plan B, IHSS, etc.) may have small copays for their medications. Please see your plan materials to determine if you have a copay.

### **Can providers make suggestions to CCHP to improve the formulary?**

Absolutely. The formulary is a tool to promote cost-effective prescription drug use. CCHP has made every attempt to create a document that meets all therapeutic needs, however the art of medicine makes this a formidable task. CCHP welcomes the participation of physicians, pharmacists, and ancillary medical providers in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions or comments to CCHP via e-mail at: [cchp\\_pharmacy\\_director@hsd.cccounty.us](mailto:cchp_pharmacy_director@hsd.cccounty.us).

### **What if I need more information?**

For more information about your pharmacy benefits, please review your Evidence of Coverage documents or call CCHP directly to discuss. CCHP member services department and pharmacy department staff are available to answer questions Monday through Friday from 8:00am to 5:00pm Pacific Time at the phone numbers listed below:

CCHP Member Services Department: **(877) 661-6230 x2**

CCHP Pharmacy Department: **(877) 661-6230 x3**

## **Definitions & Abbreviations:**

There are a number of terms that are used in this document that Contra Costa Health Plan wants to make sure that you understand. Below are some definitions and abbreviations:

**“Brand name drug”** is a drug that is marketed under a proprietary, trademark protected name. The brand name drug is listed in all CAPITAL letters.

**“Coinsurance”** is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

**“Copayment”** is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

**“Deductible”** is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

**“Drug Tier”** is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

**“Enrollee”** is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

**“Exception request”** is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing healthcare provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

**“Exigent circumstances”** are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

**“Formulary”** is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list,

“**Generic drug**” is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters.

“**Nonformulary drug**” is a prescription drug that is not listed on the health plan's formulary.

“**Out-of-pocket cost**” are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

“**Prescribing provider**” is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

“**Prescription**” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“**Prescription drug**” is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

“**Prior Authorization**” is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“**Step therapy**” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

“**Subscriber**” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

Additional abbreviations and terms used on the CCHP formulary document are explained below:

<b>Abbreviation</b>	<b>Term</b>	<b>What it means</b>
AL	Age Limit	Some drugs are only covered for certain ages.
NF	Non-Formulary	These drugs are not covered on the Drug List. If your doctor feels you need a drug that is not covered, he or she can ask us to make an exception.
PA	Prior Authorization	Your doctor must ask for approval from CCHP before some drugs will be covered.
QL	Quantity Limit	Some drugs are only covered for a certain amount.
SCO	State Carve-Out	These drugs are carved out by the Department of Health Care Services. This means these drugs are covered by the Medi-Cal Fee-for-Service program and must be billed to the State by the pharmacy.
ST	Step Therapy	In some cases, you must first try certain drugs before CalViva Health covers another drug for your medical condition.  For example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first.

The CCHP formulary uses a 3 tier structure – the tiers are explained below:

<b>Abbreviation</b>	<b>Term</b>	<b>What it means</b>
T1	Tier 1	Tier 1 medications are preferred on the CCHP formulary and are available without restriction or prior authorization.
T2	Tier 2	Tier 2 medications are preferred on the CCHP formulary and are available without prior authorization, BUT may have certain restrictions such as quantity limits, step therapy, etc. (the specific restrictions are listed on the CCHP formulary).
T3	Tier 3	Tier 3 medications are non-preferred. These medications require prior authorization.



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# Plan de Salud de Contra Costa CCHP) ORGANIZACIÓN DE ADMINISTRACIÓN DE SALUD (HMO) COMERCIAL Formulario

## Última actualización: 1 de octubre de 2024

Nota: El formulario del CCHP está sujeto a cambios, y todas las versiones anteriores ya no están vigentes.

- Para acceder a la versión electrónica del formulario del CCHP en el sitio web del plan de salud, visite la siguiente dirección web: <https://cchealth.org/healthplan/pdf/pdf.pdf>
- Para acceder a la herramienta de búsqueda del formulario interactivo del CCHP, visite la siguiente dirección web: <https://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC>
- Para acceder a la información de cobertura específica del plan que incluye información de costos compartidos, manual para miembros y otros materiales importantes como los documentos de su Evidencia de cobertura (EOC), visite la siguiente dirección web:  
<https://cchealth.org/healthplan/member-publications.php>

# Preguntas frecuentes

## ¿Qué es el formulario del CCHP?

El formulario del CCHP (también conocido como la lista de medicamentos preferidos del CCHP, o PDL) incluye medicamentos utilizados para tratar enfermedades o problemas de salud comunes. Este formulario aplica solo a los medicamentos para pacientes en consulta externa y medicamentos autoadministrados, no aplica a medicamentos utilizados en el entorno de pacientes internados o en consultorios médicos.

El formulario es una lista de medicamentos preferidos examinada y revisada continuamente en función de la seguridad, eficacia y rentabilidad. Se actualiza mensualmente y es efectiva el primer día de cada mes. Las actualizaciones se basan en comentarios de un grupo de médicos y farmacéuticos que se reúnen regularmente para decidir qué medicamentos deben incluirse. Estas actualizaciones pueden incluir, entre otros, lo siguiente: (i) eliminación o adición de medicamentos o formas farmacéuticas, (ii) cambios en la colocación de nivel de un medicamento, (iii) cambios en las restricciones de administración de utilización (como límites de cantidad, tratamiento escalonado, etc.). Los documentos actualizados están disponibles en línea en: <https://www.cchealth.org>.

## ¿Cómo uso el formulario del CCHP?

La lista de medicamentos de formulario comienza en la Página 1. Para ubicar un medicamento en el formulario, simplemente busque el nombre del medicamento en el índice al final de este folleto. El índice enumera todos los medicamentos en el formulario, incluidos los medicamentos de marca y los medicamentos genéricos. Una vez que haya ubicado el nombre del medicamento en el índice, verá el número de página en donde puede encontrar más información sobre el medicamento indicado junto a este.

En lugar de usar el índice, también se puede buscar en el formulario usando ctrl+F para encontrar un medicamento específico por marca, nombre genérico o clase terapéutica.

Una versión para teléfonos celulares del formulario del CCHP también está disponible usando la aplicación ePocrates. Después de que haya descargado la aplicación a su dispositivo móvil, simplemente elija el formulario "Plan de Salud de Contra Costa Medical" para mostrar el estado de formulario de los medicamentos en la aplicación. Si tiene alguna pregunta sobre la instalación o uso de la aplicación Epocrates, comuníquese con atención al cliente de Epocrates al (800)230-2150 o [goldsupport@epocrates.com](mailto:goldsupport@epocrates.com).





La presencia de un medicamento que requiere receta en el formulario del CCHP no garantiza que el proveedor que emite recetas le recete a un miembro ese medicamento para una afección médica particular.

Si un medicamento no está en el formulario del CCHP, requerirá una autorización previa para que esté cubierto (la información específica sobre el proceso de autorización previa del CCHP se encuentra a continuación en la sección titulada “¿Qué sucede si el medicamento que necesito no está en el formulario del CCHP?”)

### ¿Cómo se indican los medicamentos en el formulario?

Los medicamentos están indicados alfabéticamente por marca y nombre genérico en la categoría terapéutica y clase a la que pertenecen. Los medicamentos de marca aparecerán en MAYÚSCULAS, con el nombre genérico indicado en paréntesis después de la marca todo escrito en **letra minúscula negrita y cursiva**. Si el medicamento genérico está disponible, se indicará de forma separada del medicamento de marca y siempre se indicará en **letra minúscula negrita y cursiva**. Si un genérico equivalente de un medicamento de marca no está disponible, el medicamento genérico no estará indicado de forma separada del medicamento de marca. En situaciones en las que un equivalente genérico aprobado por la Administración de Alimentos y Medicamentos (Food & Drug Administration, FDA) está disponible, las marcas se indican con fines de referencia únicamente, y no denotan cobertura para la marca, a menos que se indique específicamente.

Una lista de ejemplo del formulario del CCHP se encuentra a continuación:

<b>Clase terapéutica</b>		<b>Nivel de medicamento</b>	
↓		↓	
<b>Insulins - Drugs For Diabetes</b>			
LANTUS SOLOSTAR U-100 INSULIN ( <i>insulin glargine</i> )		T2	QL (30mL per 30 days)
↑	↑	↑	
<b>Marca</b>	<b>Nombre genérico</b>	<b>Limites de cobertura</b>	

### ¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?

Si su medicamento no figura en el formulario del CCHP, puede preguntarle a su médico si hay un medicamento diferente en el formulario que funcione de la misma manera. Si su médico decide que necesita un medicamento que no está en el formulario, puede pedirle al CCHP que haga una excepción a través del proceso de autorización previa. Todas las solicitudes de autorización previa serán evaluadas por un médico del plan de salud (farmacéutico o médico) según los criterios de autorización previa del CCHP

aprobados por el comité de Farmacia y Terapéutica (P&T) del CCHP. En los casos en que no existan criterios específicos, se utilizarán para la evaluación indicaciones de la FDA, literatura revisada por pares, otros criterios del plan, pautas nacionales de tratamiento (como IDSA, NCCN, AACE, etc.) y otros compendios médicos. Se pueden hacer excepciones por una variedad de motivos diferentes:

- Su médico puede pedirle al CCHP que cubra un medicamento que figura en el formulario que requiere una autorización previa (PA): estos medicamentos requieren aprobación antes de ser despachados en una farmacia de la red. Cada solicitud será revisada por un médico del plan de salud, y si la solicitud no cumple con las pautas establecidas por el plan, no será aprobada, y se puede recomendar una terapia alternativa.
- Su médico puede pedirle al CCHP que cubra un medicamento que no figura en el formulario: cualquier medicamento que no se encuentre en esta lista se considera no incluido en el formulario. La persona que emite la receta puede solicitar cobertura para agentes que no figuran en el formulario. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada y si no hay un agente alternativo en el formulario.
- Su médico puede pedirle al CCHP que haga una excepción a los límites de un medicamento. Por ejemplo, si un medicamento tiene un límite de 1 tableta por día, su médico puede pedirnos que cubramos más. Si se necesitan cantidades que exceden el límite, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada sin comprometer la seguridad.
- Su médico puede pedirle al CCHP que haga una excepción a los requisitos de tratamiento escalonado (ST): estos medicamentos requieren que se prueben uno o más medicamentos de primer paso antes de pasar al medicamento de segundo paso (por ejemplo, si el medicamento A y el medicamento B tratan su afección de salud, el CCHP puede no cubrir el medicamento B a menos que primero pruebe el medicamento A). Si existe una necesidad médica de usar un medicamento de segundo paso sin probar un medicamento de primer paso, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada. Si ya probó el medicamento preferido y este falló, o si ya está tomando un medicamento sujeto a tratamiento escalonado cuando se cambia al CCHP, no tendrá que probar los medicamentos preferidos nuevamente. Su médico simplemente puede solicitar una aprobación a través del plan para la continuación del tratamiento.

Para comenzar el proceso de autorización previa del CCHP o para solicitar una excepción, su médico debe enviar por fax una solicitud de autorización previa al CCHP al **1-866-428-7369** para solicitudes urgentes, o **1-866-205-8014** para solicitudes

estándar. Su médico también puede enviar la solicitud electrónicamente al CCHP utilizando la historia clínica electrónica. Si se aprueba la solicitud, podrá surtir su medicamento en una farmacia que trabaje con el CCHP. Si denegamos la solicitud, le enviaremos una carta a usted y a su médico y le diremos cómo presentar una apelación o una queja formal. Una "apelación" es cuando desea que el plan de salud revise nuevamente una decisión (generalmente con información adicional), y una "queja formal" es una queja o inquietud relacionada con el plan de salud.

El CCHP tomará la decisión de denegar o aprobar todas las solicitudes de autorización previa y de excepción dentro de las 24 horas posteriores a la recepción de la solicitud. Si el CCHP no responde a una autorización previa o solicitud de tratamiento escalonado dentro de las 72 horas de haber recibido una solicitud no urgente o 24 horas después de recibir una solicitud basada en circunstancias exigentes, la solicitud se considerará aprobada.

El CCHP proporcionará cobertura de conformidad con una solicitud no urgente por la duración de la receta, incluidos los resurtidos. El CCHP proporcionará cobertura, incluidos los resurtidos, de conformidad con una solicitud basada en circunstancias exigentes por la duración de la exigencia.

Si desea descargar el formulario de autorización previa del CCHP, está disponible en: [https://cchealth.org/healthplan/pdf/performrx\\_medication\\_prior\\_auth\\_form.pdf](https://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf)

¿Qué sucede si necesito mi medicamento con urgencia? ¿Las farmacias tienen la capacidad de surtir suministros de medicamentos de emergencia?

Sí. Para garantizar que los miembros del CCHP tengan acceso a un suministro suficiente de medicamentos en situaciones de emergencia, el CCHP ha establecido una Política de suministros de emergencia que permite a los farmacéuticos utilizar su criterio clínico para anular los reclamos que rechazan en el punto de venta. Cuando un farmacéutico determina que un medicamento es médicamente necesario, puede ingresar un código de autorización que le permita surtir un suministro de medicamentos de emergencia para 5 días para cualquier miembro del CCHP. El CCHP promueve el uso de la Política de suministros de emergencia a través de mensajes en el punto de venta.

En lugar de utilizar la Política de suministros de emergencia para 5 días, las farmacias también pueden optar por llamar al centro de llamadas del proveedor de PerformRx al 877-234-4269; los representantes están disponibles las 24 horas del día, los 365 días del año. El personal del centro de llamadas tiene la capacidad de anular las recetas en función de la orientación proporcionada por el CCHP.

¿Qué sucede si soy un miembro nuevo del CCHP?

Si es un miembro nuevo del CCHP, puede estar tomando medicamentos que no están en nuestro formulario, o puede estar tomando medicamentos que están en nuestro formulario, pero que tienen límites. Si es posible, debe hablar con su médico para ver si puede cambiar a un medicamento preferido en el formulario del CCHP. Si no puede cambiarse a un medicamento preferido, entonces su médico deberá solicitarle al CCHP una excepción para cubrir un medicamento que ha estado tomando (conocido como continuación del tratamiento). Consulte la sección anterior titulada "¿Qué sucede si el medicamento que necesito no figura en el formulario del CCHP?" para obtener más información.

### ¿El CCHP cubre medicamentos genéricos y de marca?

El CCHP cubre medicamentos de marca y genéricos, pero cuando hay un medicamento genérico disponible, el CCHP requiere que se use. Todos los medicamentos que están disponibles genéricamente están sujetos a revisión por parte del comité de Farmacia y Terapéutica del CCHP.

Una persona que emite una receta puede solicitar un producto de marca en lugar de un genérico aprobado si determina que existe una necesidad médica documentada del equivalente de marca. Este tipo de solicitud de cobertura se puede realizar a través del proceso de autorización previa del CCHP descrito anteriormente en la sección titulada "¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?"

### ¿Hay medicamentos que están excluidos de la cobertura?

El formulario de Medi-Cal del CCHP es muy similar a la Lista de Medicamentos con Contrato de Medi-Cal de California. Los siguientes tipos de medicamentos generalmente no son un beneficio cubierto para los miembros de Medi-Cal (tenga en cuenta que esta lista está sujeta a cambios):

- Medicamentos para la disfunción eréctil o sexual
- Medicamentos utilizados por razones estéticas o crecimiento del cabello
- Medicamentos que se consideran experimentales, o que se usan de manera experimental
- Medicamentos utilizados para tratar la infertilidad
- Medicamentos específicamente enumerados como "no cubiertos" en el formulario
- Medicamentos extranjeros o medicamentos no aprobados por la Administración de Alimentos y Medicamentos de los Estados Unidos (FDA)

Si se modifica la cobertura del CCHP para excluir un medicamento que hemos estado cubriendo y proporcionándole bajo su cobertura actual, continuaremos proporcionándole el medicamento si un médico del plan continúa recetándolo para la misma afección y para un uso aprobado por la Administración de Alimentos y Medicamentos.

Algunos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de

pago por servicio de Medi-Cal para miembros de Medi-Cal, no por el CCHP. Los siguientes tipos de medicamentos están excluidos:

- Medicamentos antipsicóticos
- Medicamentos para el VIH/sida
- Medicamentos exclusivos para el tratamiento de desintoxicación y dependencia del alcohol y heroína
- Medicamentos exclusivos para tratar la hemofilia

#### ¿Puedo ir a cualquier farmacia por mi medicamento?

No, los miembros deben usar una farmacia que esté en la red del CCHP. Para encontrar una farmacia de la red, visite el sitio web del CCHP o llame al plan de salud directamente para que uno de los miembros del personal de servicios para miembros o de farmacia le ayuden a ubicar una farmacia cercana (consulte la sección a continuación titulada "¿Cómo encuentro una farmacia?").

#### ¿Cómo encuentro una farmacia?

Para encontrar una farmacia cercana, visite el sitio web del CCHP en <https://cchealth.org/healthplan/>. Una vez que haya navegado al sitio web del CCHP, siga las instrucciones a continuación:

- (1) Desplácese hacia abajo y haga clic en el botón "Buscar médicos/clínicas/farmacias en mi área" (Search Doctors/Clinics/Pharmacies in My Area)
- (2) Haga clic en el botón rojo "Comenzar aquí" (Begin Your Search Here) (se abrirá una nueva ventana)
- (3) Haga clic en la pestaña "Instalaciones" (Facility) y elija "Farmacia" (Pharmacy) como tipo de instalación
- (4) Elija cómo desea buscar (por código postal, distancia, etc.)
- (5) Haga clic en "Buscar una instalación" (Find a Facility): los resultados aparecerán inmediatamente (como un mapa y una lista)

Asegúrese de mostrar su tarjeta de identificación de miembro del CCHP cuando surta sus recetas en la farmacia.

Nota: algunos medicamentos están sujetos a una distribución limitada por parte de la Administración de Alimentos y Medicamentos de EE. UU. Estos tipos de medicamentos se denominan "medicamentos de especialidad" porque requieren un manejo especial, coordinación de proveedores o instrucciones especiales que es posible que su farmacia local no le proporcione. El CCHP tiene un contrato con Walgreens para proporcionar este tipo de medicamentos. Si tiene preguntas específicas sobre este tipo de medicamentos, comuníquese directamente con la unidad de farmacia del CCHP.

#### ¿Qué medicamentos están cubiertos por el CCHP?

Usted puede obtener los siguientes medicamentos y otros artículos cuando los haya recetado su médico y sean médicamente necesarios:

- Medicamentos recetados que figuran en el formulario del CCHP
- Medicamentos sin receta o medicamentos de venta libre (como jarabes para la tos/resfrío, pastillas para la tos o aspirina) mencionados en el formulario del CCHP
- Suministros para diabéticos del formulario: insulina, jeringas de insulina, tiras reactivas de glucosa, lancetas y dispositivos de punción de lancetas, sistemas de administración de plumas y monitores de glucosa en sangre
- Anticonceptivos aprobados por la FDA que figuran en el formulario del CCHP
- Anticoncepción de emergencia
- Epipens, medidores de flujo máximo y espaciadores

### ¿Los medicamentos intravenosos (IV) e inyectables están cubiertos por el CCHP?

Sí, el formulario del CCHP enumera ciertos productos inyectables que están cubiertos como un beneficio de farmacia. El CCHP también cubre la mayoría de los demás medicamentos intravenosos a través del beneficio médico. Los medicamentos que generalmente están cubiertos a través del beneficio médico son aquellos que se administran en el consultorio de un médico, clínica u hospital. Las solicitudes de cobertura de un medicamento a través del beneficio médico deben dirigirse al Departamento de Administración de Utilización del CCHP descargando el formulario de referencia médica en <https://cchealth.org/healthplan/providers/> y enviando un fax al (925) 313-6058 para solicitudes de rutina o (925) 313-6458 para solicitudes urgentes.

La cobertura de medicamentos intravenosos e inyectables a través del beneficio de farmacia se detalla a continuación:

- Soluciones intravenosas simples: las soluciones intravenosas simples normalmente se usan para la terapia de hidratación. Se incluyen soluciones comercialmente disponibles (no compuestas) como solución salina normal, dextrosa (hasta 10% en agua) y solución de ringer lactato; las soluciones de cloruro de potasio preparadas comercialmente en tales soluciones también se incluyen en esta definición. Las soluciones intravenosas simples se deben facturar utilizando el número del Código Nacional de Medicamentos (National Drug Code, NDC) del producto.
- Soluciones de nutrición parenteral (TPN o hiperalimentación): restringidas para dispensar dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando se inició la terapia (IV) con el mismo producto antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. (Las soluciones de nutrición parenteral son productos nutricionales administrados por vía intravenosa o intraarterial que suelen ser suspensiones o soluciones de aminoácidos o proteínas, dextrosa, lípidos, electrolitos, suplementos vitamínicos y/o minerales y oligoelementos). Los complementos a la nutrición parenteral son otros medicamentos que se mezclan físicamente con una solución de nutrición parenteral en cualquier momento antes de

la administración. Facture estos productos como parte de la facturación de nutrición parenteral. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

- Lípidos intravenosos administrados por separado: restringidos para ser dispensados dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia (IV) con el mismo producto se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. Las soluciones o suspensiones de lípidos intravenosos que se administran por separado de las soluciones de nutrición parenteral (es decir, no se mezclan físicamente en el recipiente de la solución de nutrición parenteral) deben facturarse utilizando el número NDC del producto.
- Soluciones intravenosas de antibióticos no incluidos en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo antibiótico se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.
- Soluciones intravenosas de otros medicamentos no indicados en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo medicamento se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

### ¿Cuánto pagaré por mis medicamentos?

Los miembros de Medi-Cal del CCHP **no** tienen que pagar los servicios cubiertos; los medicamentos están disponibles sin copago.

Los miembros comerciales del CCHP (con planes como el plan comercial A, el plan B, IHSS, etc.) pueden tener que pagar pequeños copagos por sus medicamentos.

Consulte los materiales de su plan para determinar si tiene un copago.

### ¿Los proveedores pueden hacer sugerencias al CCHP para mejorar el formulario?

Por supuesto que sí. El formulario es una herramienta para promover el uso rentable de medicamentos recetados. El CCHP ha hecho todo lo posible para crear un documento que satisfaga todas las necesidades terapéuticas; sin embargo, el arte de la medicina hace que esta sea una tarea formidable. El CCHP agradece la participación de médicos, farmacéuticos y proveedores de servicios médicos auxiliares en este proceso dinámico. Se alienta a los médicos y farmacéuticos a dirigir

cualquier sugerencia o comentario al CCHP por correo electrónico a:  
[cchp\\_pharmacy\\_director@hsd.cccounty.us](mailto:cchp_pharmacy_director@hsd.cccounty.us).

¿Qué puedo hacer si necesito más información?

Para obtener más información sobre sus beneficios de farmacia, revise los documentos de su Evidencia de cobertura o llame al CCHP directamente para hablar sobre ellos. El departamento de servicios para miembros del CCHP y el personal del departamento de farmacia están disponibles para responder preguntas de lunes a viernes de 8 a.m. a 5 p.m., hora del Pacífico, en los números de teléfono que se detallan a continuación:

Departamento de Servicios a Miembros del CCHP: **(877) 661-6230 x2**

Departamento de Farmacia del CCHP: **(877) 661-6230 x3**



## **Definiciones y abreviaturas:**

En este documento, se usan varios términos que el Plan de Salud Contra Costa quiere asegurarse de que usted entienda. A continuación se presentan algunas definiciones y abreviaturas:

**“Medicamento de marca”** es un medicamento que se comercializa bajo un nombre patentado y protegido por marca registrada. El medicamento de marca aparece en todas las letras en MAYÚSCULAS.

**“Coseguro”** es un porcentaje del costo de un beneficio de atención médica cubierto que un afiliado paga después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

**“Copago”** es un monto fijo en dólares que un afiliado paga por un beneficio de atención médica cubierto después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

**“Deducible”** es el monto que un afiliado paga por los beneficios de atención médica cubiertos antes de que el plan de salud del afiliado comience a pagar la totalidad o parte del costo del beneficio de atención médica según los términos de la póliza.

**“Nivel de medicamento”** es un grupo de medicamentos recetados que corresponde a un nivel de costo compartido especificado en la cobertura de medicamentos recetados del plan de salud. El nivel en el que se coloca un medicamento recetado determina la parte del costo del medicamento para el afiliado.

**“Afiliado”** es una persona inscrita en un plan de salud que tiene derecho a recibir servicios del plan. Todas las referencias a los afiliados en esta plantilla del formulario también incluirán suscriptores como se define en esta sección a continuación.

**“Solicitud de excepción”** es una solicitud de cobertura de un medicamento recetado. Si un afiliado, su persona designada o el proveedor de atención médica que emite la receta presenta una solicitud de excepción para la cobertura de un medicamento recetado, el plan de salud debe cubrir el medicamento recetado cuando se determina que el medicamento es médicamente necesario para tratar la afección del afiliado.

**“Circunstancias exigentes”** se producen cuando un afiliado sufre una afección de salud que puede poner en grave peligro la vida, la salud o la capacidad del afiliado de recuperar su función máxima, o cuando un afiliado se somete a un tratamiento actual con un medicamento que no figura en el formulario.

“**Formulario**” es la lista completa de medicamentos preferidos para su uso y elegibles para la cobertura de un producto del plan de salud, e incluye todos los medicamentos cubiertos bajo el beneficio de medicamentos recetados para pacientes ambulatorios del producto del plan de salud. El formulario también se conoce como una lista de medicamentos recetados,

“**Medicamento genérico**” es el mismo medicamento que su equivalente de marca en dosis, seguridad, concentración, cómo se toma, calidad, rendimiento y uso previsto. Un medicamento genérico aparece en **letra minúscula negrita y cursiva**.

“**Medicamento que no figura en el formulario**” es un medicamento recetado que no figura en el formulario del plan de salud.

“**Costo de bolsillo**” son copagos, coseguros y el deducible aplicable, más todos los costos por servicios de atención médica que no están cubiertos por el plan de salud.

“**Proveedor que emite la receta**” es un proveedor de atención médica autorizado para emitir una receta médica para tratar una afección médica de un afiliado al plan de salud.

“**Receta**” es una orden oral, escrita o electrónica de un proveedor que emite recetas para un afiliado específico que contiene el nombre del medicamento recetado, la cantidad del medicamento recetado, la fecha de emisión, el nombre y la información de contacto del proveedor que receta, la firma del proveedor que emite recetas si la receta es por escrito, y si la persona inscrita lo solicita, la afección médica o el propósito para el cual se receta el medicamento.

“**Medicamento recetado**” es un medicamento recetado por el proveedor del afiliado que emite recetas y requiere una receta en virtud de la ley aplicable.

“**Autorización previa**” es un requisito del plan de salud de que el afiliado o el proveedor del afiliado que emite recetas obtenga la autorización del plan de salud para un medicamento recetado antes de que el plan de salud cubra el medicamento. El plan de salud otorgará una autorización previa cuando sea médicamente necesario que el afiliado obtenga el medicamento.

“**Tratamiento escalonado**” es un proceso que especifica la secuencia en la que se recetan diferentes medicamentos recetados para una afección médica determinada y médicamente apropiados para un paciente en particular. El plan de salud puede requerir que el afiliado pruebe uno o más medicamentos para tratar la afección médica del afiliado antes de que el plan de salud cubra un medicamento en particular para la afección de conformidad con una solicitud de tratamiento escalonado. Si el proveedor que emite recetas al afiliado presenta una solicitud de excepción de tratamiento

escalonado, los planes de salud harán excepciones al tratamiento escalonado cuando se cumplan los criterios.

“**Suscriptor**” es la persona responsable del pago de un plan o cuyo empleo u otra circunstancia, excepto la dependencia familiar, es la base para la elegibilidad para la membresía en el plan.

A continuación se explican abreviaturas y términos adicionales utilizados en el documento del formulario del CCHP:

<b>Abreviatura</b>	<b>Término</b>	<b>Qué significa</b>
AL	Límite de edad	Algunos medicamentos solo están cubiertos para ciertas edades.
NF	No figura en el formulario	Estos medicamentos no están cubiertos en la Lista de medicamentos. Si su médico considera que necesita un medicamento que no está cubierto, puede solicitarnos que hagamos una excepción.
PA	Autorización previa	Su médico debe solicitar la aprobación del CCHP antes de que se cubran algunos medicamentos.
QL	Límite de cantidad	Algunos medicamentos solo están cubiertos para ciertas cantidades.
SCO	Exclusión estatal	Estos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de tarifa por servicio de Medi-Cal y deben ser facturados al estado por la farmacia.
ST	Tratamiento escalonado	En algunos casos, primero debe probar ciertos medicamentos antes de que CalViva Health cubra otro medicamento para su afección médica.  Por ejemplo, si el Medicamento A y el Medicamento B tratan su afección de salud, es posible que el CCHP no cubra el Medicamento B a menos que pruebe el Medicamento A primero.

El formulario del CCHP utiliza una estructura de 3 niveles; los niveles se explican a continuación:

<b>Abreviatura</b>	<b>Término</b>	<b>Qué significa</b>
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T1	Nivel 1	Los medicamentos de nivel 1 se prefieren en el formulario del CCHP y están disponibles sin restricción o autorización previa.
T2	Nivel 2	Los medicamentos de nivel 2 se prefieren en el formulario del CCHP y están disponibles sin autorización previa, PERO pueden tener ciertas restricciones, como límites de cantidad, tratamiento escalonado, etc. (las restricciones específicas se enumeran en el formulario del CCHP).
T3	Nivel 3	Los medicamentos de nivel 3 no son preferidos. Estos medicamentos requieren autorización previa.

Contra Costa Health Plan Commercial Formulary

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## Informational Section

**CURRENT AS OF 11/01/2024**

		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE = Brand name</b> drugs	<b>Drug Tier</b> T1 = Formulary Medication	<b>PA = Prior Authorization</b>
		<b>QL = Quantity Limit</b>
		<b>ST = Step Therapy</b>
<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b>Antidote Therapeutics</b>		
<b>Acetaminophen Antidote</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
<b>Alcohol Deterrents (91:02)</b>		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	T1	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<b>Antidote Therapeutics</b>		
<i>atropine sulfate ophthalmic ointment 1 %</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	T1	
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	T1	
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA
<i>glucagon emergency injection kit 1 mg</i>	T1	
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	T1	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	T1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	T1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	T1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	T1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	T1	

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**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	T1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	T1	
<i>hyosyne oral solution 0.125 mg/ml</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
IOSAT ORAL TABLET 65 MG ( <i>potassium iodide (antidote)</i> )	T1	
<i>hyoscyamine sulfate</i> (Nulev Oral Tablet Dispersible 0.125 Mg)	T1	
<i>oscimin oral tablet 0.125 mg</i>	T1	
<i>oscimin sublingual tablet sublingual 0.125 mg</i>	T1	
<i>penicillamine oral capsule 250 mg</i>	T1	PA
<i>penicillamine oral tablet 250 mg</i>	T1	PA
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<b>Antidotes (91:04)</b>		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	QL (2 ML per 180 days)
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML ( <i>naloxone hcl</i> )	T1	QL (1 ML per 180 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Chemotherapy Antidotes/Protectants</b>		
<i>leucovorin calcium oral tablet 5 mg</i>	T1	
<b>Cyanide Antidotes</b>		
EXODERM EXTERNAL LOTION 25-1 % ( <i>sod thiosulfate-salicylic acid</i> )	T1	
<b>Antihistamine Drugs</b>		
<b>Antihistamine Drugs</b>		
<i>promethazine hcl oral tablet 25 mg</i>	T1	
<b>Ethanolamine Derivatives</b>		
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	

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**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>cvs sleep-aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>diphen oral tablet 25 mg</i>	T1	
<i>diphenhist oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral tablet 25 mg</i>	T1	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	T1	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>eq allergy relief oral capsule 25 mg</i>	T1	
<i>eq allergy relief oral tablet 25 mg</i>	T1	
<i>eql allergy oral tablet 25 mg</i>	T1	
<i>eql allergy relief oral tablet 25 mg</i>	T1	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>eql sleep aid oral capsule 50 mg</i>	T1	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	
<i>gnp allergy relief oral tablet 25 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>gnp sleep aid oral tablet 25 mg</i></b>	T1	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML <b><i>(diphenhydramine hcl)</i></b>	T1	
<b><i>liquid allergy relief oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>m-dryl oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>night time sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>nighttime sleep aid oral tablet 25 mg</i></b>	T1	
PERCOGESIC ORAL TABLET 12.5-325 MG <b><i>(diphenhydramine-acetaminophen)</i></b>	T1	
<b><i>pharbedryl oral capsule 25 mg, 50 mg</i></b>	T1	
<b><i>qc allergy childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>qc complete allergy medicine oral tablet 25 mg</i></b>	T1	
<b><i>qc sleep aid max st oral capsule 50 mg</i></b>	T1	
<b><i>ra allergy medication oral capsule 25 mg</i></b>	T1	
<b><i>ra allergy medication oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>ra allergy medication oral tablet 25 mg</i></b>	T1	
<b><i>ra allergy oral tablet 25 mg</i></b>	T1	
<b><i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>ra allergy relief oral capsule 25 mg</i></b>	T1	
<b><i>ra complete allergy oral tablet 25 mg</i></b>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML <b><i>(diphenhydramine hcl)</i></b>	T1	
<b><i>ra nighttime sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i></b>	T1	
<b><i>ra sleep aid oral capsule 50 mg</i></b>	T1	
<b><i>ra sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>siladryl allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>sleep aid (diphenhydramine) oral tablet 25 mg</i></b>	T1	
<b><i>sleep aid (doxylamine) oral tablet 25 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sleep aid oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sleep-aid oral tablet 25 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>sm sleep aid oral tablet 25 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	
<i>wal-som oral tablet 25 mg</i>	T1	
<b>First Gen. Antihist. Derivatives, Misc.</b>		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	
<b>First Generation Antihistamines</b>		
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>aller-chlor oral tablet 4 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy oral tablet 4 mg</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief d oral tablet 4-60 mg</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg, 4 mg</i>	T1	
ANTIVERT ORAL TABLET 50 MG ( <i>meclizine hcl</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>bio-dtuss dmx oral liquid 30-1-20 mg/5ml</i>	T1	
<i>bio-rytuss oral liquid 5-2-10 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>chlorhist oral tablet 4 mg</i>	T1	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	T1	
<i>chlorpheniramine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs motion sickness relief oral tablet chewable 25 mg</i>	T1	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>cvs sleep-aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	
<i>diphen oral tablet 25 mg</i>	T1	
<i>diphenhist oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral tablet 25 mg</i>	T1	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	T1	
DRAMAMINE LESS DROWSY ORAL TABLET 25 MG ( <i>meclizine hcl</i> )	T1	
DRAMAMINE ORAL TABLET 25 MG ( <i>meclizine hcl</i> )	T1	
ED A-HIST ORAL LIQUID 4-10 MG/5ML ( <i>chlorpheniramine-phenylephrine</i> )	T1	
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	T1	
<i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i>	T1	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>eq allergy relief oral capsule 25 mg</i>	T1	
<i>eq allergy relief oral tablet 25 mg</i>	T1	
<i>eql allergy oral tablet 25 mg</i>	T1	
<i>eql allergy relief oral tablet 25 mg</i>	T1	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>eql motion sickness relief oral tablet 25 mg</i>	T1	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>eql sleep aid oral capsule 50 mg</i>	T1	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
GILTUSS ALLERGY COUGH & CONGES ORAL LIQUID 5-2-10 MG/5ML ( <i>phenylephrine-chlorphen-dm</i> )	T1	
<i>glenmax peb dm oral liquid 5-2-10 mg/5ml</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>gnp allergy relief oral tablet 25 mg, 4 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp motion sickness relief oral tablet 25 mg</i>	T1	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>gnp sleep aid oral tablet 25 mg</i>	T1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	T1	
LOHIST-D ORAL LIQUID 2-30 MG/5ML ( <i>chlorpheniramine-pseudoeph</i> )	T1	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	T1	
<i>maxi-tuss pe oral liquid 2-5 mg/5ml</i>	T1	
<i>maxi-tuss tr oral liquid 1.25-30 mg/5ml</i>	T1	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	T1	
<i>meclizine hcl oral tablet chewable 25 mg</i>	T1	
MICLARA LQ ORAL LIQUID 1.25 MG/5ML ( <i>triprolidine hcl</i> )	T1	
<i>motion sickness relief oral tablet 25 mg</i>	T1	
<i>motion sickness relief oral tablet chewable 25 mg</i>	T1	
<i>motion-time oral tablet chewable 25 mg</i>	T1	
<i>night time sleep aid oral tablet 25 mg</i>	T1	
<i>nighttime sleep aid oral tablet 25 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	T1	
<i>nohist-lq oral liquid 4-10 mg/5ml</i>	T1	
PERCOGESIC ORAL TABLET 12.5-325 MG ( <i>diphenhydramine-acetaminophen</i> )	T1	
<i>pharbechlor oral tablet 4 mg</i>	T1	
<i>pharbedryl oral capsule 25 mg, 50 mg</i>	T1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ( <i>promethazine hcl</i> )	T1	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>qc chlor-pheniramine oral tablet 4 mg</i>	T1	
<i>qc complete allergy medicine oral tablet 25 mg</i>	T1	
<i>qc sleep aid max st oral capsule 50 mg</i>	T1	
<i>ra allergy medication oral capsule 25 mg</i>	T1	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy medication oral tablet 25 mg</i>	T1	
<i>ra allergy oral tablet 25 mg</i>	T1	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra allergy relief oral tablet 4 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra chlorpheniramine maleate oral tablet 4 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra motion sickness relief oral tablet chewable 25 mg</i>	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>ra sleep aid oral tablet 25 mg</i>	T1	
<i>rynex pse oral liquid 1-15 mg/5ml</i>	T1	
SCOT-TUSSIN DM ORAL LIQUID 2-15 MG/5ML ( <i>chlorpheniramine-dm</i> )	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>sleep aid oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sleep-aid oral tablet 25 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>sm motion sickness oral tablet 25 mg</i>	T1	
<i>sm sleep aid oral tablet 25 mg</i>	T1	
<i>stahist ad oral tablet 25-60 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
<i>travel-ease oral tablet 25 mg</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG <i>(diphenhydramine hcl)</i>	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML <i>(diphenhydramine hcl)</i>	T1	
WAL-FINATE ORAL TABLET 4 MG <i>(chlorpheniramine maleate)</i>	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	
<i>wal-som oral tablet 25 mg</i>	T1	
<b>Other Antihistamines</b>		
<i>acid controller max st oral tablet 20 mg</i>	T1	
<i>acid controller oral tablet 10 mg</i>	T1	
<i>acid reducer maximum strength oral tablet 20 mg</i>	T1	
<i>acid reducer oral tablet 10 mg</i>	T1	
<i>cimetidine 200 oral tablet 200 mg</i>	T1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	T1	
<i>cvs acid controller max st oral tablet 20 mg</i>	T1	
<i>cvs acid controller oral tablet 10 mg</i>	T1	
<i>cvs allergy eye drops ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>cvs eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>cvs heartburn relief oral tablet 200 mg</i>	T1	
<i>cvs olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>cvs olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>eq acid reducer oral tablet 10 mg, 200 mg</i>	T1	
<i>eq famotidine max st oral tablet 20 mg</i>	T1	
<i>eq heartburn prevention oral tablet 10 mg, 20 mg</i>	T1	
<i>eye allergy itch relief ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>eye allergy itch/redness rel ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>famotidine maximum strength oral tablet 20 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	T1	
<i>famotidine oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>famotidine orig st oral tablet 10 mg</i>	T1	
<i>gnp acid reducer max st oral tablet 20 mg</i>	T1	
<i>gnp acid reducer oral tablet 10 mg</i>	T1	
<i>gnp olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>gnp olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>heartburn relief max st oral tablet 20 mg</i>	T1	
<i>heartburn relief oral tablet 10 mg</i>	T1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>ketotifen fumarate ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>kls acid controller max st oral tablet 20 mg</i>	T1	
<i>olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>qc acid controller max st oral tablet 20 mg</i>	T1	
<i>qc acid controller oral tablet 10 mg</i>	T1	
<i>qc olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>ra acid reducer max st oral tablet 20 mg</i>	T1	
<i>ra acid reducer oral tablet 10 mg</i>	T1	
<i>ra eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>sm acid reducer max st oral tablet 20 mg</i>	T1	
<i>sm acid reducer oral tablet 10 mg, 200 mg</i>	T1	
<i>sm olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
ZANTAC 360 MAX ST ORAL TABLET 20 MG ( <i>famotidine</i> )	T1	
ZANTAC 360 ORAL TABLET 10 MG ( <i>famotidine</i> )	T1	
<b>Phenothiazine Derivatives</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ( <i>promethazine hcl</i> )	T1	
<b>Piperazine Derivatives</b>		
<i>stahist ad oral tablet 25-60 mg</i>	T1	
<b>Propylamine Derivatives</b>		
<i>aller-chlor oral tablet 4 mg</i>	T1	
<i>allergy oral tablet 4 mg</i>	T1	
<i>allergy relief d oral tablet 4-60 mg</i>	T1	
<i>allergy relief oral tablet 4 mg</i>	T1	
<i>bio-dtuss dmx oral liquid 30-1-20 mg/5ml</i>	T1	
<i>bio-rytuss oral liquid 5-2-10 mg/5ml</i>	T1	
<i>chlorhist oral tablet 4 mg</i>	T1	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	T1	
<i>chlorpheniramine maleate oral tablet 4 mg</i>	T1	
ED A-HIST ORAL LIQUID 4-10 MG/5ML ( <i>chlorpheniramine-phenylephrine</i> )	T1	
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	T1	
<i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GILTUSS ALLERGY COUGH & CONGES ORAL LIQUID 5-2-10 MG/5ML ( <i>phenylephrine-chlorphen-dm</i> )	T1	
<i>glenmax peb dm oral liquid 5-2-10 mg/5ml</i>	T1	
<i>gnp allergy relief oral tablet 4 mg</i>	T1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
LOHIST-D ORAL LIQUID 2-30 MG/5ML ( <i>chlorpheniramine-pseudoeph</i> )	T1	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	T1	
<i>maxi-tuss pe oral liquid 2-5 mg/5ml</i>	T1	
<i>maxi-tuss tr oral liquid 1.25-30 mg/5ml</i>	T1	
MICLARA LQ ORAL LIQUID 1.25 MG/5ML ( <i>triprolidine hcl</i> )	T1	
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	T1	
<i>nohist-lq oral liquid 4-10 mg/5ml</i>	T1	
<i>pharbechlor oral tablet 4 mg</i>	T1	
<i>qc chlor-pheniramine oral tablet 4 mg</i>	T1	
<i>ra allergy relief oral tablet 4 mg</i>	T1	
<i>ra chlorpheniramine maleate oral tablet 4 mg</i>	T1	
<i>rynex pse oral liquid 1-15 mg/5ml</i>	T1	
SCOT-TUSSIN DM ORAL LIQUID 2-15 MG/5ML ( <i>chlorpheniramine-dm</i> )	T1	
WAL-FINATE ORAL TABLET 4 MG ( <i>chlorpheniramine maleate</i> )	T1	
<b>Second Generation Antihistamines</b>		
<i>12 hour allergy-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>12hr allergy relief oral tablet 60 mg</i>	T1	ST
<i>24hr allergy relief oral tablet 180 mg</i>	T1	ST

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>all day allergy d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy 24-hr oral tablet 180 mg</i>	T1	ST
<i>allergy relief cetirizine oral tablet 5 mg</i>	T1	PA
<i>allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy relief d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>allergy relief d-12 oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>allergy relief d-24 oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>allergy relief oral tablet 180 mg, 60 mg</i>	T1	ST
<i>allergy relief/nasal decongest oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy relief/nasal decongest oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	T1	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % ( <i>Iodoxamide tromethamine</i> )	T1	PA
<i>cetirizine hcl childrens oral solution 5 mg/5ml</i>	T1	
<i>cetirizine hcl oral tablet 5 mg</i>	T1	
<i>cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
CLARITIN REDITABS ORAL TABLET DISPERSIBLE 5 MG ( <i>loratadine</i> )	T1	
<i>cvs allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>cvs allergy relief oral tablet 180 mg, 60 mg</i>	T1	ST

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cvs allergy relief oral tablet dispersible 10 mg</i></b>	T1	
<b><i>cvs allergy relief-d oral tablet extended release 12 hour 5-120 mg</i></b>	T1	PA
<b><i>cvs allergy relief-d oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>cvs allergy relief-d12 oral tablet extended release 12 hour 5-120 mg</i></b>	T1	
<b><i>desloratadine oral tablet 5 mg</i></b>	T1	PA
<b><i>desloratadine oral tablet dispersible 5 mg</i></b>	T1	PA
<b><i>epinastine hcl ophthalmic solution 0.05 %</i></b>	T1	PA
<b><i>eq allergy relief oral tablet 180 mg</i></b>	T1	ST
<b><i>eql allergy relief oral tablet 180 mg</i></b>	T1	ST
<b><i>fexofenadine hcl oral tablet 180 mg, 60 mg</i></b>	T1	ST
<b><i>gnp all day allergy-d oral tablet extended release 12 hour 5-120 mg</i></b>	T1	PA
<b><i>gnp allergy &amp; congestion oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>gnp allergy relief oral tablet 180 mg</i></b>	T1	ST
<b><i>gnp allergy/congestion relief oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>gnp loratadine oral tablet dispersible 10 mg</i></b>	T1	
<b><i>goodsense aller-ease oral tablet 180 mg</i></b>	T1	ST
<b><i>hm allergy relief/nasal decong oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>hm fexofenadine hcl oral tablet 180 mg</i></b>	T1	ST
<b>KLS ALLERCLEAR D-12HR ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (<i>loratadine-pseudoephedrine</i>)</b>	T1	
<b>KLS ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-240 MG (<i>loratadine-pseudoephedrine</i>)</b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLS ALLER-FEX ORAL TABLET 180 MG ( <i>fexofenadine hcl</i> )	T1	ST
KLS ALLER-TEC D ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG ( <i>cetirizine-pseudoephedrine</i> )	T1	PA
<i>loratadine oral tablet dispersible 10 mg</i>	T1	
<i>loratadine-d 12hr oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>meijer allergy relief-d oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>mm fexofenadine hcl oral tablet 180 mg</i>	T1	ST
<i>qc loratadine-d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>ra allergy relief oral tablet 180 mg</i>	T1	ST
<i>ra allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>ra cetiri-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>ra lorata-d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>sm all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>sm allergy relief oral tablet 60 mg</i>	T1	ST
<i>sm fexofenadine hcl oral tablet 180 mg</i>	T1	ST
<i>sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>sm lorata-dine d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<b>Anti-Infective Agents</b>		
<b>1St Generation Cephalosporin Antibiotics</b>		
<i>cefadroxil oral capsule 500 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i></b>	T1	
<b><i>cefadroxil oral tablet 1 gm</i></b>	T1	
<b><i>cephalexin oral capsule 250 mg, 500 mg</i></b>	T1	
<b><i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	
<b><i>cephalexin oral tablet 250 mg, 500 mg</i></b>	T1	PA
<b>2Nd Generation Cephalosporin Antibiotics</b>		
<b><i>cefactor er oral tablet extended release 12 hour 500 mg</i></b>	T1	PA
<b><i>cefactor oral capsule 250 mg, 500 mg</i></b>	T1	
<b><i>cefactor oral suspension reconstituted 250 mg/5ml</i></b>	T1	
<b><i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	
<b><i>cefprozil oral tablet 250 mg, 500 mg</i></b>	T1	
<b><i>cefuroxime axetil oral tablet 250 mg, 500 mg</i></b>	T1	
<b>3Rd Generation Cephalosporin Antibiotics</b>		
<b><i>cefdinir oral capsule 300 mg</i></b>	T1	QL (60 EA per 30 days)
<b><i>cefdinir oral suspension reconstituted 125 mg/5ml</i></b>	T1	QL (9000 ML per 30 days)
<b><i>cefdinir oral suspension reconstituted 250 mg/5ml</i></b>	T1	QL (6000 ML per 30 days)
<b><i>cefixime oral capsule 400 mg</i></b>	T1	QL (2 EA per 30 days)
<b><i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i></b>	T1	
<b><i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i></b>	T1	QL (112 EA per 180 days)
<b>Adamantane Antivirals</b>		
<b><i>amantadine hcl oral capsule 100 mg</i></b>	T1	
<b><i>amantadine hcl oral solution 50 mg/5ml</i></b>	T1	
<b><i>amantadine hcl oral tablet 100 mg</i></b>	T1	
<b><i>rimantadine hcl oral tablet 100 mg</i></b>	T1	
<b>Allylamine Antifungals</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>terbinafine hcl oral tablet 250 mg</i>	T1	
<b>Amebicides</b>		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<b>Aminoglycoside Antibiotics</b>		
<i>neomycin sulfate oral tablet 500 mg</i>	T1	
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	T1	QL (1 EA per 30 days)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	T1	PA
<b>Aminopenicillin Antibiotics</b>		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	T1	PA
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	T1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	T1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	T1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral tablet chewable 400-57 mg</i>	T1	
<i>ampicillin oral capsule 500 mg</i>	T1	
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg, 2 gm, 250 mg, 500 mg</i>	T1	
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	T1	
Anthelmintics		
<i>albendazole oral tablet 200 mg</i>	T1	PA
<i>cvs pinworm treatment oral suspension 144 (50 base) mg/ml</i>	T1	
EMVERM ORAL TABLET CHEWABLE 100 MG ( <i>mebendazole</i> )	T1	QL (60 EA per 30 days)
<i>ivermectin oral tablet 3 mg</i>	T1	QL (30 EA per 365 days)
<i>pin-away oral suspension 144 (50 base) mg/ml</i>	T1	
<i>pinworm medicine oral suspension 144 (50 base) mg/ml</i>	T1	
<i>reeses pinworm medicine oral suspension 144 (50 base) mg/ml</i>	T1	
Antifungals, Miscellaneous		
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	T1	
<i>griseofulvin microsize oral tablet 500 mg</i>	T1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
IOSAT ORAL TABLET 65 MG ( <i>potassium iodide (antidote)</i> )	T1	
Anti-Infectives (Systemic), Misc.		
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Antileprosy Agents</b>		
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
<b>Antimalarials</b>		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg</i>	T1	QL (180 EA per 365 days)
<i>atovaquone-proguanil hcl oral tablet 62.5-25 mg</i>	T1	QL (540 EA per 365 days)
<i>avidoxy oral tablet 100 mg</i>	T1	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	T1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline hyclate oral tablet 100 mg</i>	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	T1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	T1	
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	T1	
<i>mefloquine hcl oral tablet 250 mg</i>	T1	
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	T1	
<i>pyrimethamine oral tablet 25 mg</i>	T1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	T1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	T1	
<i>quinine sulfate oral capsule 324 mg</i>	T1	PA
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	
<b>Antimycobacterials, Miscellaneous</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
<b>Antiprotozoals, Cryptosporidiosis</b>		
<i>nitazoxanide oral tablet 500 mg</i>	T1	
<b>Antiprotozoals, Miscellaneous</b>		
<i>atovaquone oral suspension 750 mg/5ml</i>	T1	PA
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>nitazoxanide oral tablet 500 mg</i>	T1	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	T1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	T1	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	T1	
<b>Antiprotozoals, Nitroimidazole-Derivative</b>		
<i>tinidazole oral tablet 250 mg, 500 mg</i>	T1	
<b>Antiretrovirals, Miscellaneous</b>		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG ( <i>lenacapavir sodium</i> )	T1	
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML ( <i>lenacapavir sodium</i> )	T1	
<b>Antituberculosis Agents</b>		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	PA
<b><i>clarithromycin oral tablet 250 mg, 500 mg</i></b>	T1	
<b><i>cycloserine oral capsule 250 mg</i></b>	T1	
<b><i>ethambutol hcl oral tablet 100 mg, 400 mg</i></b>	T1	
<b><i>isoniazid oral syrup 50 mg/5ml</i></b>	T1	
<b><i>isoniazid oral tablet 100 mg, 300 mg</i></b>	T1	
<b><i>levofloxacin oral solution 25 mg/ml</i></b>	T1	
<b><i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i></b>	T1	QL (30 EA per 30 days)
<b><i>moxifloxacin hcl oral tablet 400 mg</i></b>	T1	QL (30 EA per 30 days)
PRIFTIN ORAL TABLET 150 MG ( <i>rifapentine</i> )	T1	
<b><i>pyrazinamide oral tablet 500 mg</i></b>	T1	
<b><i>rifabutin oral capsule 150 mg</i></b>	T1	
<b><i>rifampin oral capsule 150 mg, 300 mg</i></b>	T1	
<b><i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i></b>	T1	QL (1 EA per 30 days)
TRECTOR ORAL TABLET 250 MG ( <i>ethionamide</i> )	T1	
<b>Antivirals, Miscellaneous</b>		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG ( <i>nirmatrelvir-ritonavir</i> )	T1	QL (30 EA per 180 days); AL (Min 12 Years)
<b>Azole Antifungals</b>		
<b><i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i></b>	T1	
<b><i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i></b>	T1	
<b><i>itraconazole oral capsule 100 mg</i></b>	T1	PA
<b><i>itraconazole oral solution 10 mg/ml</i></b>	T1	PA
<b><i>posaconazole oral tablet delayed release 100 mg</i></b>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>voriconazole intravenous solution reconstituted 200 mg</i>	T1	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	T1	PA
<i>voriconazole oral tablet 200 mg, 50 mg</i>	T1	PA
<b>Erythromycin Antibiotics</b>		
<i>ery external pad 2 %</i>	T1	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	T1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	T1	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	T1	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
<b>Glycopeptide Antibiotics</b>		
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	T1	
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	T1	
<b>Hcv Polymerase Inhibitor Antivirals</b>		
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	T1	PA
<b>Hcv Protease Inhibitor Antivirals</b>		
MAVYRET ORAL PACKET 50-20 MG ( <i>glecaprevir-pibrentasvir</i> )	T1	PA
MAVYRET ORAL TABLET 100-40 MG ( <i>glecaprevir-pibrentasvir</i> )	T1	PA
ZEPATIER ORAL TABLET 50-100 MG ( <i>elbasvir-grazoprevir</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Hcv Replication Complex Inhibitors</b>		
MAVYRET ORAL PACKET 50-20 MG ( <i>glecaprevir-pibrentasvir</i> )	T1	PA
MAVYRET ORAL TABLET 100-40 MG ( <i>glecaprevir-pibrentasvir</i> )	T1	PA
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	T1	PA
ZEPATIER ORAL TABLET 50-100 MG ( <i>elbasvir-grazoprevir</i> )	T1	PA
<b>Hiv Capsid Inhibitors</b>		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG ( <i>lenacapavir sodium</i> )	T1	
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML ( <i>lenacapavir sodium</i> )	T1	
<b>Hiv Entry And Fusion Inhibitors</b>		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG ( <i>enfuvirtide</i> )	T1	
<i>maraviroc oral tablet 150 mg, 300 mg</i>	T1	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG ( <i>fostemsavir tromethamine</i> )	T1	
SELZENTRY ORAL SOLUTION 20 MG/ML ( <i>maraviroc</i> )	T1	
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML ( <i>ibalizumab-uiyk</i> )	T1	
<b>Hiv Integrase Inhibitor Antiretrovirals</b>		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML ( <i>cabotegravir</i> )	T1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir-emtricitab-tenofov</i> )	T1	
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML ( <i>cabotegravir &amp; rilpivirine</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOVATO ORAL TABLET 50-300 MG ( <i>dolutegravir-lamivudine</i> )	T1	
GENVOYA ORAL TABLET 150-150-200-10 MG ( <i>elviteg-cobic-emtricit-tenofaf</i> )	T1	
ISENTRESS HD ORAL TABLET 600 MG ( <i>raltegravir potassium</i> )	T1	
ISENTRESS ORAL PACKET 100 MG ( <i>raltegravir potassium</i> )	T1	
ISENTRESS ORAL TABLET 400 MG ( <i>raltegravir potassium</i> )	T1	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG ( <i>raltegravir potassium</i> )	T1	
JULUCA ORAL TABLET 50-25 MG ( <i>dolutegravir-rilpivirine</i> )	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i>elviteg-cobic-emtricit-tenofdf</i> )	T1	
TIVICAY ORAL TABLET 50 MG ( <i>dolutegravir sodium</i> )	T1	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG ( <i>dolutegravir sodium</i> )	T1	
TRIUMEQ ORAL TABLET 600-50-300 MG ( <i>abacavir-dolutegravir-lamivud</i> )	T1	
<i>triumeq pd oral tablet soluble 60-5-30 mg</i>	T1	
VOCABRIA ORAL TABLET 30 MG ( <i>cabotegravir sodium</i> )	T1	
<b>Hiv Nonnucleoside Rev. Transcrip. Inhib.</b>		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir-emtricitab-tenofov</i> )	T1	
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML ( <i>cabotegravir &amp; rilpivirine</i> )	T1	
COMPLERA ORAL TABLET 200-25-300 MG ( <i>emtricitab-rilpivir-tenofov</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DELSTRIGO ORAL TABLET 100-300-300 MG ( <i>doravirin-lamivudin-tenofof df</i> )	T1	
EDURANT ORAL TABLET 25 MG ( <i>rilpivirine hcl</i> )	T1	
<i>efavirenz oral tablet 600 mg</i>	T1	
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	T1	
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	T1	
<i>etravirine oral tablet 100 mg, 200 mg</i>	T1	
INTELENCE ORAL TABLET 25 MG ( <i>etravirine</i> )	T1	
JULUCA ORAL TABLET 50-25 MG ( <i>dolutegravir-rilpivirine</i> )	T1	
<i>methocarbamol oral tablet 500 mg</i>	T1	
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	T1	
<i>nevirapine oral suspension 50 mg/5ml</i>	T1	
<i>nevirapine oral tablet 200 mg</i>	T1	
ODEFSEY ORAL TABLET 200-25-25 MG ( <i>emtricitab-rilpivir-tenofof af</i> )	T1	
PIFELTRO ORAL TABLET 100 MG ( <i>doravirine</i> )	T1	
<b>Hiv Nucleoside, Nucleotide Rt Inhibitors</b>		
<i>abacavir sulfate oral solution 20 mg/ml</i>	T1	
<i>abacavir sulfate oral tablet 300 mg</i>	T1	
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	T1	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG ( <i>bictegravir-emtricitab-tenofof</i> )	T1	
CIMDUO ORAL TABLET 300-300 MG ( <i>lamivudine-tenofovir</i> )	T1	
COMPLERA ORAL TABLET 200-25-300 MG ( <i>emtricitab-rilpivir-tenofovir</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DELSTRIGO ORAL TABLET 100-300-300 MG ( <i><b>doravirin-lamivudin-tenofov df</b></i> )	T1	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG ( <i><b>emtricitabine-tenofov af</b></i> )	T1	
DOVATO ORAL TABLET 50-300 MG ( <i><b>dolutegravir-lamivudine</b></i> )	T1	
<i><b>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</b></i>	T1	
<i><b>efavirenz-lamivudine-tenofov oral tablet 400-300-300 mg, 600-300-300 mg</b></i>	T1	
<i><b>emtricitabine oral capsule 200 mg</b></i>	T1	
<i><b>emtricitabine-tenofov df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg</b></i>	T1	
EMTRIVA ORAL SOLUTION 10 MG/ML ( <i><b>emtricitabine</b></i> )	T1	
GENVOYA ORAL TABLET 150-150-200-10 MG ( <i><b>elviteg-cobic-emtricit-tenofaf</b></i> )	T1	
<i><b>lamivudine oral solution 10 mg/ml</b></i>	T1	
<i><b>lamivudine oral tablet 100 mg</b></i>	T1	PA
<i><b>lamivudine oral tablet 150 mg, 300 mg</b></i>	T1	
<i><b>lamivudine-zidovudine oral tablet 150-300 mg</b></i>	T1	
ODEFSEY ORAL TABLET 200-25-25 MG ( <i><b>emtricitab-rilpivir-tenofov af</b></i> )	T1	
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML ( <i><b>zidovudine</b></i> )	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i><b>elviteg-cobic-emtricit-tenofdf</b></i> )	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i><b>darun-cobic-emtricit-tenofaf</b></i> )	T1	
<i><b>tenofov disoproxil fumarate oral tablet 300 mg</b></i>	T1	
TRIUMEQ ORAL TABLET 600-50-300 MG ( <i><b>abacavir-dolutegravir-lamivud</b></i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trumeq pd oral tablet soluble 60-5-30 mg</i>	T1	
VIREAD ORAL POWDER 40 MG/GM ( <i>tenofovir disoproxil fumarate</i> )	T1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG ( <i>tenofovir disoproxil fumarate</i> )	T1	
<i>zidovudine oral capsule 100 mg</i>	T1	
<i>zidovudine oral syrup 50 mg/5ml</i>	T1	
<i>zidovudine oral tablet 300 mg</i>	T1	
Hiv Protease Inhibitor Antiretrovirals		
APTIVUS ORAL CAPSULE 250 MG ( <i>tipranavir</i> )	T1	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	T1	
<i>darunavir oral tablet 600 mg, 800 mg</i>	T1	
EVOTAZ ORAL TABLET 300-150 MG ( <i>atazanavir-cobicistat</i> )	T1	
<i>fosamprenavir calcium oral tablet 700 mg</i>	T1	
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	T1	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	T1	
NORVIR ORAL PACKET 100 MG ( <i>ritonavir</i> )	T1	
PREZCOBIX ORAL TABLET 800-150 MG ( <i>darunavir-cobicistat</i> )	T1	
PREZISTA ORAL SUSPENSION 100 MG/ML ( <i>darunavir</i> )	T1	
PREZISTA ORAL TABLET 150 MG, 75 MG ( <i>darunavir</i> )	T1	
REYATAZ ORAL PACKET 50 MG ( <i>atazanavir sulfate</i> )	T1	
<i>ritonavir oral tablet 100 mg</i>	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	T1	
VIRACEPT ORAL TABLET 250 MG, 625 MG ( <i>nelfinavir mesylate</i> )	T1	
Interferon Antivirals		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML ( <i>peginterferon alfa-2a</i> )	T1	PA
<b>Lincomycin Antibiotics</b>		
CLEOCIN VAGINAL SUPPOSITORY 100 MG ( <i>clindamycin phosphate</i> )	T1	ST
<i>clindamycin phosphate</i> (Clindacin Etz External Swab 1 %)	T1	
<i>clindamycin phosphate</i> (Clindacin-P External Swab 1 %)	T1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	T1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	T1	PA
<i>clindamycin phosphate external gel 1 %</i>	T1	
<i>clindamycin phosphate external lotion 1 %</i>	T1	
<i>clindamycin phosphate external solution 1 %</i>	T1	
<i>clindamycin phosphate external swab 1 %</i>	T1	
<i>clindamycin phosphate vaginal cream 2 %</i>	T1	
<b>Natural Penicillin Antibiotics</b>		
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML ( <i>penicillin g benzathine &amp; proc</i> )	T1	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML ( <i>penicillin g benzathine &amp; proc</i> )	T1	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML ( <i>penicillin g benzathine</i> )	T1	
<i>penicillin g potassium injection solution reconstituted 2000000 unit, 5000000 unit</i>	T1	
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	T1	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PFIZERPEN INJECTION SOLUTION RECONSTITUTED 20000000 UNIT, 5000000 UNIT ( <i>penicillin g potassium</i> )	T1	
<b>Neuraminidase Inhibitor Antivirals</b>		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	T1	QL (10 EA per 180 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	T1	QL (120 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT ( <i>zanamivir</i> )	T1	QL (20 EA per 180 days)
<b>Nitroimidazole Derivatives, Misc</b>		
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
<b>Nucleoside And Nucleotide Antivirals</b>		
<i>acyclovir external cream 5 %</i>	T1	PA
<i>acyclovir external ointment 5 %</i>	T1	PA
<i>acyclovir oral capsule 200 mg</i>	T1	
<i>acyclovir oral suspension 200 mg/5ml</i>	T1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	T1	
<i>adefovir dipivoxil oral tablet 10 mg</i>	T1	PA
COMPLERA ORAL TABLET 200-25-300 MG ( <i>emtricitabine-rilpivir-tenofovir</i> )	T1	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG ( <i>emtricitabine-tenofovir af</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg</i></b>	T1	
<b><i>entecavir oral tablet 0.5 mg, 1 mg</i></b>	T1	
<b><i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i></b>	T1	PA
LAGEVRIO ORAL CAPSULE 200 MG ( <b><i>molnupiravir</i></b> )	T1	QL (40 EA per 180 days); AL (Min 18 Years)
ODEFSEY ORAL TABLET 200-25-25 MG ( <b><i>emtricitabiripivir-tenofov af</i></b> )	T1	
<b><i>ribavirin oral capsule 200 mg</i></b>	T1	
<b><i>ribavirin oral tablet 200 mg</i></b>	T1	
<b><i>valacyclovir hcl oral tablet 1 gm, 500 mg</i></b>	T1	
<b><i>valganciclovir hcl oral tablet 450 mg</i></b>	T1	PA
VEMLIDY ORAL TABLET 25 MG ( <b><i>tenofovir alafenamide fumarate</i></b> )	T1	PA
<b>Other Macrolide Antibiotics</b>		
<b><i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i></b>	T1	PA
<b><i>azithromycin oral packet 1 gm</i></b>	T1	
<b><i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i></b>	T1	
<b><i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i></b>	T1	
<b><i>clarithromycin er oral tablet extended release 24 hour 500 mg</i></b>	T1	PA
<b><i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	PA
<b><i>clarithromycin oral tablet 250 mg, 500 mg</i></b>	T1	
<b>Other Macrolides (8:12.12.92)</b>		
<b><i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i></b>	T1	PA
<b><i>azithromycin oral packet 1 gm</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i></b>	T1	
<b><i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i></b>	T1	
<b><i>clarithromycin er oral tablet extended release 24 hour 500 mg</i></b>	T1	PA
<b><i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	PA
<b><i>clarithromycin oral tablet 250 mg, 500 mg</i></b>	T1	
<b>Oxazolidinone Antibiotics</b>		
<b><i>linezolid oral suspension reconstituted 100 mg/5ml</i></b>	T1	PA
<b><i>linezolid oral tablet 600 mg</i></b>	T1	PA
<b>Penicillinase-Resistant Penicillins</b>		
<b><i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i></b>	T1	
<b><i>nafcillin sodium injection solution reconstituted 1 gm</i></b>	T1	
<b><i>oxacillin sodium injection solution reconstituted 1 gm, 2 gm</i></b>	T1	
<b>Polyene Antifungals</b>		
<b><i>nystatin mouth/throat suspension 100000 unit/ml</i></b>	T1	
<b><i>nystatin oral tablet 500000 unit</i></b>	T1	
<b>Polymyxin Antibiotics</b>		
<b><i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i></b>	T1	
<b>Quinolone Antibiotics</b>		
<b><i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i></b>	T1	
<b><i>levofloxacin oral solution 25 mg/ml</i></b>	T1	
<b><i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i></b>	T1	QL (30 EA per 30 days)
<b><i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i></b>	T1	PA
<b><i>moxifloxacin hcl ophthalmic solution 0.5 %</i></b>	T1	
<b><i>moxifloxacin hcl oral tablet 400 mg</i></b>	T1	QL (30 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ofloxacin ophthalmic solution 0.3 %</i></b>	T1	
<b><i>ofloxacin oral tablet 300 mg, 400 mg</i></b>	T1	PA
<b><i>ofloxacin otic solution 0.3 %</i></b>	T1	
<b>Rifamycin Antibiotics</b>		
PRIFTIN ORAL TABLET 150 MG ( <i>rifapentine</i> )	T1	
<b><i>rifabutin oral capsule 150 mg</i></b>	T1	
<b><i>rifampin oral capsule 150 mg, 300 mg</i></b>	T1	
XIFAXAN ORAL TABLET 200 MG ( <i>rifaximin</i> )	T1	PA
<b>Sulfonamide Antibiotics (Systemic)</b>		
<b><i>sulfadiazine oral tablet 500 mg</i></b>	T1	
<b><i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i></b>	T1	
<b><i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i></b>	T1	
<b><i>sulfasalazine oral tablet 500 mg</i></b>	T1	
<b><i>sulfasalazine oral tablet delayed release 500 mg</i></b>	T1	
<b>Tetracycline Antibiotics</b>		
<b><i>avidoxy oral tablet 100 mg</i></b>	T1	
<b><i>demeclocycline hcl oral tablet 150 mg, 300 mg</i></b>	T1	PA
<b><i>doxycycline hyclate oral capsule 100 mg, 50 mg</i></b>	T1	
<b><i>doxycycline hyclate oral tablet 100 mg</i></b>	T1	
<b><i>doxycycline hyclate oral tablet 20 mg</i></b>	T1	PA
<b><i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i></b>	T1	
<b><i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i></b>	T1	
<b><i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i></b>	T1	
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	
<b>Urinary Anti-Infectives</b>		
<i>fosfomycin tromethamine oral packet 3 gm</i>	T1	
<i>methenamine hippurate oral tablet 1 gm</i>	T1	
<i>methenamine mandelate oral tablet 0.5 gm, 1 gm</i>	T1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	T1	
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	T1	
<i>trimethoprim oral tablet 100 mg</i>	T1	
<i>urin ds oral tablet 81.6 mg</i>	T1	
<i>urneva oral capsule 120 mg</i>	T1	
<b>Antineoplastic Agents</b>		
<b>Antineoplastic Agents</b>		
<i>anastrozole oral tablet 1 mg</i>	T1	QL (30 EA per 30 days)
<i>bexarotene oral capsule 75 mg</i>	T1	PA
<i>bicalutamide oral tablet 50 mg</i>	T1	
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG ( <i>cabozantinib s-malate</i> )	T1	PA
<i>capecitabine oral tablet 150 mg, 500 mg</i>	T1	PA
COTELLIC ORAL TABLET 20 MG ( <i>cobimetinib fumarate</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cyclophosphamide oral tablet 25 mg, 50 mg</i></b>	T1	
<b><i>dasatinib oral tablet 100 mg, 20 mg, 50 mg, 70 mg</i></b>	T1	PA
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG ( <b><i>hydroxyurea</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 22.5 MG ( <b><i>leuprolide acetate (3 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 30 MG ( <b><i>leuprolide acetate (4 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 45 MG ( <b><i>leuprolide acetate (6 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 7.5 MG ( <b><i>leuprolide acetate</i></b> )	T1	
<b><i>erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg</i></b>	T1	PA
<b><i>etoposide oral capsule 50 mg</i></b>	T1	
<b><i>exemestane oral tablet 25 mg</i></b>	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG ( <b><i>degarelix acetate</i></b> )	T1	QL (1 EA per 30 days)
<b><i>fluorouracil external cream 5 %</i></b>	T1	
<b><i>fluorouracil external solution 2 %, 5 %</i></b>	T1	
<b><i>gefitinib oral tablet 250 mg</i></b>	T1	PA
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG ( <b><i>lomustine</i></b> )	T1	
<b><i>hydroxyurea oral capsule 500 mg</i></b>	T1	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG ( <b><i>palbociclib</i></b> )	T1	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG ( <b><i>palbociclib</i></b> )	T1	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG ( <b><i>ponatinib hcl</i></b> )	T1	PA
<b><i>imatinib mesylate oral tablet 100 mg, 400 mg</i></b>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG ( <i>ruxolitinib phosphate</i> )	T1	PA
<i>lapatinib ditosylate oral tablet 250 mg</i>	T1	PA
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	T1	PA
<i>letrozole oral tablet 2.5 mg</i>	T1	QL (30 EA per 30 days)
LEUKERAN ORAL TABLET 2 MG ( <i>chlorambucil</i> )	T1	
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG ( <i>leuprolide acetate</i> )	T1	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG ( <i>leuprolide acetate (3 month)</i> )	T1	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG ( <i>leuprolide acetate (4 month)</i> )	T1	PA
LYSODREN ORAL TABLET 500 MG ( <i>mitotane</i> )	T1	
MATULANE ORAL CAPSULE 50 MG ( <i>procarbazine hcl</i> )	T1	
<i>megestrol acetate oral suspension 40 mg/ml</i>	T1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	T1	
<i>mercaptopurine oral tablet 50 mg</i>	T1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1	
MYLERAN ORAL TABLET 2 MG ( <i>busulfan</i> )	T1	
<i>nilutamide oral tablet 150 mg</i>	T1	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML ( <i>peginterferon alfa-2a</i> )	T1	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG ( <i>pomalidomide</i> )	T1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG ( <i>lenalidomide</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIKLOS ORAL TABLET 100 MG, 1000 MG ( <i>hydroxyurea</i> )	T1	PA
<i>sorafenib tosylate oral tablet 200 mg</i>	T1	PA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 50 mg</i>	T1	PA
TABLOID ORAL TABLET 40 MG ( <i>thioguanine</i> )	T1	
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG ( <i>talazoparib tosylate</i> )	T1	PA
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	T1	
TASIGNA ORAL CAPSULE 200 MG ( <i>nilotinib hcl</i> )	T1	PA
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	T1	PA
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG ( <i>bcg live</i> )	T1	
<i>toremifene citrate oral tablet 60 mg</i>	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG ( <i>triptorelin pamoate</i> )	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG ( <i>triptorelin pamoate</i> )	T1	
<i>tretinoin oral capsule 10 mg</i>	T1	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG ( <i>abemaciclib</i> )	T1	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG ( <i>crizotinib</i> )	T1	PA
ZELBORAF ORAL TABLET 240 MG ( <i>vemurafenib</i> )	T1	PA
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG ( <i>goserelin acetate</i> )	T1	
ZOLINZA ORAL CAPSULE 100 MG ( <i>vorinostat</i> )	T1	PA
<b>Antitoxins, Immune Glob, Toxoids, Vaccines</b>		
<b>Antitoxins And Immune Globulins</b>		
HYPERRHO S/D INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT ( <i>rho d immune globulin</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT ( <i>rho d immune globulin</i> )	T1	
<b>Toxoids</b>		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	T1	QL (0.5 ML per 1 FILL)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	T1	QL (0.5 ML per 1 FILL)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML ( <i>tetanus-diphtheria toxoids td</i> )	T1	QL (0.5 ML per 1 FILL)
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU ( <i>tetanus-diphtheria toxoids td</i> )	T1	QL (0.5 ML per 1 FILL)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-ipv-hib-hepatitis b recomb</i> )	T1	QL (0.5 ML per 1 Fill)
<b>Vaccines</b>		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML ( <i>rsv pre-fusion f a&amp;b vac rcmb</i> )	T1	QL (0.5 ml per 1 Dose)
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED ( <i>haemophilus b polysac conj vac</i> )	T1	QL (1 ML per 1 Fill)
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	T1	QL (0.5 ML per 1 FILL)
AFLURIA INTRAMUSCULAR SUSPENSION ( <i>influenza virus vaccine split</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza virus vacc split pf</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML ( <i>rsvpref3 vac recomb adjuvanted</i> )	T1	QL (0.5 ml per 1 Dose); AL (Min 50 Years)
<i>bcg vaccine injection solution reconstituted 50 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>meningococcal b recomb omv adj</i> )	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 ( <i>tetanus-diphth-acell pertussis</i> )	T1	QL (0.5 ML per 1 FILL)
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 21-valent conjuga</i> )	T1	QL (0.5 dose per 1 lifetime); AL (Min 18 Years)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	T1	QL (2 ML per 1 Fill)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML ( <i>hepatitis b vac recombinant</i> )	T1	QL (2 ML per 1 Fill)
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac a&amp;b surf ant adj</i> )	T1	QL (1 EA per 270 days); AL (Min 65 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza virus vacc split pf</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac recombinant ha</i> )	T1	QL (1 EA per 270 days); AL (Min 18 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION ( <i>influenza vac tiss-cult subunt</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac tiss-cult subunt</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza virus vacc split pf</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
FLUMIST NASAL LIQUID ( <i>influenza virus vaccine live</i> )	T1	QL (1 dose per 270 days); AL (Min 3 Years and Max 49 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza vac split high-dose</i> )	T1	QL (1 EA per 270 days); AL (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION ( <i>influenza virus vaccine split</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>influenza virus vacc split pf</i> )	T1	QL (1 EA per 270 days); AL (Min 3 Years)
GARDASIL 9 INTRAMUSCULAR SUSPENSION ( <i>hpv 9-valent recomb vaccine</i> )	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>hpv 9-valent recomb vaccine</i> )	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML ( <i>hepatitis a vaccine</i> )	T1	QL (1 ML per 1 Fill)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML ( <i>hepatitis b vac recomb adj</i> )	T1	QL (0.5 ML per 1 Fill); AL (Min 18 Years)
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG ( <i>haemophilus b polysac conj vac</i> )	T1	QL (1 ML per 1 Fill)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML ( <i>rabies virus vaccine, hdc</i> )	T1	QL (1 ML per 1 Fill)
IPOL INJECTION INJECTABLE ( <i>poliovirus vaccine inactivated</i> )	T1	QL (0.5 ML per 1 Fill)
MENQUADFI INTRAMUSCULAR SOLUTION ( <i>mening acy&amp;w-135 tetanus conj</i> )	T1	QL (0.5 ML per 1 Fill)
MENVEO INTRAMUSCULAR SOLUTION ( <i>meningococcal a c y&amp;w-135 olig</i> )	T1	QL (0.5 ML per 1 Fill); AL (Max 55 Years)
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED ( <i>meningococcal a c y&amp;w-135 olig</i> )	T1	QL (1 ml per 1 Fill); AL (Max 55 Years)
M-M-R II INJECTION SOLUTION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	T1	QL (1 EA per 1 Fill)
MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML ( <i>covid-19 mrna virus vaccine</i> )	T1	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML ( <i>rsv mrna pre-f virus vaccine</i> )	T1	QL (0.5 dose per 1 lifetime); AL (Min 60 Years)
<i>novavax covid-19 vaccine intramuscular suspension prefilled syringe 5 mcg/0.5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML ( <i>haemophilus b polysac conj vac</i> )	T1	QL (0.5 ML per 1 Fill)
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>mening acyw(tet conj)-b(rcmb)</i> )	T1	QL (1 vial per 1 Fill); AL (Max 25 Years)
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML ( <i>hepatitis b vac 3-antigen rcmb</i> )	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 20-val conj vacc</i> )	T1	QL (0.5 ML per 1 Fill)
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>measles, mumps &amp; rubella vac</i> )	T1	QL (1 EA per 1 Fill)
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED ( <i>measles-mumps-rubella-varicell</i> )	T1	QL (1 EA per 1 Fill)
RABAERT INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>rabies vaccine, pcec</i> )	T1	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	T1	QL (1 ML per 1 Fill)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML ( <i>hepatitis b vac recombinant</i> )	T1	QL (1 ML per 1 Fill)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML ( <i>zoster vac recomb adjuvanted</i> )	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG ( <i>bcg live</i> )	T1	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>meningococcal b vac (recomb)</i> )	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML ( <i>hepatitis a-hep b recomb vac</i> )	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML ( <i>typhoid vi polysaccharide vacc</i> )	T1	QL (0.5 ML per 270 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML ( <i>typhoid vi polysaccharide vacc</i> )	T1	QL (0.5 ML per 270 days)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML ( <i>hepatitis a vaccine</i> )	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION 50 UNIT/ML ( <i>hepatitis a vaccine</i> )	T1	QL (1 ML per 1 Fill)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE ( <i>dtap-ipv-hib-hepatitis b recomb</i> )	T1	QL (0.5 ML per 1 Fill)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML ( <i>pneumococcal 15-val conj vacc</i> )	T1	QL (0.5 ML per 1 Fill)
VIVOTIF ORAL CAPSULE DELAYED RELEASE ( <i>typhoid vaccine</i> )	T1	QL (4 EA per 5 years)
<b>Autonomic Drugs</b>		
<b>Alpha- And Beta-Adrenergic Agonists</b>		
<i>12 hour allergy-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>12 hour decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>all day allergy d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>all day allergy-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy relief d oral tablet 4-60 mg</i>	T1	
<i>allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy relief d oral tablet extended release 24 hour 10-240 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>allergy relief d-12 oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>allergy relief d-24 oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>allergy relief/nasal decongest oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>allergy relief/nasal decongest oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>bio-dtuss dmx oral liquid 30-1-20 mg/5ml</i>	T1	
<i>bupivacaine-epinephrine (pf) injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>bupivacaine-epinephrine injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>cvs 12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>cvs allergy relief d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>cvs allergy relief-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA
<i>cvs allergy relief-d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>cvs allergy relief-d12 oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>cvs mucus d extended release oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>cvs mucus d max st er oral tablet extended release 12 hour 1200-120 mg</i>	T1	QL (60 EA per 30 days)
<i>cvs nasal decongestant oral tablet 30 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>epinephrine (anaphylaxis) injection solution 1 mg/ml, 30 mg/30ml</i></b>	T1	
<b><i>epinephrine hcl (nasal) nasal solution 0.1 %</i></b>	T1	
<b><i>epinephrine injection solution 1 mg/ml</i></b>	T1	
<b><i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i></b>	T1	QL (4 EA per 180 days)
<b><i>epinephrine pf injection solution 1 mg/ml</i></b>	T1	
<b><i>eql nasal decongestant oral tablet 30 mg</i></b>	T1	
<b><i>gnp all day allergy-d oral tablet extended release 12 hour 5-120 mg</i></b>	T1	PA
<b><i>gnp allergy &amp; congestion oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>gnp allergy/congestion relief oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>gnp nasal decongestant oral tablet 30 mg</i></b>	T1	
<b><i>gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg</i></b>	T1	
<b><i>hm allergy relief/nasal decong oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b>KLS ALLERCLEAR D-12HR ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (<i>loratadine-pseudoephedrine</i>)</b>	T1	
<b>KLS ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-240 MG (<i>loratadine-pseudoephedrine</i>)</b>	T1	
<b>KLS ALLER-TEC D ORAL TABLET EXTENDED RELEASE 12 HOUR 5-120 MG (<i>cetirizine-pseudoephedrine</i>)</b>	T1	PA
<b><i>kp pseudoephedrine hcl oral tablet 30 mg, 60 mg</i></b>	T1	
<b><i>lidocaine-epinephrine (pf) injection solution 1 %-1:100000</i></b>	T1	
<b><i>lidocaine-epinephrine injection solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOHIST-D ORAL LIQUID 2-30 MG/5ML <i>(chlorpheniramine-pseudoeph)</i>	T1	
<i>loratadine-d 12hr oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>maxi-tuss tr oral liquid 1.25-30 mg/5ml</i>	T1	
<i>meijer allergy relief-d oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>meijer nasal decongestant oral tablet 30 mg</i>	T1	
<i>mucus relief d oral tablet extended release 12 hour 120-1200 mg</i>	T1	QL (60 EA per 30 days)
<i>mucus relief d oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>nasal decongestant d oral tablet 30 mg</i>	T1	
<i>nasal decongestant oral tablet 30 mg</i>	T1	
<i>pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg</i>	T1	
<i>pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	T1	
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 120-1200 mg</i>	T1	QL (60 EA per 30 days)
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>qc loratadine-d oral tablet extended release 24 hour 10-240 mg</i>	T1	
<i>qc nasal decongestant pe oral tablet 30 mg</i>	T1	
<i>qc suphedrine maximum strength oral tablet extended release 12 hour 120 mg</i>	T1	
<i>ra allergy/congestion relief oral tablet extended release 12 hour 5-120 mg</i>	T1	
<i>ra cetiri-d oral tablet extended release 12 hour 5-120 mg</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ra lorata-d oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>ra mucus relief d max strength oral tablet extended release 12 hour 120-1200 mg</i></b>	T1	QL (60 EA per 30 days)
<b><i>ra mucus relief d oral tablet extended release 12 hour 600-60 mg</i></b>	T1	QL (120 EA per 30 days)
<b><i>ra sinus/congestion relief oral tablet extended release 12 hour 120 mg</i></b>	T1	
<b><i>ra suphedrine oral tablet 30 mg</i></b>	T1	
<b><i>ra suphedrine oral tablet extended release 12 hour 120 mg</i></b>	T1	
<b><i>rynex pse oral liquid 1-15 mg/5ml</i></b>	T1	
<b><i>bupivacaine-epinephrine</i></b> (Sensorcaine/Epinephrine Injection Solution 0.25% -1:200000, 0.5% -1:200000)	T1	
<b><i>bupivacaine-epinephrine</i></b> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % ( <b><i>bupivacaine-epinephrine</i></b> )	T1	
<b><i>sinus 12 hour oral tablet extended release 12 hour 120 mg</i></b>	T1	
<b><i>sm all day allergy-d oral tablet extended release 12 hour 5-120 mg</i></b>	T1	PA
<b><i>sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg</i></b>	T1	
<b><i>sm lorata-dine d oral tablet extended release 24 hour 10-240 mg</i></b>	T1	
<b><i>sm nasal decongestant max st oral tablet 30 mg</i></b>	T1	
<b><i>sm nasal decongestant oral tablet extended release 12 hour 120 mg</i></b>	T1	
<b><i>stahist ad oral tablet 25-60 mg</i></b>	T1	
SUDOGEST ORAL TABLET 60 MG ( <b><i>pseudoephedrine hcl</i></b> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>suphedrine 12hour oral tablet extended release 12 hour 120 mg</i></b>	T1	
TUSNEL ORAL TABLET 60-30-400 MG <b><i>(pseudoephedrine-dm-gg)</i></b>	T1	
WAL-PHED 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 120 MG <b><i>(pseudoephedrine hcl)</i></b>	T1	
WAL-PHED D ORAL TABLET 30 MG <b><i>(pseudoephedrine hcl)</i></b>	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 <b><i>(lidocaine-epinephrine)</i></b>	T1	
Alpha-Adrenergic Agonists		
<b><i>actidom dmx oral liquid 10-30-200 mg/5ml</i></b>	T1	
<b><i>biodesp dm oral syrup 5-15-100 mg/5ml</i></b>	T1	
<b><i>bio-rytuss oral liquid 5-2-10 mg/5ml</i></b>	T1	
<b><i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i></b>	T1	
<b><i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i></b>	T1	
<b><i>cvs cold &amp; cough childrens oral solution 2.5-5 mg/5ml</i></b>	T1	
<b><i>despec dm oral syrup 5-10-100 mg/5ml</i></b>	T1	
<b><i>despec dm-g oral syrup 5-10-100 mg/5ml</i></b>	T1	
<b><i>despec eda oral liquid 2.5-5-50 mg/ml</i></b>	T1	
<b><i>dometuss-dmx oral liquid 10-30-200 mg/5ml</i></b>	T1	
ED A-HIST ORAL LIQUID 4-10 MG/5ML <b><i>(chlorpheniramine-phenylephrine)</i></b>	T1	
<b><i>ed bron gp oral liquid 5-100 mg/5ml</i></b>	T1	
<b><i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i></b>	T1	
GILTUSS ALLERGY COUGH & CONGES ORAL LIQUID 5-2-10 MG/5ML <b><i>(phenylephrine-chlorphen-dm)</i></b>	T1	
<b><i>glenmax peb dm oral liquid 5-2-10 mg/5ml</i></b>	T1	
<b><i>gnp tussin cf cough &amp; cold oral syrup 5-10-100 mg/5ml</i></b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>goodsense tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>g-supress dx pediatric oral liquid 2.5-5-50 mg/ml</i>	T1	
G-TRON PED ORAL LIQUID 10-15-350 MG/5ML ( <i>phenylephrine-dm-gg</i> )	T1	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	T1	
<i>maxi-tuss jr oral liquid 2.5-5 mg/5ml</i>	T1	
<i>maxi-tuss pe max oral liquid 5-100 mg/5ml</i>	T1	
<i>maxi-tuss pe oral liquid 2-5 mg/5ml</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	T1	
<i>nohist-lq oral liquid 4-10 mg/5ml</i>	T1	
<i>pres gen pediatric oral liquid 2.5-5-75 mg/5ml</i>	T1	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	T1	
<i>qc tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml</i>	T1	
ROBITUSSIN CHILD COUGH/COLD CF ORAL LIQUID 2.5-5-50 MG/5ML ( <i>phenylephrine-dm-gg</i> )	T1	
<i>sm tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>supress-dx pediatric oral liquid 2.5-5-50 mg/ml</i>	T1	
<i>tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<b>Antimuscarinics/Antispasmodics</b>		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT ( <i>umeclidinium- vilanterol</i> )	T1	
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic ointment 1 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>atropine sulfate ophthalmic solution 1 %</i></b>	T1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT ( <b><i>ipratropium bromide hfa</i></b> )	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <b><i>budeson-glycopyrrol-formoterol</i></b> )	T1	PA
<b><i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i></b>	T1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <b><i>ipratropium-albuterol</i></b> )	T1	
<b><i>dicyclomine hcl oral capsule 10 mg</i></b>	T1	
<b><i>dicyclomine hcl oral tablet 20 mg</i></b>	T1	
<b><i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i></b>	T1	
<b><i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i></b>	T1	
<b><i>glycopyrrolate oral tablet 1 mg, 2 mg</i></b>	T1	
<b><i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i></b>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<b><i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i></b>	T1	QL (45 EA per 30 days); AL (Min 18 Years)
<b><i>hydromet oral solution 5-1.5 mg/5ml</i></b>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<b><i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i></b>	T1	
<b><i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i></b>	T1	
<b><i>hyoscyamine sulfate oral solution 0.125 mg/ml</i></b>	T1	
<b><i>hyoscyamine sulfate oral tablet 0.125 mg</i></b>	T1	
<b><i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i></b>	T1	
<b><i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i></b>	T1	
<b><i>hyosyne oral elixir 0.125 mg/5ml</i></b>	T1	
<b><i>hyosyne oral solution 0.125 mg/ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT ( <i>umeclidinium bromide</i> )	T1	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	T1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
MOTOFEN ORAL TABLET 1-0.025 MG ( <i>difenoxin-atropine</i> )	T1	
<i>hyoscyamine sulfate</i> (Nulev Oral Tablet Dispersible 0.125 Mg)	T1	
<i>oscimin oral tablet 0.125 mg</i>	T1	
<i>oscimin sublingual tablet sublingual 0.125 mg</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral tablet 16.2 mg</i>	T1	
<i>phenobarbital-belladonna alk oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine</i> (Phenohtro Oral Tablet 16.2 Mg)	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT ( <i>tiotropium bromide monohydrate</i> )	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT ( <i>tiotropium bromide-olodaterol</i> )	T1	
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	T1	PA
<i>urin ds oral tablet 81.6 mg</i>	T1	
<i>urneva oral capsule 120 mg</i>	T1	
<b>Antiparkinsonian Agents</b>		

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	QL (120 EA per 30 days)
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>diphen oral tablet 25 mg</i>	T1	
<i>diphenhist oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral tablet 25 mg</i>	T1	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	T1	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>eq allergy relief oral capsule 25 mg</i>	T1	
<i>eq allergy relief oral tablet 25 mg</i>	T1	
<i>eql allergy oral tablet 25 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>eql allergy relief oral tablet 25 mg</i>	T1	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>eql sleep aid oral capsule 50 mg</i>	T1	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	
<i>gnp allergy relief oral tablet 25 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	T1	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	T1	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>night time sleep aid oral tablet 25 mg</i>	T1	
<i>nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>pharbedryl oral capsule 25 mg, 50 mg</i>	T1	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>qc complete allergy medicine oral tablet 25 mg</i>	T1	
<i>qc sleep aid max st oral capsule 50 mg</i>	T1	
<i>ra allergy medication oral capsule 25 mg</i>	T1	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy medication oral tablet 25 mg</i>	T1	
<i>ra allergy oral tablet 25 mg</i>	T1	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	T1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	
Autonomic Drugs, Miscellaneous		
<i>cvs nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>gnp nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>gnp nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>goodsense nicotine mouth/throat lozenge 2 mg</i>	T1	
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>hm nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>hm nicotine polacrilex mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE 2 MG ( <i>nicotine polacrilex</i> )	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE 4 MG ( <i>nicotine polacrilex</i> )	T1	QL (324 EA per 30 days)
<i>nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
NICOTROL INHALATION INHALER 10 MG ( <i>nicotine</i> )	T1	PA
NICOTROL NS NASAL SOLUTION 10 MG/ML ( <i>nicotine</i> )	T1	PA
<i>qc nicotine transdermal system transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>ra mini nicotine mouth/throat lozenge 2 mg</i>	T1	
<i>ra mini nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>ra nicotine gum mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>ra nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>ra nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>ra nicotine transdermal patch 24 hour 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>sm nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	T1	QL (180 EA per 365 days)
Botulinum Toxins		
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT ( <i>abobotulinumtoxinA</i> )	T1	PA
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT ( <i>incobotulinumtoxinA</i> )	T1	PA
Centrally Acting Skeletal Muscle Relaxant		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlorzoxazone oral tablet 250 mg, 500 mg</i>	T1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	T1	
<i>metaxalone oral tablet 800 mg</i>	T1	PA
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	T1	
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	T1	PA
<i>tizanidine hcl oral tablet 2 mg</i>	T1	QL (540 EA per 30 days)
<i>tizanidine hcl oral tablet 4 mg</i>	T1	QL (270 EA per 30 days)
<b>Direct-Acting Skeletal Muscle Relaxants</b>		
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<b>Gaba-Derivative Skeletal Muscle Relaxant</b>		
<i>baclofen oral tablet 10 mg, 20 mg</i>	T1	
<i>baclofen oral tablet 5 mg</i>	T1	QL (90 EA per 30 days)
<b>Indirect-Acting Skeletal Muscle Relaxant</b>		
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Oral Tablet 50-770-60 Mg)	T1	
<b>Non-Sel. Beta-Adrenergic Blocking Agents</b>		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <i>propranolol hcl sr beads</i> )	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<b>Non-Sel.Alpha-1-Adrenergic Blocking Agts</b>		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<b>Non-Sel.Alpha-Adrenergic Blocking Agents</b>		
<i>ergoloid mesylates oral tablet 1 mg</i>	T1	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	T1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <i>ergotamine-caffeine</i> )	T1	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	T1	
<b>Parasympathomimetic (Cholinergic Agents)</b>		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg</i>	T1	
<i>bethanechol chloride oral tablet 50 mg</i>	T1	PA
<i>cevimeline hcl oral capsule 30 mg</i>	T1	
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil hcl oral tablet 23 mg</i>	T1	PA
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	T1	
<i>neostigmine methylsulfate intravenous solution prefilled syringe 3 mg/3ml</i>	T1	PA
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	T1	
<i>pilocarpine hcl oral tablet 5 mg</i>	T1	
<i>pilocarpine hcl oral tablet 7.5 mg</i>	T1	PA
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>pyridostigmine bromide oral solution 60 mg/5ml</i></b>	T1	
<b><i>pyridostigmine bromide oral tablet 60 mg</i></b>	T1	
<b><i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i></b>	T1	
<b>Selective Alpha-1-Adrenergic Block.Agent</b>		
<b><i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i></b>	T1	
<b><i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i></b>	T1	
<b><i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i></b>	T1	
<b><i>tamsulosin hcl oral capsule 0.4 mg</i></b>	T1	
<b>Selective Beta-2-Adrenergic Agonists</b>		
<b><i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i></b>	T1	QL (2 GM per 30 days)
<b><i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i></b>	T1	
<b><i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml</i></b>	T1	PA
<b><i>albuterol sulfate oral syrup 2 mg/5ml</i></b>	T1	
<b><i>albuterol sulfate oral tablet 2 mg, 4 mg</i></b>	T1	
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT ( <b><i>umeclidinium-vilanterol</i></b> )	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <b><i>budeson-glycopyrrol-formoterol</i></b> )	T1	PA
<b><i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i></b>	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <b><i>ipratropium-albuterol</i></b> )	T1	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT ( <b><i>mometasone furo-formoterol fum</i></b> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>salmeterol xinafoate</i> )	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT ( <i>tiotropium bromide-olodaterol</i> )	T1	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	T1	PA
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
<b>Selective Beta-Adrenergic Blocking Agent</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<b>Skeletal Muscle Relaxants, Miscellaneous</b>		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT ( <i>abobotulinumtoxina</i> )	T1	PA
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Oral Tablet 50-770-60 Mg)	T1	
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT ( <i>incobotulinumtoxina</i> )	T1	PA
Smoking Cessation Agents		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	T1	QL (60 EA per 30 days)
<i>cvs nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>gnp nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>gnp nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i></b>	T1	QL (340 EA per 30 days)
<b><i>gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i></b>	T1	QL (324 EA per 30 days)
<b><i>gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
<b><i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i></b>	T1	QL (340 EA per 30 days)
<b><i>goodsense nicotine mouth/throat lozenge 2 mg</i></b>	T1	
<b><i>goodsense nicotine mouth/throat lozenge 4 mg</i></b>	T1	QL (324 EA per 30 days)
<b><i>hm nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i></b>	T1	QL (340 EA per 30 days)
<b><i>hm nicotine polacrilex mouth/throat lozenge 2 mg</i></b>	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE 2 MG ( <b><i>nicotine polacrilex</i></b> )	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE 4 MG ( <b><i>nicotine polacrilex</i></b> )	T1	QL (324 EA per 30 days)
<b><i>naltrexone hcl oral tablet 50 mg</i></b>	T1	
<b><i>nicotine mini mouth/throat lozenge 2 mg</i></b>	T1	
<b><i>nicotine mini mouth/throat lozenge 4 mg</i></b>	T1	QL (324 EA per 30 days)
<b><i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i></b>	T1	
<b><i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i></b>	T1	QL (340 EA per 30 days)
<b><i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i></b>	T1	QL (324 EA per 30 days)
<b><i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
<b><i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
<b><i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
<b><i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
NICOTROL INHALATION INHALER 10 MG ( <b><i>nicotine</i></b> )	T1	PA
NICOTROL NS NASAL SOLUTION 10 MG/ML ( <b><i>nicotine</i></b> )	T1	PA
<b><i>qc nicotine transdermal system transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i></b>	T1	QL (30 EA per 30 days)
<b><i>ra mini nicotine mouth/throat lozenge 2 mg</i></b>	T1	

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra mini nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>ra nicotine gum mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>ra nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>ra nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>ra nicotine transdermal patch 24 hour 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>sm nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	T1	QL (180 EA per 365 days)
<b>Blood Formation, Coagulation, Thrombosis</b>		
<b>Antianemia Drugs</b>		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML ( <i>epoetin alfa</i> )	T1	PA
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG ( <i>daprodustat</i> )	T1	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML ( <i>epoetin alfa</i> )	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML ( <i>epoetin alfa-epbx</i> )	T1	PA
<b>Anticoagulants, Miscellaneous</b>		
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML ( <i>anticoagulant cit dext soln a</i> )	T1	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	<b>PA = Prior Authorization</b> <b>QL = Quantity Limit</b> <b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Antithrombotic Agents, Miscellaneous</b>		
LODOCO ORAL TABLET 0.5 MG ( <i>colchicine</i> )	T1	PA
<b>Coumarin Derivatives</b>		
<i>warfarin sodium</i> (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	T1	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	T1	
<b>Direct Factor Xa Inhibitors</b>		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG ( <i>apixaban</i> )	T1	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG ( <i>apixaban</i> )	T1	QL (60 EA per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML ( <i>rivaroxaban</i> )	T1	QL (600 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG ( <i>rivaroxaban</i> )	T1	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG ( <i>rivaroxaban</i> )	T1	QL (42 EA per 21 days)
XARELTO ORAL TABLET 2.5 MG ( <i>rivaroxaban</i> )	T1	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG ( <i>rivaroxaban</i> )	T1	QL (51 EA per 30 days)
<b>Direct Thrombin Inhibitors</b>		
<i>dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg</i>	T1	QL (60 EA per 30 days)
<b>Hematopoietic Agents</b>		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML ( <i>epoetin alfa</i> )	T1	PA
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim-jmdb</i> )	T1	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <i>tbo-filgrastim</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG ( <b><i>daprodustat</i></b> )	T1	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <b><i>pegfilgrastim</i></b> )	T1	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML ( <b><i>filgrastim</i></b> )	T1	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <b><i>filgrastim</i></b> )	T1	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML ( <b><i>filgrastim-aafi</i></b> )	T1	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <b><i>filgrastim-aafi</i></b> )	T1	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <b><i>pegfilgrastim-apgf</i></b> )	T1	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML ( <b><i>epoetin alfa</i></b> )	T1	PA
<b><i>releuko subcutaneous solution prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml</i></b>	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML ( <b><i>epoetin alfa-epbx</i></b> )	T1	PA
STIMUFEND SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <b><i>pegfilgrastim-fpgk</i></b> )	T1	PA
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <b><i>pegfilgrastim-cbqv</i></b> )	T1	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML ( <b><i>pegfilgrastim-cbqv</i></b> )	T1	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <b><i>pegfilgrastim-cbqv</i></b> )	T1	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML ( <b><i>filgrastim-sndz</i></b> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML ( <i>pegfilgrastim-bmez</i> )	T1	PA
<b>Hemorrhheologic Agents</b>		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	T1	
<b>Hemostatics</b>		
<i>aminocaproic acid oral tablet 1000 mg</i>	T1	
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	T1	PA
<i>desmopressin acetate injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	T1	PA
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	T1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate spray nasal solution 0.01 %</i>	T1	PA
<b>Heparins</b>		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	T1	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml</i>	T1	QL (40 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml</i>	T1	QL (32 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml</i>	T1	QL (12 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml</i>	T1	QL (16 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml</i>	T1	QL (24 ML per 180 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML ( <i>dalteparin sodium</i> )	T1	
<i>heparin na (pork) lock flsh pf intravenous solution 10 unit/ml</i>	T1	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	T1	

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	T1	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml</i>	T1	
<b>Indirect Factor Xa Inhibitors</b>		
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	T1	
<b>Iron Preparations</b>		
BPROTECTED PEDIA IRON ORAL SOLUTION 75 (15 FE) MG/ML ( <i>ferrous sulfate</i> )	T1	
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 &amp; 200 mg</i>	T1	
<i>cvs iron oral tablet 325 (65 fe) mg</i>	T1	
<i>cvs slow release dried iron oral tablet extended release 45 mg</i>	T1	
ELITE-OB ORAL TABLET 50-1.25 MG ( <i>prenatal vit-iron carbonyl-fa</i> )	T1	
<i>eq slow-release iron oral tablet extended release 45 mg</i>	T1	
<i>eql carbonyl iron oral tablet 45 mg</i>	T1	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	
<i>fe c tab plus oral tablet 100-250-0.025-1 mg</i>	T1	
FEOSOL ORAL TABLET 200 (65 FE) MG ( <i>ferrous sulfate dried</i> )	T1	
FEROSUL ORAL TABLET 325 (65 FE) MG ( <i>ferrous sulfate</i> )	T1	
<i>ferric x-150 oral capsule 150 mg</i>	T1	
<i>ferrous gluconate oral tablet 324 (37.5 fe) mg, 324 (38 fe) mg</i>	T1	QL (200 EA per 30 days)
<i>ferrous sulfate oral solution 300 mg/6.8ml, 75 (15 fe) mg/ml</i>	T1	
<i>ferrous sulfate oral tablet 325 (65 fe) mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ferrous sulfate oral tablet delayed release 325 (65 fe) mg</i></b>	T1	
<b><i>fe-vite iron oral solution 75 (15 fe) mg/ml</i></b>	T1	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG ( <b><i>ferrous sulfate-c-folic acid</i></b> )	T1	
GERITOL TONIC ORAL LIQUID ( <b><i>iron-vitamins</i></b> )	T1	
<b><i>gnp iron oral tablet 200 (65 fe) mg</i></b>	T1	
<b><i>gnp prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>hematinic plus vit/minerals oral tablet 106-1 mg</i></b>	T1	
<b><i>hematinic/folic acid oral tablet 324-1 mg</i></b>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG ( <b><i>fe fum-vit c-vit b12-fa</i></b> )	T1	
<b><i>iron polysacch cmplx-b12-fa</i></b> (Iferex 150 Forte Oral Capsule 150-25-1 Mg-Mcg-Mg)	T1	
IFEREX 150 ORAL CAPSULE 150 MG ( <b><i>polysaccharide iron complex</i></b> )	T1	
INFED INJECTION SOLUTION 50 MG/ML ( <b><i>iron dextran</i></b> )	T1	
<b><i>iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml</i></b>	T1	
<b><i>iron 100 plus oral tablet 100-250-0.025-1 mg</i></b>	T1	
<b><i>iron high-potency oral tablet 325 mg</i></b>	T1	
<b><i>iron infant &amp; toddler oral solution 75 (15 fe) mg/ml</i></b>	T1	
<b><i>iron infant/toddler oral solution 75 (15 fe) mg/ml</i></b>	T1	
<b><i>iron oral tablet 325 (65 fe) mg</i></b>	T1	
<b><i>kp ferrous gluconate oral tablet 324 (37.5 fe) mg</i></b>	T1	QL (200 EA per 30 days)
<b><i>kp ferrous sulfate oral tablet 325 (65 fe) mg</i></b>	T1	
<b><i>m-natal plus oral tablet 27-1 mg</i></b>	T1	
<b><i>multiple vitamins-iron oral tablet chewable 15 mg</i></b>	T1	
NUTRIVIT ORAL LIQUID ( <b><i>b complex-lysine-min-fe-fa</i></b> )	T1	
<b><i>pc pediatric iron drops oral solution 75 (15 fe) mg/ml</i></b>	T1	
<b><i>poly-iron 150 forte oral capsule 150-25-1 mg-mcg-mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>polysaccharide iron complex oral capsule 150 mg</i></b>	T1	
<b><i>polysaccharide-iron complex oral capsule 150 mg</i></b>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG ( <b><i>prenatal mv-min-fe fum-fa-dha</i></b> )	T1	
<b><i>prenatal one daily oral tablet 27-0.8 mg</i></b>	T1	
<b><i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i></b>	T1	
<b><i>prenatal plus oral tablet 27-1 mg</i></b>	T1	
<b><i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i></b>	T1	
<b><i>prenatal vitamins oral tablet 28-0.8 mg</i></b>	T1	
<b><i>prenatal/iron oral tablet , 28-0.8 mg</i></b>	T1	
PROFERRIN-FORTE ORAL TABLET 12-1 MG ( <b><i>fe heme polypeptide-folic acid</i></b> )	T1	
<b><i>qc prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>ra high potency iron oral tablet 27 mg</i></b>	T1	
<b><i>ra iron oral tablet 325 (65 fe) mg</i></b>	T1	
<b><i>ra prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>ra slow release iron oral tablet extended release 45 mg</i></b>	T1	
<b><i>slow release iron oral tablet extended release 45 mg, 47.5 mg</i></b>	T1	
<b><i>sm iron oral tablet 325 (65 fe) mg</i></b>	T1	
<b><i>sm slow release dried iron oral tablet extended release 45 mg</i></b>	T1	
<b><i>sv iron oral tablet 325 (65 fe) mg</i></b>	T1	
<b><i>thrivite rx oral tablet 29-1 mg</i></b>	T1	
<b><i>trigels-f forte oral capsule 460-60-0.01-1 mg</i></b>	T1	
<b><i>westab plus oral tablet 27-1 mg</i></b>	T1	
<b>Liver And Stomach Preparations</b>		
<b><i>b-12 oral tablet 1000 mcg</i></b>	T1	
<b><i>b-12 oral tablet extended release 1000 mcg</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-12 tr oral tablet extended release 1000 mcg</i>	T1	
<i>cvs vitamin b12 oral tablet 1000 mcg</i>	T1	
<i>cvs vitamin b-12 oral tablet 1000 mcg</i>	T1	
<i>cvs vitamin b12 oral tablet extended release 1000 mcg</i>	T1	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	T1	
<i>cyanocobalamin</i> (Dodex Injection Solution 1000 Mcg/MI)	T1	
<i>gnp vitamin b-12 oral tablet extended release 1000 mcg</i>	T1	
<i>hydroxocobalamin acetate intramuscular solution 1000 mcg/ml</i>	T1	
<i>kp vitamin b-12 oral tablet 1000 mcg</i>	T1	
<i>neurin-sl sublingual tablet sublingual 600-600 mcg</i>	T1	
<i>ra vitamin b-12 tr oral tablet extended release 1000 mcg</i>	T1	
<i>sv vitamin b-12 er oral tablet extended release 1000 mcg</i>	T1	
<i>vitamin b-12 er oral tablet extended release 1000 mcg</i>	T1	
<i>vitamin b-12 oral tablet 1000 mcg</i>	T1	
<b>Platelet-Aggregation Inhibitors</b>		
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet 325 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>aspirin rectal suppository 300 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
BAYER ADVANCED ASPIRIN EX ST ORAL TABLET 500 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG ( <i>aspirin</i> )	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
BRILINTA ORAL TABLET 60 MG, 90 MG ( <i>ticagrelor</i> )	T1	QL (60 EA per 30 days)
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	T1	
<i>clopidogrel bisulfate oral tablet 300 mg</i>	T1	QL (2 EA per 30 days)
<i>clopidogrel bisulfate oral tablet 75 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin oral tablet 325 mg</i>	T1	
<i>cvs genuine aspirin oral tablet 325 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eq aspirin oral tablet 325 mg</i>	T1	
<i>eql aspirin ec oral tablet delayed release 325 mg</i>	T1	
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet 325 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>goodsense aspirin adults oral tablet 325 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet 325 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>hm adult aspirin oral tablet 325 mg</i>	T1	
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG ( <i>aspirin</i> )	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin oral tablet 325 mg</i>	T1	
<i>qc aspirin oral tablet delayed release 325 mg</i>	T1	
<i>qc enteric aspirin oral tablet delayed release 325 mg</i>	T1	

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>ra aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin adult low strength oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin ec adult low st oral tablet delayed release 81 mg</i>	T1	
<i>ra aspirin ec oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>ra aspirin oral tablet 325 mg</i>	T1	
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	T1	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
<b>Platelet-Reducing Agents</b>		
<i>anagrelide hcl oral capsule 0.5 mg</i>	T1	
<b>Thrombolytic Agents</b>		
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet 325 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>aspirin rectal suppository 300 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
BAYER ADVANCED ASPIRIN EX ST ORAL TABLET 500 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG ( <i>aspirin</i> )	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin oral tablet 325 mg</i>	T1	
<i>cvs genuine aspirin oral tablet 325 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eq aspirin oral tablet 325 mg</i>	T1	
<i>eql aspirin ec oral tablet delayed release 325 mg</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet 325 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>goodsense aspirin adults oral tablet 325 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet 325 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>hm adult aspirin oral tablet 325 mg</i>	T1	
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG ( <i>aspirin</i> )	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin oral tablet 325 mg</i>	T1	
<i>qc aspirin oral tablet delayed release 325 mg</i>	T1	
<i>qc enteric aspirin oral tablet delayed release 325 mg</i>	T1	
<i>ra aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin adult low strength oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin ec adult low st oral tablet delayed release 81 mg</i>	T1	
<i>ra aspirin ec oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>ra aspirin oral tablet 325 mg</i>	T1	
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
Cardiovascular Drugs		
Acl Inhibitors		
NEXLETOL ORAL TABLET 180 MG ( <i>bempedoic acid</i> )	T1	PA
NEXLIZET ORAL TABLET 180-10 MG ( <i>bempedoic acid-ezetimibe</i> )	T1	PA
Alpha-Adrenergic Blocking Agents		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Alpha-Adrenergic Blocking Agt.(Hypoten)		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Angiotensin li Receptor Antagon.(Hypotn)		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	PA
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	T1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	T1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Angiotensin II Receptor Antagonists</b>		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	PA
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG ( <i>sacubitril-valsartan</i> )	T1	QL (240 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG ( <i>sacubitril-valsartan</i> )	T1	QL (60 EA per 30 days)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	T1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	T1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	T1	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	T1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	T1	
<b>Angiotensin-Convert.Enzyme Inhib(Hypotn)</b>		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	T1	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<b>Angiotensin-Converting Enzyme Inhibitors</b>		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	T1	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<b>Antiarrhythmics, Miscellaneous</b>		

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>digoxin</i> (Digox Oral Tablet 125 Mcg, 250 Mcg)	T1	
<i>digoxin oral solution 0.05 mg/ml</i>	T1	
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG ( <i>digoxin</i> )	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<b>Antilipemic Agents, Miscellaneous</b>		
NEXLETOL ORAL TABLET 180 MG ( <i>bempedoic acid</i> )	T1	PA
NEXLIZET ORAL TABLET 180-10 MG ( <i>bempedoic acid-ezetimibe</i> )	T1	PA
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	T1	PA
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	T1	ST
<b>Beta-Adrenergic Blocking Agents</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <i>propranolol hcl sr beads</i> )	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
Bile Acid Sequestrants		
<i>cholestyramine light oral packet 4 gm</i>	T1	
<i>cholestyramine light oral powder 4 gm/dose</i>	T1	
<i>cholestyramine oral packet 4 gm</i>	T1	
<i>cholestyramine oral powder 4 gm/dose</i>	T1	
<i>colestipol hcl oral granules 5 gm</i>	T1	
<i>colestipol hcl oral packet 5 gm</i>	T1	
<i>colestipol hcl oral tablet 1 gm</i>	T1	
<i>cholestyramine light</i> (Prevalite Oral Packet 4 Gm)	T1	
<i>cholestyramine light</i> (Prevalite Oral Powder 4 Gm/Dose)	T1	
Calcium-Channel Block.Agt,Misc(Hypoten)		
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i></b>	T1	ST
<b><i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl</i></b> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i></b>	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i></b>	T1	
Calcium-Channel Blocking Agents		
<b><i>diltiazem hcl coated beads</i></b> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i></b>	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i></b>	T1	PA
<b><i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i></b>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum



		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i></b>	T1	ST
<b><i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl</i></b> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i></b>	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i></b>	T1	
<b>Calcium-Channel Blocking Agents, Misc.</b>		
<b><i>diltiazem hcl coated beads</i></b> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i></b>	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i></b>	T1	PA
<b><i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
<b>Carbonic Anhydrase Inhibitors (24:36)</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<b>Carbonic Anhydrase Inhibitors(Hypoten)</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<b>Cardiotonic Agents</b>		
<i>digoxin</i> (Digox Oral Tablet 125 Mcg, 250 Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>digoxin oral solution 0.05 mg/ml</i>	T1	
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG ( <i>digoxin</i> )	T1	
<b>Central Alpha-Agonists (25:24)</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	T1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <i>propranolol hcl sr beads</i> )	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<b>Cgmp Synthesis Agent</b>		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG ( <i>vericiguat</i> )	T1	PA
<b>Cholesterol Absorption Inhibitors</b>		
<i>ezetimibe oral tablet 10 mg</i>	T1	
NEXLIZET ORAL TABLET 180-10 MG ( <i>bempedoic acid-ezetimibe</i> )	T1	PA
<b>Class Ia Antiarrhythmics</b>		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	T1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG ( <i>disopyramide phosphate</i> )	T1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	T1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	T1	
<b>Class Ib Antiarrhythmics</b>		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG ( <i>phenytoin</i> )	T1	
DILANTIN ORAL CAPSULE 100 MG, 30 MG ( <i>phenytoin sodium extended</i> )	T1	
DILANTIN ORAL SUSPENSION 125 MG/5ML ( <i>phenytoin</i> )	T1	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	T1	
<i>phenytoin</i> (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	T1	
<i>phenytoin oral suspension 125 mg/5ml</i>	T1	
<i>phenytoin oral tablet chewable 50 mg</i>	T1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	T1	
<b>Class Ic Antiarrhythmics</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	T1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	T1	
<b>Class Ii Antiarrhythmics</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <i>propranolol hcl sr beads</i> )	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<b>Class Iii Antiarrhythmics</b>		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	T1	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	T1	
MULTAQ ORAL TABLET 400 MG ( <i>dronedarone hcl</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i></b>	T1	
<b><i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i></b>	T1	
<b>Class Iv Antiarrhythmics</b>		
<b><i>diltiazem hcl coated beads</i></b> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i></b>	T1	
<b><i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i></b>	T1	PA
<b><i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i></b>	T1	
<b><i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i></b>	T1	ST
<b><i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>diltiazem hcl</i></b> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<b><i>diltiazem hcl er beads</i></b> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i></b>	T1	PA
<b><i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i></b>	T1	
<b><i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i></b>	T1	
<b>Dihydropyridines</b>		
<b><i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i></b>	T1	
<b><i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i></b>	T1	
<b><i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i></b>	T1	
<b><i>isradipine oral capsule 2.5 mg, 5 mg</i></b>	T1	ST
<b><i>nicardipine hcl oral capsule 20 mg, 30 mg</i></b>	T1	PA
<b><i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>nifedipine oral capsule 10 mg, 20 mg</i></b>	T1	
<b><i>nimodipine oral capsule 30 mg</i></b>	T1	PA
<b><i>nisoldipine er oral tablet extended release 24 hour 20 mg, 30 mg, 40 mg</i></b>	T1	PA
<b>Dihydropyridines (Antihypertensive)</b>		
<b><i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i></b>	T1	
<b><i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i></b>	T1	
<b><i>isradipine oral capsule 2.5 mg, 5 mg</i></b>	T1	ST
<b><i>nicardipine hcl oral capsule 20 mg, 30 mg</i></b>	T1	PA
<b><i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>nifedipine oral capsule 10 mg, 20 mg</i></b>	T1	
<b><i>nimodipine oral capsule 30 mg</i></b>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nisoldipine er oral tablet extended release 24 hour 20 mg, 30 mg, 40 mg</i>	T1	PA
<b>Direct Vasodilators</b>		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG ( <i>alprostadil (vasodilator)</i> )	T1	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG ( <i>alprostadil (vasodilator)</i> )	T1	PA
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	T1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	T1	
<b>Diuretics, Miscellaneous (Hypotensive)</b>		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
<b>Fibric Acid Derivatives</b>		
<i>fenofibrate micronized oral capsule 130 mg, 43 mg</i>	T1	PA
<i>fenofibrate micronized oral capsule 134 mg</i>	T1	
<i>fenofibrate micronized oral capsule 200 mg, 67 mg</i>	T1	QL (30 EA per 30 days)
<i>fenofibrate oral capsule 134 mg</i>	T1	
<i>fenofibrate oral capsule 200 mg, 67 mg</i>	T1	QL (30 EA per 30 days)
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>gemfibrozil oral tablet 600 mg</i></b>	T1	
<b>Hmg-Coa Reductase Inhibitors</b>		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG ( <i>lovastatin</i> )	T1	PA
<b><i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i></b>	T1	
<b><i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i></b>	T1	PA
<b><i>fluvastatin sodium oral capsule 20 mg, 40 mg</i></b>	T1	PA
<b><i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i></b>	T1	
<b><i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i></b>	T1	QL (30 EA per 30 days)
<b><i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i></b>	T1	QL (30 EA per 30 days)
<b><i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i></b>	T1	
<b>Loop Diuretics (24:36)</b>		
<b><i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>ethacrynic acid oral tablet 25 mg</i></b>	T1	
<b><i>furosemide oral solution 10 mg/ml, 8 mg/ml</i></b>	T1	
<b><i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i></b>	T1	
<b><i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i></b>	T1	
<b>Loop Diuretics (Hypotensive Agents)</b>		
<b><i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>ethacrynic acid oral tablet 25 mg</i></b>	T1	
<b><i>furosemide oral solution 10 mg/ml, 8 mg/ml</i></b>	T1	
<b><i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i></b>	T1	
<b><i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i></b>	T1	
<b>Mineralocorticoid (Aldosterone) Antagnts</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
KERENDIA ORAL TABLET 10 MG, 20 MG ( <i>finerenone</i> )	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<b>Mineralocorticoid(Aldoster.)Antag(Hypot)</b>		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<b>Nitrates And Nitrites</b>		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <i>propranolol hcl sr beads</i> )	T1	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	T1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
NITRO-BID TRANSDERMAL OINTMENT 2 % ( <i>nitroglycerin</i> )	T1	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	T1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	T1	PA
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG ( <i>nitroglycerin</i> )	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
Omega-3-Mediated Antilipemics		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	T1	ST
Pcsk9 Inhibitors		
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML ( <i>alirocumab</i> )	T1	PA
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML ( <i>evolocumab</i> )	T1	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML ( <i>evolocumab</i> )	T1	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML ( <i>evolocumab</i> )	T1	PA
Phosphodiesterase Type 5 Inhibitors		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	PA
<b>Potassium-Sparing Diuretic</b>		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
<b>Potassium-Sparing Diuretics (Hypoten)</b>		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
<b>Renin-Angioten.-Aldost. Sys. Inhib, Misc</b>		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG ( <i>sacubitril-valsartan</i> )	T1	QL (240 EA per 30 days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG ( <i>sacubitril-valsartan</i> )	T1	QL (60 EA per 30 days)
<b>Steroidal Mineralocorticoid Receptor Ant</b>		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<b>Thiazide Diuretics (24:36)</b>		
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	T1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<b>Thiazide Diuretics(Hypotensive Agents)</b>		
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<b>Thiazide-Like Diuretics (24:36)</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	T1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
THALITONE ORAL TABLET 15 MG ( <i>chlorthalidone</i> )	T1	
<b>Thiazide-Like Diuretics(Hypotensive Agt)</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	T1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
THALITONE ORAL TABLET 15 MG ( <i>chlorthalidone</i> )	T1	
<b>Vasodilating Agents, Miscellaneous</b>		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG ( <i>alprostadil (vasodilator)</i> )	T1	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG ( <i>alprostadil (vasodilator)</i> )	T1	PA
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	T1	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG ( <i>treprostinil diolamine</i> )	T1	PA
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
VENTAVIS INHALATION SOLUTION 20 MCG/ML ( <i>iloprost</i> )	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG ( <i>vericiguat</i> )	T1	PA
Central Nervous System Agents		
Adamantanes (Cns)		
<i>amantadine hcl oral capsule 100 mg</i>	T1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	T1	
<i>amantadine hcl oral tablet 100 mg</i>	T1	
Amphetamines		
<i>amphetamine-dextroamphetamine er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	T1	PA
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	T1	PA
<i>methamphetamine hcl oral tablet 5 mg</i>	T1	PA
<b>Amyotrophic Lateral Sclerosis(Als) Agent</b>		
<i>riluzole oral tablet 50 mg</i>	T1	
<b>Analgesics And Antipyretics, Misc.</b>		
<i>8 hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen 8 hour oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	T1	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	T1	
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen er oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	T1	
<i>acetaminophen oral liquid 160 mg/5ml</i>	T1	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	T1	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	T1	
<i>acetaminophen oral tablet 325 mg</i>	T1	
<i>acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen rectal suppository 120 mg, 650 mg</i>	T1	
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APHEN ORAL TABLET 325 MG ( <i>acetaminophen</i> )	T1	
<i>arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>butalbital-apap-caffeine</i> (Bac Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>betatemp childrens oral suspension 160 mg/5ml</i>	T1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>childrens apap oral tablet chewable 80 mg</i>	T1	
<i>childrens non-aspirin oral tablet chewable 80 mg</i>	T1	
<i>cvs 8hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs 8hr muscle aches &amp; pain oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs acetaminophen ex st oral liquid 500 mg/15ml</i>	T1	
<i>cvs acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>cvs acetaminophen oral tablet 325 mg</i>	T1	
<i>cvs arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs fever reducing childrens rectal suppository 120 mg</i>	T1	
<i>cvs pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>cvs pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>cvs pain relief childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>cvs pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>ed-apap oral liquid 160 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>eq 8hr arthritis pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>eq acetaminophen oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq arthritis pain oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>eq pain &amp; fever childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain &amp; fever childrens oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>eq pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain relief/rapid burst oral liquid 500 mg/15ml</i></b>	T1	
<b><i>eq pain reliever ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq pain reliever oral tablet 325 mg</i></b>	T1	
<b><i>eq pain reliever oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq acetaminophen childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG ( <b><i>acetaminophen</i></b> )	T1	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG ( <b><i>acetaminophen</i></b> )	T1	
<b><i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i></b>	T1	
<b><i>gabapentin oral solution 250 mg/5ml</i></b>	T1	
<b><i>gabapentin oral tablet 600 mg, 800 mg</i></b>	T1	
<b><i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp acetaminophen oral tablet 325 mg</i></b>	T1	
<b><i>gnp acetaminophen oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>gnp children's pain &amp; fever oral suspension 160 mg/5ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp infants pain/fever oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>gnp pain relief oral tablet 325 mg</i>	T1	
<i>goodsense arthritis pain oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>goodsense pain &amp; fever child oral suspension 160 mg/5ml</i>	T1	
<i>goodsense pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>goodsense pain relief extra st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>goodsense pain relief oral tablet 325 mg</i>	T1	
HEALTHY MAMA SHAKE THAT ACHE ORAL TABLET 500 MG ( <i>acetaminophen</i> )	T1	QL (240 EA per 30 days)
<i>hm pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>infants pain &amp; fever oral suspension 160 mg/5ml</i>	T1	
<i>kls acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>liquid acetaminophen oral liquid 160 mg/5ml</i>	T1	
<i>liquid pain relief oral liquid 160 mg/5ml</i>	T1	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG ( <i>acetaminophen</i> )	T1	QL (750 EA per 30 days)
<i>mapap oral capsule 500 mg</i>	T1	
MM ACETAMINOPHEN EX STR ORAL TABLET 500 MG ( <i>acetaminophen</i> )	T1	QL (240 EA per 30 days)
<i>m-pap oral liquid 160 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>non-aspirin extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>non-aspirin oral tablet 325 mg</i>	T1	
<i>non-aspirin oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>non-aspirin pain relief oral tablet 325 mg</i>	T1	
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
<i>pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever kids oral suspension 160 mg/5ml</i>	T1	
<i>pain relief childrens oral elixir 160 mg/5ml</i>	T1	
<i>pain relief childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>pain relief oral liquid 500 mg/15ml</i>	T1	
<i>pain relief regular strength oral tablet 325 mg</i>	T1	
<i>pain reliever extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>pain reliever oral tablet 325 mg</i>	T1	
<i>pain reliever/fever reducer rectal suppository 120 mg</i>	T1	
PEDIACARE CHILDREN ORAL SUSPENSION 160 MG/5ML ( <i>acetaminophen</i> )	T1	
PERCOGESIC ORAL TABLET 12.5-325 MG ( <i>diphenhydramine-acetaminophen</i> )	T1	
PHARBETOL ORAL TABLET 325 MG ( <i>acetaminophen</i> )	T1	
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML ( <i>ziconotide acetate</i> )	T1	
<i>qc acetaminophen 8 hours oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>qc acetaminophen infants oral suspension 160 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>qc arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>qc non-aspirin extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>qc pain relief childrens oral suspension 160 mg/5ml</i>	T1	
<i>qc pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>qc pain relief oral tablet 325 mg</i>	T1	
<i>ra 8 hour pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>ra acetaminophen childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>ra acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>ra acetaminophen oral tablet 325 mg</i>	T1	
<i>ra arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>ra childrens fever/pain oral suspension 160 mg/5ml</i>	T1	
<i>ra fever reducer/pain reliever oral suspension 160 mg/5ml</i>	T1	
<i>ra pain relief acetaminophen oral tablet 325 mg</i>	T1	
<i>ra pain relief acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>sm pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>sm pain reliever ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm pain reliever oral tablet 325 mg</i>	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
<i>urin ds oral tablet 81.6 mg</i>	T1	
<i>urneva oral capsule 120 mg</i>	T1	
Anorexigenic Agents		

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG ( <i>naltrexone-bupropion hcl</i> )	T1	PA
<b>Anorexigenic Agents, Miscellaneous</b>		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG ( <i>naltrexone-bupropion hcl</i> )	T1	PA
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML ( <i>liraglutide</i> )	T1	ST; QL (9 ML per 28 days)
<b>Anticholinergic Agents (Cns)</b>		
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	QL (120 EA per 30 days)
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>diphen oral tablet 25 mg</i>	T1	
<i>diphenhist oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	T1	

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**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral tablet 25 mg</i>	T1	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	T1	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>eq allergy relief oral capsule 25 mg</i>	T1	
<i>eq allergy relief oral tablet 25 mg</i>	T1	
<i>eql allergy oral tablet 25 mg</i>	T1	
<i>eql allergy relief oral tablet 25 mg</i>	T1	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>eql sleep aid oral capsule 50 mg</i>	T1	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	
<i>gnp allergy relief oral tablet 25 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	T1	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	T1	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>night time sleep aid oral tablet 25 mg</i>	T1	
<i>nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pharbedryl oral capsule 25 mg, 50 mg</i>	T1	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>qc complete allergy medicine oral tablet 25 mg</i>	T1	
<i>qc sleep aid max st oral capsule 50 mg</i>	T1	
<i>ra allergy medication oral capsule 25 mg</i>	T1	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy medication oral tablet 25 mg</i>	T1	
<i>ra allergy oral tablet 25 mg</i>	T1	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	T1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	
<b>Anticonvulsants, Miscellaneous</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	T1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	T1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	T1	
<i>carbamazepine oral tablet 200 mg</i>	T1	
<i>carbamazepine oral tablet chewable 100 mg</i>	T1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine</i> )	T1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML ( <i>cannabidiol</i> )	T1	PA
<i>carbamazepine</i> (Epitol Oral Tablet 200 Mg)	T1	
<i>felbamate oral suspension 600 mg/5ml</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>felbamate oral tablet 400 mg, 600 mg</i></b>	T1	PA
<b><i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i></b>	T1	
<b><i>gabapentin oral solution 250 mg/5ml</i></b>	T1	
<b><i>gabapentin oral tablet 600 mg, 800 mg</i></b>	T1	
<b><i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i></b>	T1	
<b><i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i></b>	T1	
<b><i>lamotrigine oral tablet chewable 25 mg, 5 mg</i></b>	T1	
<b><i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i></b>	T1	
<b><i>levetiracetam oral solution 100 mg/ml, 500 mg/5ml</i></b>	T1	
<b><i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i></b>	T1	
<b><i>magnesium sulfate injection solution 50 %</i></b>	T1	
<b><i>oxcarbazepine oral suspension 300 mg/5ml</i></b>	T1	
<b><i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i></b>	T1	
<b><i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i></b>	T1	
<b><i>pregabalin oral solution 20 mg/ml</i></b>	T1	ST
<b><i>rufinamide oral tablet 200 mg, 400 mg</i></b>	T1	PA
<b><i>lamotrigine</i></b> (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	T1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML ( <b><i>carbamazepine</i></b> )	T1	
TEGRETOL ORAL TABLET 200 MG ( <b><i>carbamazepine</i></b> )	T1	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG ( <b><i>carbamazepine</i></b> )	T1	
<b><i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i></b>	T1	
<b><i>topiramate oral capsule sprinkle 15 mg, 25 mg</i></b>	T1	
<b><i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>valproic acid oral capsule 250 mg</i></b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<b>Antidepressants, Miscellaneous</b>		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	T1	QL (60 EA per 30 days)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	T1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	T1	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	T1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 45 mg</i>	T1	PA
<b>Antimanic Agents</b>		
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	T1	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	T1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	T1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	T1	
<i>carbamazepine oral tablet 200 mg</i>	T1	
<i>carbamazepine oral tablet chewable 100 mg</i>	T1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG ( <i>carbamazepine</i> )	T1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
<i>carbamazepine</i> (Epilex Oral Tablet 200 Mg)	T1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	T1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	T1	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg &amp; 14x100 mg</i>	T1	
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	T1	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	T1	
<i>lithium carbonate oral tablet 300 mg</i>	T1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG ( <i>lithium carbonate</i> )	T1	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	T1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	T1	
<i>risperidone oral solution 1 mg/ml</i>	T1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>risperidone oral tablet dispersible 0.25 mg</i>	T1	QL (60 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>lamotrigine</i> (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	T1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML ( <i>carbamazepine</i> )	T1	
TEGRETOL ORAL TABLET 200 MG ( <i>carbamazepine</i> )	T1	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG ( <i>carbamazepine</i> )	T1	
<i>valproic acid oral capsule 250 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	T1	PA
Antimigraine Agents, Miscellaneous		
<i>8 hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen 8 hour oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	T1	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	T1	
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen er oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	T1	
<i>acetaminophen oral liquid 160 mg/5ml</i>	T1	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	T1	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acetaminophen oral tablet 325 mg</i>	T1	
<i>acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen rectal suppository 120 mg, 650 mg</i>	T1	
APHEN ORAL TABLET 325 MG ( <i>acetaminophen</i> )	T1	
<i>arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet 325 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>aspirin rectal suppository 300 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
BAYER ADVANCED ASPIRIN EX ST ORAL TABLET 500 MG ( <i>aspirin</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG ( <i>aspirin</i> )	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>betatemp childrens oral suspension 160 mg/5ml</i>	T1	
<i>childrens apap oral tablet chewable 80 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>childrens ibuprofen 100 oral suspension 100 mg/5ml</i>	T1	
<i>childrens ibuprofen oral suspension 100 mg/5ml, 200 mg/10ml</i>	T1	
<i>childrens non-aspirin oral tablet chewable 80 mg</i>	T1	
<i>cvs 8hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs 8hr muscle aches &amp; pain oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs acetaminophen ex st oral liquid 500 mg/15ml</i>	T1	
<i>cvs acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>cvs acetaminophen oral tablet 325 mg</i>	T1	
<i>cvs arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin oral tablet 325 mg</i>	T1	
<i>cvs childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>cvs fever reducing childrens rectal suppository 120 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs genuine aspirin oral tablet 325 mg</i>	T1	
<i>cvs ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>cvs pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>cvs pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>cvs pain relief childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>cvs pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG ( <i>divalproex sodium</i> )	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>ed-apap oral liquid 160 mg/5ml</i>	T1	
<i>eq 8hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>eq acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>eq arthritis pain oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eq aspirin oral tablet 325 mg</i>	T1	
<i>eq ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum



		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>eq pain &amp; fever childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain &amp; fever childrens oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>eq pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain relief/rapid burst oral liquid 500 mg/15ml</i></b>	T1	
<b><i>eq pain reliever ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq pain reliever oral tablet 325 mg</i></b>	T1	
<b><i>eq pain reliever oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eql acetaminophen childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eql acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eql aspirin ec oral tablet delayed release 325 mg</i></b>	T1	
<b><i>eql aspirin low dose oral tablet chewable 81 mg</i></b>	T1	
<b><i>eql aspirin low dose oral tablet delayed release 81 mg</i></b>	T1	
<b><i>eql childrens ibuprofen oral suspension 100 mg/5ml</i></b>	T1	
<b><i>ergotamine-caffeine oral tablet 1-100 mg</i></b>	T1	
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG ( <b><i>acetaminophen</i></b> )	T1	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG ( <b><i>acetaminophen</i></b> )	T1	
<b><i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp acetaminophen oral tablet 325 mg</i></b>	T1	
<b><i>gnp acetaminophen oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>gnp adult aspirin low strength oral tablet chewable 81 mg</i></b>	T1	
<b><i>gnp aspirin low dose oral tablet delayed release 81 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp aspirin oral tablet 325 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>gnp childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>gnp children's pain &amp; fever oral suspension 160 mg/5ml</i>	T1	
<i>gnp infants pain/fever oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>gnp pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>gnp pain relief oral tablet 325 mg</i>	T1	
<i>goodsense arthritis pain oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>goodsense aspirin adults oral tablet 325 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet 325 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>goodsense ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>goodsense pain &amp; fever child oral suspension 160 mg/5ml</i>	T1	
<i>goodsense pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>goodsense pain relief extra st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>goodsense pain relief oral tablet 325 mg</i>	T1	
HEALTHY MAMA SHAKE THAT ACHE ORAL TABLET 500 MG ( <i>acetaminophen</i> )	T1	QL (240 EA per 30 days)
<i>hm adult aspirin oral tablet 325 mg</i>	T1	
<i>hm ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>hm pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ibuprofen oral suspension 100 mg/5ml</i></b>	T1	
<b><i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i></b>	T1	
<b><i>infants pain &amp; fever oral suspension 160 mg/5ml</i></b>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG ( <b><i>propranolol hcl sr beads</i></b> )	T1	
<b><i>ketoprofen er oral capsule extended release 24 hour 200 mg</i></b>	T1	
<b><i>ketoprofen oral capsule 50 mg</i></b>	T1	PA
<b><i>kls acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>liquid acetaminophen oral liquid 160 mg/5ml</i></b>	T1	
<b><i>liquid pain relief oral liquid 160 mg/5ml</i></b>	T1	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG ( <b><i>acetaminophen</i></b> )	T1	QL (750 EA per 30 days)
<b><i>mapap oral capsule 500 mg</i></b>	T1	
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG ( <b><i>aspirin</i></b> )	T1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <b><i>ergotamine-caffeine</i></b> )	T1	
MM ACETAMINOPHEN EX STR ORAL TABLET 500 MG ( <b><i>acetaminophen</i></b> )	T1	QL (240 EA per 30 days)
<b><i>mm aspirin oral tablet delayed release 81 mg</i></b>	T1	
<b><i>m-pap oral liquid 160 mg/5ml</i></b>	T1	
<b><i>naproxen oral suspension 125 mg/5ml</i></b>	T1	
<b><i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i></b>	T1	
<b><i>naproxen oral tablet delayed release 375 mg, 500 mg</i></b>	T1	
<b><i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i></b>	T1	
<b><i>naproxen sodium oral tablet 275 mg, 550 mg</i></b>	T1	
<b><i>non-aspirin extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>non-aspirin oral tablet 325 mg</i></b>	T1	
<b><i>non-aspirin oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>non-aspirin pain relief oral tablet 325 mg</i>	T1	
<i>pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever kids oral suspension 160 mg/5ml</i>	T1	
<i>pain relief childrens oral elixir 160 mg/5ml</i>	T1	
<i>pain relief childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>pain relief oral liquid 500 mg/15ml</i>	T1	
<i>pain relief regular strength oral tablet 325 mg</i>	T1	
<i>pain reliever extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>pain reliever oral tablet 325 mg</i>	T1	
<i>pain reliever/fever reducer rectal suppository 120 mg</i>	T1	
PEDIACARE CHILDREN ORAL SUSPENSION 160 MG/5ML ( <i>acetaminophen</i> )	T1	
PHARBETOL ORAL TABLET 325 MG ( <i>acetaminophen</i> )	T1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>qc acetaminophen 8 hours oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>qc acetaminophen infants oral suspension 160 mg/5ml</i>	T1	
<i>qc arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin oral tablet 325 mg</i>	T1	
<i>qc aspirin oral tablet delayed release 325 mg</i>	T1	
<i>qc childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>qc enteric aspirin oral tablet delayed release 325 mg</i>	T1	
<i>qc non-aspirin extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>qc pain relief childrens oral suspension 160 mg/5ml</i>	T1	
<i>qc pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>qc pain relief oral tablet 325 mg</i>	T1	
<i>ra 8 hour pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>ra acetaminophen childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>ra acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>ra acetaminophen oral tablet 325 mg</i>	T1	
<i>ra arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>ra aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin adult low strength oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin ec adult low st oral tablet delayed release 81 mg</i>	T1	
<i>ra aspirin ec oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>ra aspirin oral tablet 325 mg</i>	T1	
<i>ra childrens fever/pain oral suspension 160 mg/5ml</i>	T1	
<i>ra fever reducer/pain reliever oral suspension 160 mg/5ml</i>	T1	
<i>ra ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>ra pain relief acetaminophen oral tablet 325 mg</i>	T1	
<i>ra pain relief acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	T1	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>sm childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>sm pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>sm pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>sm pain reliever ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm pain reliever oral tablet 325 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	T1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
<i>valproic acid oral capsule 250 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
<b>Antipsychotics, Miscellaneous</b>		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	T1	
<i>pimozide oral tablet 1 mg, 2 mg</i>	T1	
<b>Anxiolytics, Sedatives, And Hypnotics, Misc</b>		
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG ( <i>suvorexant</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>bupirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i></b>	T1	
<b><i>complete allergy medicine oral capsule 25 mg</i></b>	T1	
<b><i>complete allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>cvs allergy relief adult oral liquid 50 mg/20ml</i></b>	T1	
<b><i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i></b>	T1	
<b><i>cvs allergy relief oral capsule 25 mg</i></b>	T1	
<b><i>cvs allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>cvs childrens allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>cvs sleep aid nighttime oral tablet 25 mg</i></b>	T1	
<b><i>cvs sleep-aid (doxylamine) oral tablet 25 mg</i></b>	T1	
DAYVIGO ORAL TABLET 10 MG, 5 MG ( <i>lemborexant</i> )	T1	PA
<b><i>diphen oral tablet 25 mg</i></b>	T1	
<b><i>diphenhist oral capsule 25 mg</i></b>	T1	
<b><i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i></b>	T1	
<b><i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral tablet 25 mg</i></b>	T1	
<b><i>diphenhydramine hcl oral tablet chewable 12.5 mg</i></b>	T1	
<b><i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>eq allergy relief oral capsule 25 mg</i></b>	T1	
<b><i>eq allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>eql allergy oral tablet 25 mg</i></b>	T1	
<b><i>eql allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>eql childrens allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>eql nighttime sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>eql sleep aid oral capsule 50 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i></b>	T1	
<b><i>geri-dryl oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>geri-dryl oral tablet 25 mg</i></b>	T1	
<b><i>gnp allergy oral capsule 25 mg</i></b>	T1	
<b><i>gnp allergy oral tablet 25 mg</i></b>	T1	
<b><i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>gnp allergy relief oral capsule 25 mg</i></b>	T1	
<b><i>gnp allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>gnp allergy relief oral tablet chewable 12.5 mg</i></b>	T1	
<b><i>gnp childrens allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>gnp sleep aid nighttime oral tablet 25 mg</i></b>	T1	
<b><i>gnp sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>hydroxyzine hcl oral syrup 10 mg/5ml</i></b>	T1	
<b><i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i></b>	T1	
<b>KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML (diphenhydramine hcl)</b>	T1	
<b><i>liquid allergy relief oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>m-dryl oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>meprobamate oral tablet 200 mg, 400 mg</i></b>	T1	PA
<b><i>night time sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>nighttime sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>pharbedryl oral capsule 25 mg, 50 mg</i></b>	T1	
<b><i>promethazine hcl oral solution 6.25 mg/5ml</i></b>	T1	
<b><i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i></b>	T1	
<b><i>promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ( <i>promethazine hcl</i> )	T1	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>qc complete allergy medicine oral tablet 25 mg</i>	T1	
<i>qc sleep aid max st oral capsule 50 mg</i>	T1	
<i>ra allergy medication oral capsule 25 mg</i>	T1	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy medication oral tablet 25 mg</i>	T1	
<i>ra allergy oral tablet 25 mg</i>	T1	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>ra sleep aid oral tablet 25 mg</i>	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>sleep aid oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sleep-aid oral tablet 25 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>sm sleep aid oral tablet 25 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	
<i>wal-som oral tablet 25 mg</i>	T1	
<i>zaleplon oral capsule 10 mg</i>	T1	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
Atypical Antipsychotics		
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	T1	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	T1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	T1	
<i>risperidone oral solution 1 mg/ml</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>risperidone oral tablet dispersible 0.25 mg</i>	T1	QL (60 EA per 30 days)
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	T1	PA
<b>Barbiturates (Anticonvulsants)</b>		
<i>phenobarbital oral elixir 20 mg/5ml</i>	T1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	T1	
<i>primidone oral tablet 250 mg, 50 mg</i>	T1	
<b>Barbiturates (Anxiolytic, Sedative/Hyp)</b>		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>butalbital-apap-caffeine</i> (Bac Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral tablet 16.2 mg</i>	T1	
<i>phenobarbital oral elixir 20 mg/5ml</i>	T1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	T1	
<i>phenobarbital-belladonna alk oral elixir 16.2 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>pb-hyoscy-atropine-scopolamine</i></b> (Phenoxytro Oral Tablet 16.2 Mg)	T1	
<b>Benzodiazepines (Anticonvulsants)</b>		
<b><i>clobazam oral tablet 10 mg, 20 mg</i></b>	T1	QL (60 EA per 30 days)
<b><i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i></b>	T1	
<b><i>diazepam</i></b> (Diazepam Intensol Oral Concentrate 5 Mg/ML)	T1	
<b><i>diazepam oral concentrate 5 mg/ml</i></b>	T1	
<b><i>diazepam oral solution 5 mg/5ml</i></b>	T1	
<b><i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i></b>	T1	
<b><i>lorazepam</i></b> (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	T1	
<b><i>lorazepam oral concentrate 2 mg/ml</i></b>	T1	
<b><i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b>Benzodiazepines (Anxiolytic, Sedativ/Hyp)</b>		
<b><i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i></b>	T1	
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML ( <b><i>alprazolam</i></b> )	T1	
<b><i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i></b>	T1	PA
<b><i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i></b>	T1	
<b><i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i></b>	T1	
<b><i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i></b>	T1	
<b><i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i></b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobazam oral tablet 10 mg, 20 mg</i>	T1	QL (60 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	T1	
<i>diazepam</i> (Diazepam Intensol Oral Concentrate 5 Mg/ML)	T1	
<i>diazepam oral concentrate 5 mg/ml</i>	T1	
<i>diazepam oral solution 5 mg/5ml</i>	T1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	T1	
<i>estazolam oral tablet 1 mg, 2 mg</i>	T1	
<i>lorazepam</i> (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	T1	
<i>lorazepam oral concentrate 2 mg/ml</i>	T1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	T1	PA
<i>temazepam oral capsule 15 mg, 30 mg</i>	T1	
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	T1	PA
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	T1	
<b>Butyrophenones</b>		
<i>haloperidol decanoate intramuscular solution 50 mg/ml</i>	T1	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	T1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	T1	
<b>Calcitonin Gene-Related Peptide Antag.</b>		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML ( <i>erenumab-aooe</i> )	T1	PA
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML ( <i>fremanezumab-vfrm</i> )	T1	PA
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML ( <i>fremanezumab-vfrm</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UBRELVY ORAL TABLET 100 MG, 50 MG ( <i>ubrogepant</i> )	T1	PA
<b>Catechol-O-Methyltransferase(Comt)Inhib.</b>		
<i>entacapone oral tablet 200 mg</i>	T1	
<i>tolcapone oral tablet 100 mg</i>	T1	
<b>Central Nervous System Agents, Misc.</b>		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	T1	
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 80 mg</i>	T1	
<i>atomoxetine hcl oral capsule 60 mg</i>	T1	PA
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg &amp; 21 x 10 mg, 5 mg</i>	T1	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG ( <i>viloxazine hcl</i> )	T1	PA
<i>riluzole oral tablet 50 mg</i>	T1	
<b>Cyclooxygenase-2 (Cox-2) Inhibitors</b>		
<i>celecoxib oral capsule 100 mg, 200 mg</i>	T1	
<i>celecoxib oral capsule 400 mg, 50 mg</i>	T1	PA
<b>Dibenzoxapines</b>		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	T1	
<b>Diphenylbutylperidines</b>		
<i>pimozide oral tablet 1 mg, 2 mg</i>	T1	
<b>Dopamine Precursors</b>		
<i>carbidopa oral tablet 25 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i></b>	T1	
<b><i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i></b>	T1	
<b><i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i></b>	T1	
<b>Ergot-Deriv. Dopamine Receptor Agonists</b>		
<b><i>bromocriptine mesylate oral capsule 5 mg</i></b>	T1	
<b><i>bromocriptine mesylate oral tablet 2.5 mg</i></b>	T1	
<b><i>cabergoline oral tablet 0.5 mg</i></b>	T1	
<b>Fibromyalgia Agents</b>		
<b><i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i></b>	T1	QL (60 EA per 30 days)
<b><i>duloxetine hcl oral capsule delayed release particles 40 mg</i></b>	T1	PA
<b><i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i></b>	T1	
<b><i>pregabalin oral solution 20 mg/ml</i></b>	T1	ST
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG ( <i>milnacipran hcl</i> )	T1	QL (60 EA per 30 days)
<b>Gaba-Mediated Anticonvulsants</b>		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG ( <i>divalproex sodium</i> )	T1	
<b><i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i></b>	T1	
<b><i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i></b>	T1	
<b><i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i></b>	T1	
<b><i>gabapentin oral solution 250 mg/5ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i><b>gabapentin oral tablet 600 mg, 800 mg</b></i>	T1	
<i><b>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</b></i>	T1	
<i><b>pregabalin oral solution 20 mg/ml</b></i>	T1	ST
<i><b>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</b></i>	T1	
<i><b>valproic acid oral solution 250 mg/5ml</b></i>	T1	
Hydantoins		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG ( <i><b>phenytoin</b></i> )	T1	
DILANTIN ORAL CAPSULE 100 MG, 30 MG ( <i><b>phenytoin sodium extended</b></i> )	T1	
DILANTIN ORAL SUSPENSION 125 MG/5ML ( <i><b>phenytoin</b></i> )	T1	
<i><b>phenytoin</b></i> (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	T1	
<i><b>phenytoin oral suspension 125 mg/5ml</b></i>	T1	
<i><b>phenytoin oral tablet chewable 50 mg</b></i>	T1	
<i><b>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</b></i>	T1	
Ion Channel Inhibition Agents		
<i><b>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</b></i>	T1	
<i><b>oxcarbazepine oral suspension 300 mg/5ml</b></i>	T1	
<i><b>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</b></i>	T1	
<i><b>rufinamide oral tablet 200 mg, 400 mg</b></i>	T1	PA
<i><b>zonisamide oral capsule 100 mg, 25 mg, 50 mg</b></i>	T1	
Monoamine Oxidase B Inhibitors		
<i><b>rasagiline mesylate oral tablet 0.5 mg, 1 mg</b></i>	T1	PA
<i><b>selegiline hcl oral capsule 5 mg</b></i>	T1	
<i><b>selegiline hcl oral tablet 5 mg</b></i>	T1	
Monoamine Oxidase Inhibitors		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenelzine sulfate oral tablet 15 mg</i>	T1	PA
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	T1	PA
<i>selegiline hcl oral capsule 5 mg</i>	T1	
<i>selegiline hcl oral tablet 5 mg</i>	T1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	T1	PA
<b>Non-Benzodiazepine Anxiolytics</b>		
<i>bupirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	T1	PA
<b>Non-Benzodiazepine Hypnotics</b>		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	T1	
<i>zaleplon oral capsule 10 mg</i>	T1	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
<b>Nonergot-Deriv.Dopamine Receptor Agonist</b>		
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	T1	
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	T1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	T1	
<b>Non-Opioid Analgesics</b>		
<i>8 hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen 8 hour oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	T1	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen er oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>acetaminophen extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	T1	
<i>acetaminophen oral liquid 160 mg/5ml</i>	T1	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	T1	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	T1	
<i>acetaminophen oral tablet 325 mg</i>	T1	
<i>acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>acetaminophen oral tablet chewable 160 mg</i>	T1	QL (750 EA per 30 days)
<i>acetaminophen rectal suppository 120 mg, 650 mg</i>	T1	
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)
APHEN ORAL TABLET 325 MG ( <i>acetaminophen</i> )	T1	
<i>arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>butalbital-apap-caffeine</i> (Bac Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>betatemp childrens oral suspension 160 mg/5ml</i>	T1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>childrens apap oral tablet chewable 80 mg</i>	T1	
<i>childrens non-aspirin oral tablet chewable 80 mg</i>	T1	
<i>cvs 8hr arthritis pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cvs 8hr muscle aches &amp; pain oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>cvs acetaminophen ex st oral liquid 500 mg/15ml</i></b>	T1	
<b><i>cvs acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>cvs acetaminophen oral tablet 325 mg</i></b>	T1	
<b><i>cvs arthritis pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>cvs fever reducing childrens rectal suppository 120 mg</i></b>	T1	
<b><i>cvs pain &amp; fever childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>cvs pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>cvs pain relief childrens oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>cvs pain relief extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>ed-apap oral liquid 160 mg/5ml</i></b>	T1	
<b><i>oxycodone-acetaminophen</i></b> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<b><i>oxycodone-acetaminophen</i></b> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<b><i>eq 8hr arthritis pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>eq acetaminophen oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq arthritis pain oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>eq pain &amp; fever childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain &amp; fever childrens oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>eq pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>eq pain relief/rapid burst oral liquid 500 mg/15ml</i></b>	T1	
<b><i>eq pain reliever ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eq pain reliever oral tablet 325 mg</i></b>	T1	
<b><i>eq pain reliever oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>eql acetaminophen childrens oral suspension 160 mg/5ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>eql acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG ( <b><i>acetaminophen</i></b> )	T1	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG ( <b><i>acetaminophen</i></b> )	T1	
<b><i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>gnp acetaminophen oral tablet 325 mg</i></b>	T1	
<b><i>gnp acetaminophen oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>gnp children's pain &amp; fever oral suspension 160 mg/5ml</i></b>	T1	
<b><i>gnp infants pain/fever oral suspension 160 mg/5ml</i></b>	T1	
<b><i>gnp pain &amp; fever childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>gnp pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>gnp pain relief extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>gnp pain relief oral tablet 325 mg</i></b>	T1	
<b><i>goodsense arthritis pain oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>goodsense pain &amp; fever child oral suspension 160 mg/5ml</i></b>	T1	
<b><i>goodsense pain &amp; fever infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>goodsense pain relief extra st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>goodsense pain relief oral tablet 325 mg</i></b>	T1	
HEALTHY MAMA SHAKE THAT ACHE ORAL TABLET 500 MG ( <b><i>acetaminophen</i></b> )	T1	QL (240 EA per 30 days)
<b><i>hm pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>infants pain &amp; fever oral suspension 160 mg/5ml</i>	T1	
<i>kls acetaminophen ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>liquid acetaminophen oral liquid 160 mg/5ml</i>	T1	
<i>liquid pain relief oral liquid 160 mg/5ml</i>	T1	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG ( <i>acetaminophen</i> )	T1	QL (750 EA per 30 days)
<i>mapap oral capsule 500 mg</i>	T1	
MM ACETAMINOPHEN EX STR ORAL TABLET 500 MG ( <i>acetaminophen</i> )	T1	QL (240 EA per 30 days)
<i>m-pap oral liquid 160 mg/5ml</i>	T1	
<i>non-aspirin extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>non-aspirin oral tablet 325 mg</i>	T1	
<i>non-aspirin oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>non-aspirin pain relief oral tablet 325 mg</i>	T1	
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
<i>pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>pain &amp; fever kids oral suspension 160 mg/5ml</i>	T1	
<i>pain relief childrens oral elixir 160 mg/5ml</i>	T1	
<i>pain relief childrens oral suspension 160 mg/5ml</i>	T1	
<i>pain relief extra strength oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>pain relief oral liquid 500 mg/15ml</i>	T1	
<i>pain relief regular strength oral tablet 325 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>pain reliever extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>pain reliever oral tablet 325 mg</i></b>	T1	
<b><i>pain reliever/fever reducer rectal suppository 120 mg</i></b>	T1	
PEDIACARE CHILDREN ORAL SUSPENSION 160 MG/5ML ( <b><i>acetaminophen</i></b> )	T1	
PERCOGESIC ORAL TABLET 12.5-325 MG ( <b><i>diphenhydramine-acetaminophen</i></b> )	T1	
PHARBETOL ORAL TABLET 325 MG ( <b><i>acetaminophen</i></b> )	T1	
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML ( <b><i>ziconotide acetate</i></b> )	T1	
<b><i>qc acetaminophen 8 hours oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>qc acetaminophen infants oral suspension 160 mg/5ml</i></b>	T1	
<b><i>qc arthritis pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>qc non-aspirin extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>qc pain relief childrens oral suspension 160 mg/5ml</i></b>	T1	
<b><i>qc pain relief extra strength oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>qc pain relief oral tablet 325 mg</i></b>	T1	
<b><i>ra 8 hour pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>ra acetaminophen childrens oral tablet chewable 160 mg</i></b>	T1	QL (750 EA per 30 days)
<b><i>ra acetaminophen ex st oral tablet 500 mg</i></b>	T1	QL (240 EA per 30 days)
<b><i>ra acetaminophen oral tablet 325 mg</i></b>	T1	
<b><i>ra arthritis pain relief oral tablet extended release 650 mg</i></b>	T1	QL (180 EA per 30 days)
<b><i>ra childrens fever/pain oral suspension 160 mg/5ml</i></b>	T1	
<b><i>ra fever reducer/pain reliever oral suspension 160 mg/5ml</i></b>	T1	
<b><i>ra pain relief acetaminophen oral tablet 325 mg</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra pain relief acetaminophen oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	T1	QL (180 EA per 30 days)
<i>sm pain &amp; fever childrens oral suspension 160 mg/5ml</i>	T1	
<i>sm pain &amp; fever infants oral suspension 160 mg/5ml</i>	T1	
<i>sm pain reliever ex st oral tablet 500 mg</i>	T1	QL (240 EA per 30 days)
<i>sm pain reliever oral tablet 325 mg</i>	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
<b>Nonsteroidal Anti-Inflamm. Agents, Misc</b>		
<i>childrens ibuprofen 100 oral suspension 100 mg/5ml</i>	T1	
<i>childrens ibuprofen oral suspension 100 mg/5ml, 200 mg/10ml</i>	T1	
<i>cvs childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>cvs ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>diclofenac epolamine external patch 1.3 %</i>	T1	PA
<i>diclofenac potassium oral tablet 50 mg</i>	T1	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	T1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	T1	
<i>diflunisal oral tablet 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>eq ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>eql childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	T1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	T1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>fenoprofen calcium oral capsule 200 mg</i>	T1	PA
<i>fenoprofen calcium oral tablet 600 mg</i>	T1	
<i>flurbiprofen oral tablet 100 mg</i>	T1	PA
<i>gnp childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>goodsense ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>hm ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i>	T1	
<i>ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	T1	
<i>ketoprofen oral capsule 50 mg</i>	T1	PA
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	T1	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	T1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>oxaprozin oral tablet 600 mg</i>	T1	QL (90 EA per 30 days)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	T1	
<i>qc childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ra ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>sm childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	T1	
<b>Opioid Agonists (28:08)</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	T1	
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i>	T1	
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	T1	PA
<i>fentanyl-bupivacaine-nacl epidural solution 0.2-0.1-0.9 mg/100ml-%, 0.2-0.125-0.9 mg/100ml-%, 0.5-0.1-0.9 mg/250ml-%, 0.5-0.125-0.9 mg/250ml-%</i>	T1	
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i></b>	T1	
<b><i>hydromorphone hcl oral liquid 1 mg/ml</i></b>	T1	
<b><i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i></b>	T1	
<b><i>hydromorphone hcl rectal suppository 3 mg</i></b>	T1	
<b><i>levorphanol tartrate oral tablet 2 mg</i></b>	T1	PA
<b><i>meperidine hcl oral solution 50 mg/5ml</i></b>	T1	PA
<b><i>meperidine hcl oral tablet 50 mg</i></b>	T1	PA
<b><i>methadone hcl</i></b> (Methadone Hcl Intensol Oral Concentrate 10 Mg/ML)	T1	
<b><i>methadone hcl oral concentrate 10 mg/ml</i></b>	T1	
<b><i>methadone hcl oral solution 10 mg/5ml, 5 mg/5ml</i></b>	T1	
<b><i>methadone hcl oral tablet 10 mg, 5 mg</i></b>	T1	
<b><i>methadone hcl oral tablet soluble 40 mg</i></b>	T1	
<b><i>morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml</i></b>	T1	
<b><i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	PA
<b><i>morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i></b>	T1	PA
<b><i>morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg</i></b>	T1	
<b><i>morphine sulfate oral solution 10 mg/5ml</i></b>	T1	
<b><i>morphine sulfate oral tablet 15 mg, 30 mg</i></b>	T1	
<b><i>morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i></b>	T1	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG ( <b><i>tapentadol hcl</i></b> )	T1	PA
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG ( <b><i>tapentadol hcl</i></b> )	T1	PA

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	T1	PA
<i>oxycodone hcl oral solution 5 mg/5ml</i>	T1	PA
<i>oxycodone hcl oral tablet 15 mg, 20 mg, 30 mg</i>	T1	PA
<i>oxycodone hcl oral tablet 5 mg</i>	T1	
<i>oxycodone hcl oral tablet abuse-deterrent 5 mg</i>	T1	PA
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
<i>tramadol hcl oral tablet 50 mg</i>	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
<b>Opioid Antagonists (28:10)</b>		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	T1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML ( <i>naloxone hcl</i> )	T1	QL (4 EA per 180 days)
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	QL (2 ML per 180 days)
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	T1	QL (4 EA per 180 days)
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	T1	PA
RELISTOR ORAL TABLET 150 MG ( <i>methylnaltrexone bromide</i> )	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	T1	PA
REXTOVY NASAL LIQUID 4 MG/0.25ML ( <i>naloxone hcl</i> )	T1	QL (4 EA per 180 days)
RIVIVE NASAL LIQUID 3 MG/0.1ML ( <i>naloxone hcl</i> )	T1	QL (4 EA per 180 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML ( <i>naloxone hcl</i> )	T1	QL (1 ML per 180 days)
<b>Opioid Partial Agonists</b>		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	T1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	T1	PA
<b>Orexin Receptor Antagonists</b>		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG ( <i>suvorexant</i> )	T1	PA
DAYVIGO ORAL TABLET 10 MG, 5 MG ( <i>lemborexant</i> )	T1	PA
QUVIVIQ ORAL TABLET 25 MG, 50 MG ( <i>daridorexant hcl</i> )	T1	PA
<b>Phenothiazines</b>		
<i>chlorpromazine hcl oral concentrate 100 mg/ml</i>	T1	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	T1	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	T1	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	T1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	T1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	T1	
<i>prochlorperazine rectal suppository 25 mg</i>	T1	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<b>Respiratory And Cns Stimulants</b>		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 80 mg</i>	T1	
<i>atomoxetine hcl oral capsule 60 mg</i>	T1	PA
<i>butalbital-apap-caffeine</i> (Bac Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 15 mg, 20 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	T1	
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 50 mg, 60 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg, 72 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	T1	QL (450 ML per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	T1	QL (900 ML per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG ( <i>ergotamine-caffeine</i> )	T1	
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Oral Tablet 50-770-60 Mg)	T1	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG ( <i>viloxazine hcl</i> )	T1	PA
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Reversible Cox-1/Cox-2 Inhibitors		
<i>childrens ibuprofen 100 oral suspension 100 mg/5ml</i>	T1	
<i>childrens ibuprofen oral suspension 100 mg/5ml, 200 mg/10ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>cvs ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>diflunisal oral tablet 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>eq ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>eql childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	T1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	T1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	T1	
<i>fenoprofen calcium oral capsule 200 mg</i>	T1	PA
<i>fenoprofen calcium oral tablet 600 mg</i>	T1	
<i>flurbiprofen oral tablet 100 mg</i>	T1	PA
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	T1	
<i>gnp childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>goodsense ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>hm ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i>	T1	
<i>ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	T1	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	T1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>oxaprozin oral tablet 600 mg</i>	T1	QL (90 EA per 30 days)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	T1	
<i>qc childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ra ibuprofen childrens oral suspension 100 mg/5ml</i>	T1	
<i>sm childrens ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	T1	
<b>Salicylates</b>		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet 325 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>aspirin rectal suppository 300 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
BAYER ADVANCED ASPIRIN EX ST ORAL TABLET 500 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG ( <i>aspirin</i> )	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin oral tablet 325 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs genuine aspirin oral tablet 325 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG ( <i>aspirin</i> )	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eq aspirin oral tablet 325 mg</i>	T1	
<i>eql aspirin ec oral tablet delayed release 325 mg</i>	T1	
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet 325 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>goodsense aspirin adults oral tablet 325 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet 325 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>hm adult aspirin oral tablet 325 mg</i>	T1	
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG ( <i>aspirin</i> )	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine</i> (Orphengesic Forte Oral Tablet 50-770-60 Mg)	T1	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin oral tablet 325 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>qc aspirin oral tablet delayed release 325 mg</i>	T1	
<i>qc enteric aspirin oral tablet delayed release 325 mg</i>	T1	
<i>ra aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin adult low strength oral tablet chewable 81 mg</i>	T1	
<i>ra aspirin ec adult low st oral tablet delayed release 81 mg</i>	T1	
<i>ra aspirin ec oral tablet delayed release 325 mg, 81 mg</i>	T1	
<i>ra aspirin oral tablet 325 mg</i>	T1	
<i>salsalate oral tablet 500 mg, 750 mg</i>	T1	
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	T1	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
<b>Sel.Serotonin,Norepi Reuptake Inhibitor</b>		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	T1	QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	T1	PA
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG ( <i>milnacipran hcl</i> )	T1	QL (60 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	T1	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	T1	
<b>Selective Serotonin Agonists</b>		
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	T1	ST; QL (12 EA per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	T1	QL (12 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i><b>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</b></i>	T1	QL (12 EA per 30 days)
<i><b>sumatriptan succinate oral tablet 100 mg, 50 mg</b></i>	T1	QL (18 EA per 30 days)
<i><b>sumatriptan succinate oral tablet 25 mg</b></i>	T1	QL (12 EA per 30 days)
<i><b>sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml</b></i>	T1	PA
<i><b>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</b></i>	T1	PA
<b>Selective-Serotonin Reuptake Inhibitors</b>		
<i><b>citalopram hydrobromide oral solution 10 mg/5ml</b></i>	T1	QL (900 ML per 30 days)
<i><b>citalopram hydrobromide oral tablet 10 mg, 20 mg</b></i>	T1	QL (90 EA per 30 days)
<i><b>citalopram hydrobromide oral tablet 40 mg</b></i>	T1	QL (45 EA per 30 days)
<i><b>escitalopram oxalate oral solution 5 mg/5ml</b></i>	T1	
<i><b>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</b></i>	T1	
<i><b>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</b></i>	T1	
<i><b>fluoxetine hcl oral capsule delayed release 90 mg</b></i>	T1	PA
<i><b>fluoxetine hcl oral solution 20 mg/5ml</b></i>	T1	
<i><b>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</b></i>	T1	
<i><b>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</b></i>	T1	PA
<i><b>paroxetine hcl oral suspension 10 mg/5ml</b></i>	T1	
<i><b>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</b></i>	T1	
<i><b>sertraline hcl oral concentrate 20 mg/ml</b></i>	T1	
<i><b>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</b></i>	T1	
<b>Serotonin Modulators</b>		
<i><b>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</b></i>	T1	
<i><b>mirtazapine oral tablet dispersible 15 mg, 30 mg</b></i>	T1	
<i><b>mirtazapine oral tablet dispersible 45 mg</b></i>	T1	PA
<i><b>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</b></i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	T1	
<b>Succinimides</b>		
<i>ethosuximide oral capsule 250 mg</i>	T1	
<i>ethosuximide oral solution 250 mg/5ml</i>	T1	
<b>Thioxanthenes</b>		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<b>Tricyclics, Other Norepi-Ru Inhibitors</b>		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	T1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	T1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	T1	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	T1	
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	T1	PA
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	T1	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	T1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	T1	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<b>Vesicular Monoamine Transport2 Inhibitor</b>		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG ( <i>deutetrabenazine</i> )	T1	PA
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG ( <i>deutetrabenazine</i> )	T1	PA
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG ( <i>deutetrabenazine</i> )	T1	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG ( <i>valbenazine tosylate</i> )	T1	PA
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG ( <i>valbenazine tosylate</i> )	T1	PA
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	T1	PA
<b>Wakefulness-Promoting Agents</b>		
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	T1	
<i>modafinil oral tablet 100 mg, 200 mg</i>	T1	PA
<b>Dental Agents</b>		
<b>Dental Agents</b>		
<i>sodium fluoride</i> (Denta 5000 Plus Dental Cream 1.1 %)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PERIOMED MOUTH/THROAT CONCENTRATE 0.63 % ( <i>stannous fluoride</i> )	T1	
PREVIDENT DENTAL GEL 1.1 % ( <i>sodium fluoride</i> )	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	T1	
Nutritional Supplements		
<i>sodium fluoride</i> (Denta 5000 Plus Dental Cream 1.1 %)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PERIOMED MOUTH/THROAT CONCENTRATE 0.63 % ( <i>stannous fluoride</i> )	T1	
PREVIDENT DENTAL GEL 1.1 % ( <i>sodium fluoride</i> )	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	T1	
Devices		
Devices		
ACCU-CHEK SOFTCLIX LANCETS ( <i>lancets</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs <b>UPPERCASE =</b> Brand name drugs		<b>AL =</b> Age Limit <b>PA =</b> Prior Authorization <b>QL =</b> Quantity Limit <b>ST =</b> Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE AEROSOL CLOUD ENHANCER ( <i>respiratory therapy supplies</i> )	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU LARGE ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
AIRZONE PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	T1	QL (2 EA per 365 days)
AQUALANCE LANCETS 30G ( <i>lancets</i> )	T1	
BD DISP NEEDLE 23G X 1" ( <i>needle (disp)</i> )	T1	
BD DISP NEEDLES 18G X 1-1/2" , 25G X 5/8" ( <i>needle (disp)</i> )	T1	
BD INSULIN SYRINGE 29G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
BD INSULIN SYRINGE U/F 30G X 1/2" 0.5 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
BD INTEGRA SYRINGE 21G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML ( <i>syringe/needle (disp)</i> )	T1	
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 3 ML, 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML ( <i>syringe/needle (disp)</i> )	T1	
BD PEN NEEDLE MINI U/F 31G X 5 MM ( <i>insulin pen needle</i> )	T1	
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM ( <i>insulin pen needle</i> )	T1	
BD PEN NEEDLE NANO U/F 32G X 4 MM ( <i>insulin pen needle</i> )	T1	
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM ( <i>insulin pen needle</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD PEN NEEDLE SHORT U/F 31G X 8 MM ( <i>insulin pen needle</i> )	T1	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML ( <i>syringe/needle (disp)</i> )	T1	
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML ( <i>syringe/needle (disp)</i> )	T1	
BD TB SYRINGE 27G X 1/2" 1 ML ( <i>tuberculin-allergy syringes</i> )	T1	
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
COMFORT EZ PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	T1	
DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML, 31G X 15/64" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
DROPLET MICRON 34G X 3.5 MM ( <i>insulin pen needle</i> )	T1	
DROPLET PEN NEEDLES 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM ( <i>insulin pen needle</i> )	T1	
EASIVENT ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
<i>easy comfort lancets</i>	T1	
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML ( <i>insulin syringe-needle u-100</i> )	T1	
EASY TOUCH PEN NEEDLES 31G X 5 MM , 31G X 8 MM ( <i>insulin pen needle</i> )	T1	
EMBRACE LANCETS ULTRA THIN 30G ( <i>lancets</i> )	T1	
<i>eq space chamber anti-static device</i>	T1	QL (2 EA per 365 days)
FREESTYLE LANCETS ( <i>lancets</i> )	T1	
FREESTYLE LIBRE 14 DAY READER DEVICE ( <i>continuous glucose receiver</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 14 DAY SENSOR ( <i>continuous glucose sensor</i> )	T1	PA
FREESTYLE LIBRE 2 READER DEVICE ( <i>continuous glucose receiver</i> )	T1	PA
FREESTYLE LIBRE 2 SENSOR ( <i>continuous glucose sensor</i> )	T1	PA
FREESTYLE LIBRE 3 PLUS SENSOR ( <i>continuous glucose sensor</i> )	T1	PA
FREESTYLE LIBRE 3 READER DEVICE ( <i>continuous glucose receiver</i> )	T1	PA
FREESTYLE LIBRE 3 SENSOR ( <i>continuous glucose sensor</i> )	T1	PA
<i>insulin syringe 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 1 ml</i>	T1	
<i>lancets micro thin 33g</i>	T1	
<i>lancets super thin 28g</i>	T1	
<i>lancets ultra thin 30g</i>	T1	
<i>lancing device</i>	T1	
MICROCHAMBER ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
MICROLET LANCETS ( <i>lancets</i> )	T1	
NOVOFINE PEN NEEDLE 32G X 6 MM ( <i>insulin pen needle</i> )	T1	
ONETOUCH DELICA PLUS LANCET30G ( <i>lancets</i> )	T1	
ONETOUCH DELICA PLUS LANCET33G ( <i>lancets</i> )	T1	
OPTICHAMBER DIAMOND ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-LG MASK DEVICE ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-MD MASK ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTICHAMBER DIAMOND-SM MASK ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
PEAK AIR PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	T1	QL (2 EA per 365 days)
POCKET CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
POCKET PEAK FLOW METER DEVICE ( <i>peak flow meter</i> )	T1	QL (2 EA per 365 days)
RELION TRUE MET AIR GLUC METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	T1	QL (100 EA per 90 days)
<i>sure comfort insulin syringe 28g x 1/2" 1 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml</i>	T1	
<i>sure comfort lancets 30g</i>	T1	
<i>sure comfort pen needles 31g x 8 mm</i>	T1	
<i>techlite insulin syringe 31g x 5/16" 0.3 ml</i>	T1	
TECHLITE PEN NEEDLES 31G X 8 MM ( <i>insulin pen needle</i> )	T1	
TRUE METRIX AIR GLUCOSE METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	T1	QL (1 EA per 365 days)
TRUE METRIX METER KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	T1	QL (1 EA per 365 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	T1	
TRUEPLUS LANCETS 28G ( <i>lancets</i> )	T1	
TRUEPLUS LANCETS 30G ( <i>lancets</i> )	T1	
TRUEPLUS LANCETS 33G ( <i>lancets</i> )	T1	
TRUEPLUS SAFETY LANCETS 28G ( <i>lancets</i> )	T1	
TRUETRACK BLOOD GLUCOSE KIT W/DEVICE ( <i>blood glucose monitoring suppl</i> )	T1	QL (1 EA per 365 days)
ULTICARE MICRO PEN NEEDLES 32G X 4 MM ( <i>insulin pen needle</i> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Drug Tier</b> T1 = Formulary Medication	<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNIFINE PENTIPS PLUS 31G X 8 MM ( <i>insulin pen needle</i> )	T1	
VORTEX VALVED HOLDING CHAMBER DEVICE ( <i>spacer/aero-holding chambers</i> )	T1	QL (2 EA per 365 days)
WALGREENS ULTRA THIN LANCETS ( <i>lancets</i> )	T1	
<b>Diagnostic Agents</b>		
<b>Adrenocortical Insufficiency</b>		
ACTHAR GEL SUBCUTANEOUS AUTO-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
ACTHAR INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
<b>Cardiac Function</b>		
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
<b>Diabetes Mellitus</b>		
<i>blood glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>blood glucose test strips 333 in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>cvs glucose meter test strips in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>diatrue plus test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>easy plus ii glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>easy talk blood glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>ge100 blood glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>ght test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>glucose meter test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>gnp easy touch glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>goodsense blood glucose in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>kroger blood glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>kroger premium glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)
<i>meijer blood glucose test in vitro strip</i>	T1	QL (100 EA per 90 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> = Generic drugs		AL = Age Limit
<b>UPPERCASE</b> = Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>pharmacist choice no coding in vitro strip</i></b>	T1	QL (100 EA per 90 days)
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP ( <b><i>glucose blood</i></b> )	T1	QL (100 EA per 90 days)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP ( <b><i>glucose blood</i></b> )	T1	QL (100 EA per 90 days)
TRUE METRIX PRO BLOOD GLUCOSE IN VITRO STRIP ( <b><i>glucose blood</i></b> )	T1	QL (100 EA per 90 days)
TRUETRACK TEST IN VITRO STRIP ( <b><i>glucose blood</i></b> )	T1	QL (100 EA per 90 days)
<b>Diagnostic Agents</b>		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
CARESTART COVID-19 HOME TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
<b><i>ellume covid-19 home test in vitro kit</i></b>	T1	QL (8 EA per 30 days)
<b><i>fastep covid-19 antigen test in vitro kit</i></b>	T1	QL (8 EA per 30 days)
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
IHEALTH COVID-19 RAPID TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
LUCIRA CHECK IT COVID-19 TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT ( <b><i>covid-19 at home test</i></b> )	T1	QL (8 EA per 30 days)
<b>Myasthenia Gravis</b>		
<b><i>neostigmine methylsulfate intravenous solution prefilled syringe 3 mg/3ml</i></b>	T1	PA
<b>Pheochromocytoma</b>		
<b><i>metirosine oral capsule 250 mg</i></b>	T1	
<b>Electrolytic, Caloric, And Water Balance</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Acidifying Agents</b>		
K-PHOS NO 2 ORAL TABLET 305-700 MG ( <i>pot &amp; sod ac phosphates</i> )	T1	
<b>Alkalinizing Agents</b>		
<i>cytra-2 oral solution 500-334 mg/5ml</i>	T1	
CYTRA-3 ORAL SYRUP 550-500-334 MG/5ML ( <i>pot &amp; sod cit-cit ac</i> )	T1	
<i>cytra-k oral solution 1100-334 mg/5ml</i>	T1	
ORACIT ORAL SOLUTION 490-640 MG/5ML ( <i>sod citrate-citric acid</i> )	T1	
<i>pot &amp; sod cit-cit ac oral solution 550-500-334 mg/5ml</i>	T1	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)</i>	T1	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	T1	
<i>sod citrate-citric acid oral solution 500-334 mg/5ml</i>	T1	
<i>tricitrates oral solution 550-500-334 mg/5ml</i>	T1	
<b>Ammonia Detoxicants</b>		
<i>constulose oral solution 10 gm/15ml</i>	T1	
<i>enulose oral solution 10 gm/15ml</i>	T1	
<i>generlac oral solution 10 gm/15ml</i>	T1	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	T1	
<i>lactulose oral solution 10 gm/15ml</i>	T1	
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	T1	
<i>sodium phenylbutyrate oral tablet 500 mg</i>	T1	
<b>Caloric Agents</b>		
<i>bupivacaine in dextrose intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine spinal intrathecal solution 0.75-8.25 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELLIOTTS B INTRATHECAL SOLUTION ( <i>intrathecal dextrose</i> )	T1	
I-VALEX-1 ORAL POWDER ( <i>nutritional supplements</i> )	T1	
<i>levocarnitine (dietary) oral tablet 330 mg</i>	T1	
NUTREN 2.0 ORAL LIQUID ( <i>nutritional supplements</i> )	T1	
NUTRIVIT ORAL LIQUID ( <i>b complex-lysine-min-fe-fa</i> )	T1	
RENASTART ORAL POWDER ( <i>nutritional supplements</i> )	T1	
TYR COOLER ORAL LIQUID ( <i>nutritional supplements</i> )	T1	
XTRACAL PLUS ORAL LIQUID ( <i>nutritional supplements</i> )	T1	
<b>Carbonic Anhydrase Inhibitors</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<b>Diuretics, Miscellaneous</b>		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
<b>Irrigating Solutions</b>		
<i>acetic acid glacial solution 99 %</i>	T1	
<i>acetic acid irrigation solution 0.25 %</i>	T1	
<i>acetic acid solution 5 %</i>	T1	
<i>sodium chloride (gu irrigant)</i> (Argyle Sterile Saline Irrigation Solution 0.9 %)	T1	
<i>glycine irrigation solution 1.5 %</i>	T1	
<i>glycine urologic irrigation solution 1.5 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lactated ringers irrigation solution</i>	T1	
<i>irrigation solns physiological</i> (Physiolyte Irrigation Solution)	T1	
<i>irrigation solns physiological</i> (Physiosol Irrigation Irrigation Solution)	T1	
<i>ringers irrigation irrigation solution</i>	T1	
<i>sodium chloride irrigation solution 0.9 %</i>	T1	
<i>sorbitol-mannitol irrigation solution 2.7-0.54 gm/100ml</i>	T1	
<i>sterile water for irrigation irrigation solution</i>	T1	
<i>water for irrigation, sterile irrigation solution</i>	T1	
<b>Loop Diuretics (40:28)</b>		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>ethacrynic acid oral tablet 25 mg</i>	T1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	T1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	T1	
<b>Phosphate-Removing Agents</b>		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	T1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	T1	
<i>calcium acetate oral tablet 667 mg</i>	T1	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	T1	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
<b>Potassium-Removing Agents</b>		
LOKELMA ORAL PACKET 10 GM, 5 GM ( <i>sodium zirconium cyclosilicate</i> )	T1	QL (30 EA per 30 days)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM ( <i>patiromer sorbitex calcium</i> )	T1	ST; QL (30 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Potassium-Sparing Diuretics</b>		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	T1	
<b>Replacement Preparations</b>		
<i>600+d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>actical oral capsule</i>	T1	
ADVANTAGE CARE ELECTROLYTE PED ORAL SOLUTION ( <i>oral electrolytes</i> )	T1	
<i>bupivacaine hcl-nacl epidural solution 0.125-0.9 %</i>	T1	
<i>cal-citrate plus vitamin d oral tablet 250-2.5 mg-mcg</i>	T1	
<i>calcium + vitamin d3 oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	T1	
<i>calcium 1000 + d oral tablet 1000-20 mg-mcg</i>	T1	
<i>calcium 500 + d oral tablet 500-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 500 + d3 oral tablet 500-15 mg-mcg</i>	T1	
<i>calcium 500/d oral tablet 500-5 mg-mcg</i>	T1	
<i>calcium 500+d high potency oral tablet 500-10 mg-mcg</i>	T1	
<i>calcium 500+d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 500+d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 600 + d oral tablet 600-5 mg-mcg</i>	T1	
<i>calcium 600 +d high potency oral tablet 600-10 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>calcium 600 high potency oral tablet 600 mg</i></b>	T1	
<b><i>calcium 600 oral tablet 1500 (600 ca) mg</i></b>	T1	
<b><i>calcium 600/vitamin d oral tablet 600-10 mg-mcg</i></b>	T1	
<b><i>calcium 600/vitamin d3 oral tablet 600-20 mg-mcg</i></b>	T1	
<b><i>calcium 600+d high potency oral tablet 600-10 mg-mcg</i></b>	T1	
<b><i>calcium 600+d oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i></b>	T1	
<b><i>calcium 600+d3 oral tablet 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i></b>	T1	
<b><i>calcium acetate (phos binder) oral capsule 667 mg</i></b>	T1	
<b><i>calcium acetate (phos binder) oral tablet 667 mg</i></b>	T1	
<b><i>calcium acetate oral tablet 667 mg</i></b>	T1	
<b><i>calcium carb-cholecalciferol oral tablet 500-10 mg-mcg, 500-5 mg-mcg, 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i></b>	T1	
<b><i>calcium carb-cholecalciferol oral tablet chewable 500-10 mg-mcg</i></b>	T1	
<b><i>calcium carbonate oral tablet 1250 (500 ca) mg, 1500 (600 ca) mg, 600 mg</i></b>	T1	
<b><i>calcium carbonate oral tablet chewable 1250 (500 ca) mg</i></b>	T1	
<b><i>calcium carbonate-vitamin d oral capsule 600-5 mg-mcg</i></b>	T1	
<b><i>calcium carbonate-vitamin d oral tablet 600-5 mg-mcg</i></b>	T1	
<b><i>calcium citrate + d oral tablet 250-5 mg-mcg, 315-5 mg-mcg</i></b>	T1	
<b><i>calcium citrate + d3 maximum oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>calcium citrate + d3 oral tablet 200-6.25 mg-mcg, 315-5 mg-mcg</i></b>	T1	
<b><i>calcium citrate malate-vit d oral tablet 250-2.5 mg-mcg</i></b>	T1	
<b><i>calcium citrate oral tablet 250 mg, 950 (200 ca) mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcium citrate plus/magnesium oral tablet</i>	T1	
<i>calcium citrate+d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	T1	
<i>calcium citrate-vitamin d oral tablet 200-3.125 mg-mcg, 315-5 mg-mcg</i>	T1	
<i>calcium citrate-vitamin d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>calcium for women oral tablet chewable 500-100-40</i>	T1	
<i>calcium high potency oral tablet 1500 (600 ca) mg</i>	T1	
<i>calcium high potency/vitamin d oral tablet 600-5 mg-mcg</i>	T1	
<i>calcium oral tablet chewable 500-2.5 mg-mcg</i>	T1	
<i>calcium plus vitamin d oral tablet 500-5 mg-mcg</i>	T1	
<i>calcium plus vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>calcium/c/d oral tablet chewable 500-10-250 mg-mg-unit</i>	T1	
<i>calcium+d3 oral tablet 500-10 mg-mcg, 500-15 mg-mcg, 600-20 mg-mcg</i>	T1	
<i>calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	T1	
<i>calcium-magnesium-zinc-d3 oral tablet</i>	T1	
<i>calcium-vitamin d3 oral capsule 600-10 mg-mcg</i>	T1	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg</i>	T1	
<i>centravites 50 plus oral tablet</i>	T1	
CITRACAL MAXIMUM ORAL TABLET 315-6.25 MG-MCG ( <i>calcium citrate-vitamin d</i> )	T1	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	T1	
<i>complete natal dha oral 29-1-200 &amp; 200 mg</i>	T1	
<i>coral calcium oral capsule 185-50-100 mg-mg-unit</i>	T1	
<i>cvs calcium + d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>cvs calcium 600 &amp; vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>cvs calcium 600+d oral tablet 600-20 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
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UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	T1	
<i>cvs calcium oral tablet 600 mg</i>	T1	
<i>cvs one daily essential oral tablet</i>	T1	
<i>cvs oyster shell calcium-vit d oral tablet 500-3.125 mg-mcg</i>	T1	
<i>cvs ped electrolyte freeze pop oral solution</i>	T1	
<i>cvs pediatric electrolyte oral solution</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG ( <b><i>b complex-c-biotin-e-min-fa</i></b> )	T1	
DIALYVITE/ZINC ORAL TABLET ( <b><i>b complex-c-zn-folic acid</i></b> )	T1	
<b><i>potassium bicarbonate</i></b> (Effer-K Oral Tablet Effervescent 25 Meq)	T1	
ELLIOTTS B INTRATHECAL SOLUTION ( <b><i>intrathecal electrodextrose</i></b> )	T1	
<i>eq calcium 500+d oral tablet 500-5 mg-mcg</i>	T1	
<i>eq calcium 600+d oral tablet 600-20 mg-mcg</i>	T1	
<i>eq calcium citrate+d oral tablet 315-6.25 mg-mcg</i>	T1	
<i>eql calcium citrate/vitamin d oral tablet 315-6.25 mg-mcg</i>	T1	
<i>eql calcium citrate/vitamin d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>eql calcium/vitamin d oral tablet 600-10 mg-mcg</i>	T1	
<i>eql calcium/vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>essential one daily multivit oral tablet</i>	T1	
<b><i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i></b>	T1	
<b><i>fentanyl-bupivacaine-nacl epidural solution 0.2-0.1-0.9 mg/100ml-%, 0.2-0.125-0.9 mg/100ml-%, 0.5-0.1-0.9 mg/250ml-%, 0.5-0.125-0.9 mg/250ml-%</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GALZIN ORAL CAPSULE 25 MG, 50 MG ( <i>zinc acetate (oral)</i> )	T1	PA
<i>gnp calcium 500 +d3 oral tablet 500-15 mg-mcg</i>	T1	
<i>gnp calcium 600 +d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>gnp calcium oral tablet 1500 (600 ca) mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE ( <i>pediatric multivit-minerals</i> )	T1	
<i>h-e-b oral electrolyte oral solution</i>	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
INFASURF INTRATRACHEAL SUSPENSION 35-0.9 MG/ML-% ( <i>calfactant in nacl</i> )	T1	
KINDERLYTE ORAL SOLUTION ( <i>oral electrolytes</i> )	T1	
KINDERLYTE PREMAX ORAL SOLUTION ( <i>oral electrolytes</i> )	T1	
<i>potassium chloride crys er</i> (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	T1	
<i>potassium chloride crys er</i> (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	T1	
<i>potassium bicarbonate</i> (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)	T1	
<i>kp calcium citrate+d oral tablet 315-6.25 mg-mcg</i>	T1	
K-PHOS ORAL TABLET 500 MG ( <i>potassium phosphate monobasic</i> )	T1	
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ ( <i>potassium chloride</i> )	T1	
<i>liquid calcium/vitamin d oral capsule 600-5 mg-mcg</i>	T1	
<i>magnesium chloride injection solution 200 mg/ml</i>	T1	
<i>magnesium oxide -mg supplement oral tablet 400 (240 mg) mg</i>	T1	
NUTRIVIT ORAL LIQUID ( <i>b complex-lysine-min-fe-fa</i> )	T1	

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UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORALYTE ORAL SOLUTION ( <i>oral electrolytes</i> )	T1	
OYSCO 500+D ORAL TABLET 500-5 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	T1	
<i>oyster shell calcium + d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium + d3 oral tablet 500-10 mg-mcg</i>	T1	
<i>oyster shell calcium oral tablet 500 mg</i>	T1	
<i>oyster shell calcium plus d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium w/d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/vit d3 oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/vitamin d oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>ped electrolyte freeze pops oral solution</i>	T1	
<i>ped electrolyte freezer pops oral solution</i>	T1	
<i>pediatric electrolyte oral solution</i>	T1	
<i>k phos mono-sod phos di &amp; mono</i> (Phospha 250 Neutral Oral Tablet 155-852-130 Mg)	T1	
<i>phosphorous oral tablet 155-852-130 mg</i>	T1	
<i>potassium phosphate monobasic</i> (Phospha-Trin K500 Oral Tablet 500 Mg)	T1	
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq</i>	T1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	T1	
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i></b>	T1	
<b><i>prenatal gummies/dha &amp; fa oral tablet chewable 0.4-32.5 mg</i></b>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG ( <b><i>prenatal mv-min-fe fum-fa-dha</i></b> )	T1	
<b><i>prenatal/iron oral tablet</i></b>	T1	
<b><i>pure calcium carbonate oral tablet 1500 (600 ca) mg</i></b>	T1	
<b><i>ra calcium 600 oral tablet 1500 (600 ca) mg</i></b>	T1	
<b><i>ra calcium 600/vit d/minerals oral tablet 600-200 mg-unit</i></b>	T1	
<b><i>ra calcium 600/vitamin d-3 oral tablet 600-10 mg-mcg</i></b>	T1	
<b><i>ra calcium cit plus vit d-3 oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>ra calcium cit-vit d-3 petites oral tablet 200-6.25 mg-mcg</i></b>	T1	
<b><i>ra calcium-boron oral tablet 500-1.5 mg</i></b>	T1	
RA HI CAL ORAL TABLET 500-5 MG-MCG ( <b><i>calcium carb-cholecalciferol</i></b> )	T1	
<b><i>ra pediatric electrolyte oral solution</i></b>	T1	
<b><i>saline bacteriostatic injection solution 0.9 %</i></b>	T1	
<b><i>sm calcium citrate+/vit d3 oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>sm calcium citrate+/vit d3 max oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>sm calcium/vitamin d oral tablet 500-5 mg-mcg</i></b>	T1	
<b><i>sm pediatric electrolyte oral solution</i></b>	T1	
<b><i>sodium chloride (pf) injection solution 0.9 %</i></b>	T1	
<b><i>sodium chloride bacteriostatic injection solution 0.9 %</i></b>	T1	
<b><i>sodium chloride injection solution 2.5 meq/ml</i></b>	T1	
<b><i>super calcium oral tablet 1500 (600 ca) mg</i></b>	T1	
<b><i>support oral liquid</i></b>	T1	
SUPPORT-500 ORAL CAPSULE ( <b><i>multiple vitamins-minerals</i></b> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>v-c forte oral capsule</i>	T1	
<i>multiple vitamins-minerals</i> (Vic-Forte Oral Capsule)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE ( <i>pediatric multivit-minerals</i> )	T1	
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	T1	
<b>Salt And Sugar Substitutes</b>		
<i>aspartame (for compounding) powder</i>	T1	
<b>Thiazide Diuretics</b>		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
DIURIL ORAL SUSPENSION 250 MG/5ML ( <i>chlorothiazide</i> )	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	

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lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i></b>	T1	
<b><i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i></b>	T1	
<b><i>spironolactone-hctz oral tablet 25-25 mg</i></b>	T1	
<b><i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i></b>	T1	PA
<b><i>triamterene-hctz oral capsule 37.5-25 mg</i></b>	T1	
<b><i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i></b>	T1	
<b><i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i></b>	T1	
<b>Thiazide-Like Diuretics</b>		
<b><i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i></b>	T1	
<b><i>chlorthalidone oral tablet 25 mg, 50 mg</i></b>	T1	
<b><i>indapamide oral tablet 1.25 mg, 2.5 mg</i></b>	T1	
<b><i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i></b>	T1	
THALITONE ORAL TABLET 15 MG ( <i>chlorthalidone</i> )	T1	
<b>Uricosuric Agents</b>		
<b><i>colchicine-probenecid oral tablet 0.5-500 mg</i></b>	T1	
<b><i>probenecid oral tablet 500 mg</i></b>	T1	
<b>Enzymes</b>		
<b>Enzyme Inhibitors</b>		
<b><i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i></b>	T1	
<b>Enzymes</b>		
AMPHADASE INJECTION SOLUTION 150 UNIT/ML ( <i>hyaluronidase bovine</i> )	T1	
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML ( <i>dornase alfa</i> )	T1	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM ( <i>collagenase</i> )	T1	
SUCRAID ORAL SOLUTION 8500 UNIT/ML ( <i>sacrosidase</i> )	T1	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	T1	
<b>Eye, Ear, Nose And Throat (Eent) Preps.</b>		
<b>Alpha-Adrenergic Agonists (Eent)</b>		
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	T1	
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	T1	PA
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	T1	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
IOPIDINE OPHTHALMIC SOLUTION 1 % ( <i>apraclonidine hcl</i> )	T1	
<b>Antiallergic Agents</b>		
<i>allergy eye ophthalmic solution 0.025-0.3 %</i>	T1	
ALOCRILOPHTHALMIC SOLUTION 2 % ( <i>nedocromil sodium</i> )	T1	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % ( <i>lodoxamide tromethamine</i> )	T1	PA
<i>azelastine hcl nasal solution 0.1 %, 0.15 %, 137 mcg/spray</i>	T1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	T1	QL (6 ML per 30 days)
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	T1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs allergy eye drops ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>cvs eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
<i>cvs eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>cvs olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>cvs olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>epinastine hcl ophthalmic solution 0.05 %</i>	T1	PA
<i>eq eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
<i>eye allergy itch relief ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>eye allergy itch/redness rel ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>eye allergy relief ophthalmic solution 0.025-0.3 %, 0.027-0.315 %</i>	T1	
<i>eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>gnp olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>gnp olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>ketotifen fumarate ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>olopatadine hcl ophthalmic solution 0.1 %</i>	T1	QL (5 ML per 25 days)
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>qc olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<i>ra eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
<i>ra eye itch relief ophthalmic solution 0.035 %</i>	T1	QL (10 ML per 30 days)
<i>sm olopatadine hcl ophthalmic solution 0.2 %</i>	T1	QL (2.5 ML per 25 days)
<b>Antibacterials (52:04)</b>		
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	T1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
CILOXAN OPHTHALMIC OINTMENT 0.3 % ( <i>ciprofloxacin hcl</i> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Drug Tier</b> T1 = Formulary Medication	<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CIPRO HC OTIC SUSPENSION 0.2-1 % ( <i>ciprofloxacin-hydrocortisone</i> )	T1	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	T1	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	T1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML ( <i>neomycin-colist-hc-thonzonium</i> )	T1	
<i>ery external pad 2 %</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	T1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	T1	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	T1	PA
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	T1	
<i>neomycin sulfate oral tablet 500 mg</i>	T1	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 % , 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	T1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic solution 1 % , 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	T1	
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ophthalmic Ointment 1 %)	T1	
<i>neomycin-bacitracin zn-polymyx</i> (Neo-Polycin Ophthalmic Ointment 3.5-400-10000)	T1	
<i>ofloxacin ophthalmic solution 0.3 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ofloxacin otic solution 0.3 %</i></b>	T1	
<b><i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i></b>	T1	
<b><i>sulfacetamide sodium ophthalmic ointment 10 %</i></b>	T1	
<b><i>sulfacetamide sodium ophthalmic solution 10 %</i></b>	T1	
<b><i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i></b>	T1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % ( <b><i>tobramycin-dexamethasone</i></b> )	T1	
<b><i>tobramycin inhalation nebulization solution 300 mg/5ml</i></b>	T1	PA
<b><i>tobramycin ophthalmic solution 0.3 %</i></b>	T1	
<b><i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i></b>	T1	
TOBREX OPHTHALMIC OINTMENT 0.3 % ( <b><i>tobramycin</i></b> )	T1	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % ( <b><i>loteprednol-tobramycin</i></b> )	T1	
<b>Antifungals (Eent)</b>		
NATACYN OPHTHALMIC SUSPENSION 5 % ( <b><i>natamycin</i></b> )	T1	
<b>Antiglaucoma Agents, Miscellaneous</b>		
<b><i>epinephrine injection solution 1 mg/ml</i></b>	T1	
<b><i>epinephrine pf injection solution 1 mg/ml</i></b>	T1	
<b>Anti-Infectives, Miscellaneous (52:04)</b>		
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % ( <b><i>povidone-iodine</i></b> )	T1	
<b><i>chlorhexidine gluconate mouth/throat solution 0.12 %</i></b>	T1	
<b><i>chlorhexidine gluconate</i></b> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<b><i>silver nitrate external solution 0.5 %</i></b>	T1	
<b>Anti-Inflammatory Agents (Eent)</b>		
CEQUA OPHTHALMIC SOLUTION 0.09 % ( <b><i>cyclosporine</i></b> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	T1	PA
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG ( <i>cyclosporine modified</i> )	T1	
NEORAL ORAL SOLUTION 100 MG/ML ( <i>cyclosporine modified</i> )	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG ( <i>cyclosporine</i> )	T1	
XIIDRA OPHTHALMIC SOLUTION 5 % ( <i>lifitegrast</i> )	T1	PA
<b>Antivirals (Eent)</b>		
<i>trifluridine ophthalmic solution 1 %</i>	T1	
<b>Astringents (52:04)</b>		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<b>Beta-Adrenergic Blocking Agents (Eent)</b>		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % ( <i>timolol hemihydrate</i> )	T1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % ( <i>betaxolol hcl</i> )	T1	PA
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
<i>carteolol hcl ophthalmic solution 1 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	T1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	T1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	T1	
<i>timolol maleate</i> (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)	T1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	T1	
<b>Carbonic Anhydrase Inhibitors (Eent)</b>		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<i>brinzolamide ophthalmic suspension 1 %</i>	T1	PA
<i>dorzolamide hcl ophthalmic solution 2 %</i>	T1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	T1	
<b>Corticosteroids (Eent)</b>		
<i>ala-cort external cream 1 %</i>	T1	
<i>allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>allergy spray 24 hour nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
ALREX OPHTHALMIC SUSPENSION 0.2 % ( <i>loteprednol etabonate</i> )	T1	
<i>anti-itch maximum strength external cream 1 %</i>	T1	
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % ( <i>hydrocortisone</i> )	T1	
AQUANIL HC EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
AQUAPHOR ITCH RELIEF MAX STR EXTERNAL OINTMENT 1 % ( <i>hydrocortisone</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i></b>	T1	
<b><i>beta hc external lotion 1 %</i></b>	T1	
<b><i>budesonide nasal suspension 32 mcg/act</i></b>	T1	QL (8.43 ML per 30 days)
CIPRO HC OTIC SUSPENSION 0.2-1 % ( <b><i>ciprofloxacin-hydrocortisone</i></b> )	T1	
<b><i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i></b>	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <b><i>hc-pramoxine-chloroxylonol</i></b> )	T1	
CORTIFOAM EXTERNAL FOAM 10 % ( <b><i>hydrocortisone acetate</i></b> )	T1	PA
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML ( <b><i>neomycin-colist-hc-thonzonium</i></b> )	T1	
CORTIZONE-10 EXTERNAL OINTMENT 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 FEMININE ITCH EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 INTENSIVE HEALING EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 INTENSIVE MOISTURE EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 OVERNIGHT EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 OVERNIGHT ITCH EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 PLUS EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 SENSITIVE SKIN EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	
CORTIZONE-10 SOOTHING ALOE EXTERNAL CREAM 1 % ( <b><i>hydrocortisone</i></b> )	T1	

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		Coverage Requirements and Limits
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Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIZONE-10 ULTRA SOOTHING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10/ALOE EXTERNAL LIQUID 1 % ( <i>hydrocortisone</i> )	T1	
<i>cvs budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>cvs cortisone maximum strength external cream 1 %</i>	T1	
<i>cvs cortisone maximum strength external gel 1 %</i>	T1	
<i>cvs cortisone maximum strength external ointment 1 %</i>	T1	
<i>cvs fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>cvs nasal allergy spray nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
DERMAREST ECZEMA EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	T1	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	T1	ST; QL (5 ML per 30 days)
<i>eq allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>eq hydrocortisone external cream 1 %</i>	T1	
<i>eq hydrocortisone max st external cream 1 %</i>	T1	
<i>eq nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>eql anti-itch intensive heal external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external ointment 1 %</i>	T1	
FLAREX OPHTHALMIC SUSPENSION 0.1 % ( <i>fluorometholone acetate</i> )	T1	
FLOXASE SENSIMIST CHILDRENS NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
FLOXASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinolone acetonide body external oil 0.01 %</i>	T1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	T1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	T1	
<i>fluocinolone acetonide external solution 0.01 %</i>	T1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	T1	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	T1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 GM per 30 days)
FML FORTE OPHTHALMIC SUSPENSION 0.25 % ( <i>fluorometholone</i> )	T1	
<i>gnp 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>gnp budesonide nasal spray nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>gnp fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>gnp hydrocortisone external cream 0.5 %</i>	T1	
<i>gnp hydrocortisone max st external ointment 1 %</i>	T1	
<i>gnp hydrocortisone plus external cream 1 %</i>	T1	
<i>gnp hydrocortisone/aloe external cream 1 %</i>	T1	
<i>goodsense nasal allergy spray nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	T1	
<i>hydrocortisone acetate external cream 1 %</i>	T1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone anti-itch external cream 1 %</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 0.5 %, 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external ointment 0.5 %, 1 %, 2.5 %</i>	T1	
<i>hydrocortisone max st external cream 1 %</i>	T1	
<i>hydrocortisone max st external ointment 1 %</i>	T1	
<i>hydrocortisone max st/12 moist external cream 1 %</i>	T1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone/aloe max str external cream 1 %</i>	T1	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	T1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % ( <i>dexamethasone</i> )	T1	
<i>nasal allergy 24 hour nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	T1	
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ophthalmic Ointment 1 %)	T1	
PANDEL EXTERNAL CREAM 0.1 % ( <i>hydrocortisone probutate</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRED MILD OPHTHALMIC SUSPENSION 0.12 % ( <i>prednisolone acetate</i> )	T1	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	T1	
<i>prednisolone oral solution 15 mg/5ml</i>	T1	
<i>prednisolone oral tablet 5 mg</i>	T1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	T1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 6.7 (5 base) mg/5ml</i>	T1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
<i>qc anti-itch aloe external cream 1 %</i>	T1	
<i>ra anti-itch maximum strength external cream 1 %</i>	T1	
<i>ra anti-itch maximum strength external ointment 1 %</i>	T1	
<i>ra budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>ra nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>scalp relief maximum strength external solution 1 %</i>	T1	
<i>sm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>sm hydrocortisone external cream 1 %</i>	T1	
<i>sm hydrocortisone max st external ointment 1 %</i>	T1	
<i>sm hydrocortisone plus external cream 1 %</i>	T1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % ( <i>hydrocortisone</i> )	T1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % ( <i>tobramycin-dexamethasone</i> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	T1	
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
VANICREAM HC MAXIMUM STRENGTH EXTERNAL CREAM 1.12 %(1% BASE) ( <i>hydrocortisone acetate</i> )	T1	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % ( <i>loteprednol-tobramycin</i> )	T1	
<b>Eent Anti-Inflammatory Agents, Misc.</b>		
CEQUA OPHTHALMIC SOLUTION 0.09 % ( <i>cyclosporine</i> )	T1	PA
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	T1	PA
XIIDRA OPHTHALMIC SOLUTION 5 % ( <i>lifitegrast</i> )	T1	PA
<b>Eent Drugs, Miscellaneous</b>		
<i>acetic acid otic solution 2 %</i>	T1	
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE 9.6 MG/0.8ML ( <i>sodium hyaluronate</i> )	T1	
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	T1	
<i>carboxymethylcellulose sodium ophthalmic gel 1 %</i>	T1	QL (30 ML per 30 days)
<i>carboxymethylcellulose sodium ophthalmic solution 0.5 %</i>	T1	QL (30 ML per 30 days)
<i>cromolyn sodium ophthalmic solution 4 %</i>	T1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	T1	
<i>cvs dry-eye relief nighttime ophthalmic ointment 42.5-57.3 %</i>	T1	QL (7 GM per 30 days)
<i>cvs lubricant drops fast act ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<i>cvs lubricant eye drops ophthalmic solution 0.4-0.3 %, 0.5 %</i>	T1	QL (30 ML per 30 days)
<i>cvs lubricating eye/overnight ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
<i>cvs nighttime dry-eye relief ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
<i>cvs sod chloride hypertonicity ophthalmic ointment 5 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs sodium chloride ophthalmic solution 5 %</i>	T1	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % ( <i>sulfuric acid-sulf phenolics</i> )	T1	
<i>eq lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
EQ RESTORE PM OPHTHALMIC OINTMENT ( <i>white petrolatum-mineral oil</i> )	T1	QL (7 GM per 30 days)
<i>eye lubricant ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
GONIOTAIRE OPHTHALMIC SOLUTION 2.5 % ( <i>hypromellose</i> )	T1	
<i>goodsense ultra lubricant drop ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
IOPIDINE OPHTHALMIC SOLUTION 1 % ( <i>apraclonidine hcl</i> )	T1	
<i>lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 EA per 30 days)
<i>lubricant eye drops ophthalmic solution 0.5 %</i>	T1	QL (30 ML per 30 days)
<i>lubricant eye nighttime ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
<i>lubricant eye ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
<i>lubricant pm ophthalmic ointment</i>	T1	QL (7 GM per 30 days)
<i>lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
MURO 128 OPHTHALMIC SOLUTION 2 % ( <i>sodium chloride (hypertonic)</i> )	T1	
<i>polyvinyl alcohol ophthalmic solution 1.4 %</i>	T1	QL (30 ML per 30 days)
<i>ra lubricant eye drops ophthalmic solution 0.5 %</i>	T1	QL (30 ML per 30 days)
<i>ra lubricant eye ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<i>sm lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<i>sm lubricating tears ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<i>sodium chloride (hypertonic) ophthalmic ointment 5 %</i>	T1	
<i>sodium chloride (hypertonic) ophthalmic solution 5 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYRVAYA NASAL SOLUTION 0.03 MG/ACT ( <i>varenicline tartrate</i> )	T1	PA
ULTRA FRESH OPHTHALMIC SOLUTION 0.5 % ( <i>carboxymethylcellulose sodium</i> )	T1	QL (30 ML per 30 days)
<i>ultra lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	T1	QL (30 ML per 30 days)
<b>Eent Nonsteroidal Anti-Inflam. Agents</b>		
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	T1	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	T1	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA
<b>Local Anesthetics (Eent)</b>		
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	T1	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	T1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	T1	
<b>Miotics</b>		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % ( <i>echothiophate iodide</i> )	T1	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	T1	
<b>Mydriatics</b>		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic ointment 1 %</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % ( <i>cyclopentolate-phenylephrine</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
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drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 % ( <i>homatropine hbr</i> )	T1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	T1	
<i>tropicamide ophthalmic solution 0.5 %, 1 %</i>	T1	
<b>Prostaglandin Analogs</b>		
<i>bimatoprost ophthalmic solution 0.03 %</i>	T1	PA
<i>latanoprost ophthalmic solution 0.005 %</i>	T1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % ( <i>bimatoprost</i> )	T1	PA
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % ( <i>netarsudil-latanoprost</i> )	T1	PA
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	T1	PA
<b>Rho Kinase Inhibitors</b>		
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % ( <i>netarsudil-latanoprost</i> )	T1	PA
<b>Vasoconstrictors</b>		
<i>allergy eye ophthalmic solution 0.025-0.3 %</i>	T1	
<i>cvs eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % ( <i>cyclopentolate-phenylephrine</i> )	T1	
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
<i>eq eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
<i>eye allergy relief ophthalmic solution 0.025-0.3 %, 0.027-0.315 %</i>	T1	

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		Coverage Requirements and Limits
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UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	T1	
<i>ra eye allergy relief ophthalmic solution 0.027-0.315 %</i>	T1	
<b>Gastrointestinal Drugs</b>		
<b>5-Ht3 Receptor Antagonists</b>		
AKYNZEO ORAL CAPSULE 300-0.5 MG ( <i>netupitant-palonosetron</i> )	T1	PA
<i>granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml</i>	T1	PA
<i>granisetron hcl oral tablet 1 mg</i>	T1	ST; QL (12 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5ml</i>	T1	
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T1	
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	T1	
<b>Antacids And Adsorbents</b>		
ACID GONE ORAL SUSPENSION 95-358 MG/15ML ( <i>alum hydroxide-mag carbonate</i> )	T1	
ACID GONE ORAL TABLET CHEWABLE 160-105 MG ( <i>alum hydroxide-mag carbonate</i> )	T1	
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML ( <i>alum &amp; mag hydroxide-simeth</i> )	T1	
<i>aluminum hydroxide gel oral suspension 320 mg/5ml</i>	T1	
<i>aluminum-magnesium-simethicone oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid advanced oral suspension 400-400-40 mg/5ml</i>	T1	
<i>antacid anti-gas max strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>antacid calcium oral tablet chewable 500 mg</i>	T1	
<i>antacid calcium rich oral tablet chewable 500 mg</i>	T1	
<i>antacid extra strength oral tablet chewable 160-105 mg, 750 mg</i>	T1	
<i>antacid fast relief oral suspension 200-200-20 mg/5ml</i>	T1	

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lowercase bold italics = Generic drugs		AL = Age Limit
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTACID FLAVOR CHEWS ORAL TABLET CHEWABLE 750 MG ( <i>calcium carbonate antacid</i> )	T1	
<i>antacid liquid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid m oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid maximum oral tablet chewable 1000 mg</i>	T1	
<i>antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml</i>	T1	
<i>antacid oral suspension 200-200-20 mg/5ml, 400-400-40 mg/10ml</i>	T1	
<i>antacid oral tablet chewable 500 mg, 750 mg</i>	T1	
<i>antacid regular strength oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid ultra strength oral tablet chewable 1000 mg</i>	T1	
<i>antacid/antigas oral suspension 400-400-40 mg/10ml</i>	T1	
<i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i>	T1	
<i>bismuth oral tablet chewable 262 mg</i>	T1	
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	T1	
<i>calcium antacid extra strength oral tablet chewable 750 mg</i>	T1	
<i>calcium antacid oral tablet chewable 500 mg</i>	T1	
<i>calcium carbonate antacid oral suspension 1250 mg/5ml</i>	T1	
<i>calcium carbonate antacid oral tablet 648 mg</i>	T1	
<i>calcium carbonate antacid oral tablet chewable 500 mg</i>	T1	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG ( <i>calcium carbonate antacid</i> )	T1	
<i>childrens pepto oral tablet chewable 400 mg</i>	T1	
<i>comfort gel antacid &amp; anti-gas oral suspension 200-200-20 mg/5ml</i>	T1	
<i>comfort gel antacid anti-gas oral suspension 400-400-40 mg/5ml</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cv</i> s antacid & anti-gas oral tablet chewable 1000-60 mg	T1	
<i>cv</i> s antacid extra strength oral tablet chewable 750 mg	T1	
<i>cv</i> s antacid kids oral tablet chewable 750 mg	T1	
<i>cv</i> s antacid plus antigas oral suspension 400-400-40 mg/5ml	T1	
<i>cv</i> s antacid ultra strength oral tablet chewable 1000 mg	T1	
<i>cv</i> s antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml	T1	
<i>cv</i> s anti-diarrheal oral suspension 262 mg/15ml	T1	
CVS CHEWY NOT CHALKY FLAVOR ORAL TABLET CHEWABLE 750 MG ( <i>calcium carbonate antacid</i> )	T1	
<i>cv</i> s heartburn relief ex st oral suspension 254-237.5 mg/5ml	T1	
<i>cv</i> s heartburn relief oral tablet chewable 160-105 mg	T1	
<i>cv</i> s smooth antacid extra st oral tablet chewable 750 mg	T1	
<i>cv</i> s stomach relief max st oral suspension 525 mg/15ml	T1	
<i>cv</i> s stomach relief oral suspension 525 mg/30ml	T1	
<i>cv</i> s stomach relief oral tablet 262 mg	T1	
<i>cv</i> s stomach relief oral tablet chewable 262 mg	T1	
<i>di</i> arrhea oral suspension 262 mg/15ml	T1	
<i>eq</i> antacid extra strength oral tablet chewable 750 mg	T1	
<i>eq</i> antacid maximum strength oral suspension 400-400-40 mg/5ml	T1	
<i>eq</i> antacid ultra strength oral tablet chewable 1000 mg	T1	
<i>eq</i> pink-bismuth oral tablet chewable 262 mg	T1	
<i>eq</i> stomach relief oral suspension 262 mg/15ml	T1	
<i>eq</i> l stomach relief max st oral suspension 525 mg/15ml	T1	
<i>eq</i> l stomach relief oral suspension 262 mg/15ml	T1	
<i>eq</i> l stomach relief oral tablet chewable 262 mg	T1	

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UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GELUSIL ORAL TABLET CHEWABLE 200-200-25 MG ( <i>alum &amp; mag hydroxide-simeth</i> )	T1	
<i>geri-lanta maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>geri-lanta oral suspension 200-200-20 mg/5ml</i>	T1	
<i>geri-lanta supreme oral suspension 400-135 mg/5ml</i>	T1	
<i>geri-mox oral suspension 200-200-20 mg/5ml</i>	T1	
<i>gnp antacid &amp; anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	T1	
<i>gnp antacid &amp; anti-gas oral tablet chewable 1000-60 mg</i>	T1	
<i>gnp antacid extra strength oral tablet chewable 160-105 mg, 750 mg</i>	T1	
<i>gnp antacid oral tablet chewable 500 mg</i>	T1	
<i>gnp antacid regular strength oral suspension 200-200-20 mg/5ml</i>	T1	
<i>gnp antacid ultra strength oral tablet chewable 1000 mg</i>	T1	
<i>gnp pink bismuth oral tablet 262 mg</i>	T1	
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	T1	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>goodsense advanced antacid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>goodsense antacid &amp; gas relief oral suspension 400-400-40 mg/5ml</i>	T1	
<i>goodsense antacid oral tablet chewable 750 mg</i>	T1	
<i>goodsense stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>heartburn antacid ex st oral tablet chewable 160-105 mg</i>	T1	
<i>heartburn relief ex st oral suspension 254-237.5 mg/5ml</i>	T1	
<i>hm antacid extra strength oral tablet chewable 750 mg</i>	T1	
KAOPECTATE EXTRA STRENGTH ORAL SUSPENSION 525 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	

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<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
KAOPECTATE ORAL SUSPENSION 262 MG/15ML <i>(bismuth subsalicylate)</i>	T1	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	T1	
<i>mag-al plus xs oral liquid 400-400-40 mg/5ml</i>	T1	
<i>magnesium oxide -mg supplement oral tablet 400 (240 mg) mg</i>	T1	
<i>meijer antacid oral suspension 400-400-40 mg/5ml</i>	T1	
<i>mintox maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG <i>(alum &amp; mag hydroxide-simeth)</i>	T1	
<i>pink bismuth oral suspension 262 mg/15ml</i>	T1	
<i>qc antacid extra strength oral tablet chewable 750 mg</i>	T1	
<i>qc antacid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>qc antacid oral tablet chewable 500 mg</i>	T1	
<i>qc antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	T1	
<i>qc diarrhea relief oral suspension 262 mg/15ml</i>	T1	
<i>qc heartburn antacid oral tablet chewable 160-105 mg</i>	T1	
<i>qc stomach relief oral tablet chewable 262 mg</i>	T1	
<i>ra antacid/anti-gas max st oral suspension 400-400-40 mg/5ml</i>	T1	
<i>ra antacid/anti-gas oral suspension 200-200-20 mg/5ml</i>	T1	
<i>ra antacid/gas relief max st oral suspension 400-400-40 mg/5ml</i>	T1	
<i>ra stomach relief oral suspension 262 mg/15ml</i>	T1	
<i>sm antacid advanced oral suspension 200-200-20 mg/5ml</i>	T1	
<i>sm antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>sm antacid oral suspension 400-400-40 mg/10ml</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm antacid oral tablet chewable 500 mg</i>	T1	
<i>sm calcium antacid ex st oral tablet chewable 750 mg</i>	T1	
<i>sm stomach relief oral tablet chewable 262 mg</i>	T1	
<i>smooth antacid extra strength oral tablet chewable 750 mg</i>	T1	
SOOTHE ORAL SUSPENSION 262 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
SOOTHE ORAL TABLET CHEWABLE 262 MG ( <i>bismuth subsalicylate</i> )	T1	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	T1	
<i>stomach relief oral suspension 525 mg/15ml, 525 mg/30ml</i>	T1	
<i>stomach relief oral tablet 262 mg</i>	T1	
<i>stomach relief oral tablet chewable 262 mg</i>	T1	
<i>stomach relief ultra oral suspension 525 mg/15ml</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
<b>Antidiarrhea Agents</b>		
<i>anti-diarrheal oral capsule 2 mg</i>	T1	
<i>anti-diarrheal oral tablet 2 mg</i>	T1	
<i>bismuth oral tablet chewable 262 mg</i>	T1	
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	T1	
<i>cvs anti-diarrheal oral capsule 2 mg</i>	T1	
<i>cvs anti-diarrheal oral suspension 262 mg/15ml</i>	T1	
<i>cvs anti-diarrheal oral tablet 2 mg</i>	T1	
<i>cvs stomach relief max st oral suspension 525 mg/15ml</i>	T1	
<i>cvs stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>cvs stomach relief oral tablet 262 mg</i>	T1	
<i>cvs stomach relief oral tablet chewable 262 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diamode oral tablet 2 mg</i>	T1	
<i>diarrhea oral suspension 262 mg/15ml</i>	T1	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	T1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	T1	
<i>eq anti-diarrheal oral capsule 2 mg</i>	T1	
<i>eq anti-diarrheal oral tablet 2 mg</i>	T1	
<i>eq pink-bismuth oral tablet chewable 262 mg</i>	T1	
<i>eq stomach relief oral suspension 262 mg/15ml</i>	T1	
<i>eql anti-diarrheal oral tablet 2 mg</i>	T1	
<i>eql stomach relief max st oral suspension 525 mg/15ml</i>	T1	
<i>eql stomach relief oral suspension 262 mg/15ml</i>	T1	
<i>eql stomach relief oral tablet chewable 262 mg</i>	T1	
<i>gnp anti-diarrheal oral capsule 2 mg</i>	T1	
<i>gnp anti-diarrheal oral tablet 2 mg</i>	T1	
<i>gnp pink bismuth oral tablet 262 mg</i>	T1	
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	T1	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>goodsense stomach relief oral suspension 525 mg/30ml</i>	T1	
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	
KAOPECTATE EXTRA STRENGTH ORAL SUSPENSION 525 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
KAOPECTATE ORAL SUSPENSION 262 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
<i>loperamide hcl oral capsule 2 mg</i>	T1	
<i>loperamide hcl oral tablet 2 mg</i>	T1	
<i>meijer anti-diarrheal oral tablet 2 mg</i>	T1	
MOTOFEN ORAL TABLET 1-0.025 MG ( <i>difenoxin-atropine</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pink bismuth oral suspension 262 mg/15ml</i>	T1	
<i>qc anti-diarrheal oral capsule 2 mg</i>	T1	
<i>qc anti-diarrheal oral tablet 2 mg</i>	T1	
<i>qc diarrhea relief oral suspension 262 mg/15ml</i>	T1	
<i>qc stomach relief oral tablet chewable 262 mg</i>	T1	
<i>ra anti-diarrheal oral tablet 2 mg</i>	T1	
<i>ra stomach relief oral suspension 262 mg/15ml</i>	T1	
<i>sm anti-diarrheal oral capsule 2 mg</i>	T1	
<i>sm anti-diarrheal oral tablet 2 mg</i>	T1	
<i>sm stomach relief oral tablet chewable 262 mg</i>	T1	
SOOTHE ORAL SUSPENSION 262 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
SOOTHE ORAL TABLET CHEWABLE 262 MG ( <i>bismuth subsalicylate</i> )	T1	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	T1	
<i>stomach relief oral suspension 525 mg/15ml, 525 mg/30ml</i>	T1	
<i>stomach relief oral tablet 262 mg</i>	T1	
<i>stomach relief oral tablet chewable 262 mg</i>	T1	
<i>stomach relief ultra oral suspension 525 mg/15ml</i>	T1	
<b>Antiemetics, Miscellaneous</b>		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG ( <i>promethazine hcl</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Antiflatulents</b>		
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML ( <i>alum &amp; mag hydroxide-simeth</i> )	T1	
<i>aluminum-magnesium-simethicone oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid advanced oral suspension 400-400-40 mg/5ml</i>	T1	
<i>antacid anti-gas max strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>antacid fast relief oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid liquid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid m oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml</i>	T1	
<i>antacid oral suspension 200-200-20 mg/5ml, 400-400-40 mg/10ml</i>	T1	
<i>antacid regular strength oral suspension 200-200-20 mg/5ml</i>	T1	
<i>antacid/antigas oral suspension 400-400-40 mg/10ml</i>	T1	
<i>comfort gel antacid &amp; anti-gas oral suspension 200-200-20 mg/5ml</i>	T1	
<i>comfort gel antacid anti-gas oral suspension 400-400-40 mg/5ml</i>	T1	
<i>cvs antacid &amp; anti-gas oral tablet chewable 1000-60 mg</i>	T1	
<i>cvs antacid plus antigas oral suspension 400-400-40 mg/5ml</i>	T1	
<i>cvs antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	T1	
<i>cvs gas relief extra strength oral tablet chewable 125 mg</i>	T1	
<i>cvs gas relief oral tablet chewable 80 mg</i>	T1	
<i>drxchoice gas relief oral tablet chewable 80 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eq antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>eq gas relief extra strength oral tablet chewable 125 mg</i>	T1	
<i>eq gas relief oral capsule 125 mg</i>	T1	
<i>eql gas relief oral capsule 125 mg</i>	T1	
<i>gas relief extra strength oral capsule 125 mg</i>	T1	
<i>gas relief extra strength oral tablet chewable 125 mg</i>	T1	
<i>gas relief oral tablet chewable 80 mg</i>	T1	
GELUSIL ORAL TABLET CHEWABLE 200-200-25 MG ( <i>alum &amp; mag hydroxide-simeth</i> )	T1	
<i>geri-lanta maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>geri-lanta oral suspension 200-200-20 mg/5ml</i>	T1	
<i>geri-mox oral suspension 200-200-20 mg/5ml</i>	T1	
<i>gnp antacid &amp; anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	T1	
<i>gnp antacid &amp; anti-gas oral tablet chewable 1000-60 mg</i>	T1	
<i>gnp antacid regular strength oral suspension 200-200-20 mg/5ml</i>	T1	
<i>gnp gas relief extra strength oral capsule 125 mg</i>	T1	
<i>gnp gas relief extra strength oral tablet chewable 125 mg</i>	T1	
<i>gnp gas relief oral tablet chewable 80 mg</i>	T1	
<i>goodsense advanced antacid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>goodsense antacid &amp; gas relief oral suspension 400-400-40 mg/5ml</i>	T1	
<i>goodsense gas relief extra st oral capsule 125 mg</i>	T1	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	T1	
<i>mag-al plus xs oral liquid 400-400-40 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>meijer antacid oral suspension 400-400-40 mg/5ml</i>	T1	
<i>mintox maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG ( <i>alum &amp; mag hydroxide-simeth</i> )	T1	
<i>qc antacid oral suspension 200-200-20 mg/5ml</i>	T1	
<i>qc antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	T1	
<i>qc gas relief extra strength oral capsule 125 mg</i>	T1	
<i>ra antacid/anti-gas max st oral suspension 400-400-40 mg/5ml</i>	T1	
<i>ra antacid/anti-gas oral suspension 200-200-20 mg/5ml</i>	T1	
<i>ra antacid/gas relief max st oral suspension 400-400-40 mg/5ml</i>	T1	
<i>ra gas relief extra strength oral tablet chewable 125 mg</i>	T1	
<i>ra gas relief oral capsule 125 mg</i>	T1	
<i>simethicone oral capsule 125 mg</i>	T1	
<i>simethicone oral tablet chewable 125 mg, 80 mg</i>	T1	
<i>sm antacid advanced oral suspension 200-200-20 mg/5ml</i>	T1	
<i>sm antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	T1	
<i>sm antacid oral suspension 400-400-40 mg/10ml</i>	T1	
<i>sm gas relief oral tablet chewable 125 mg, 80 mg</i>	T1	
<b>Antihistamines (Gi Drugs)</b>		
ANTIVERT ORAL TABLET 50 MG ( <i>meclizine hcl</i> )	T1	
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	T1	
<i>cvs motion sickness relief oral tablet chewable 25 mg</i>	T1	
DRAMAMINE LESS DROWSY ORAL TABLET 25 MG ( <i>meclizine hcl</i> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Drug Tier</b> T1 = Formulary Medication	<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRAMAMINE ORAL TABLET 25 MG ( <i>meclizine hcl</i> )	T1	
<i>eql motion sickness relief oral tablet 25 mg</i>	T1	
<i>gnp motion sickness relief oral tablet 25 mg</i>	T1	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	T1	
<i>meclizine hcl oral tablet chewable 25 mg</i>	T1	
<i>motion sickness relief oral tablet 25 mg</i>	T1	
<i>motion sickness relief oral tablet chewable 25 mg</i>	T1	
<i>motion-time oral tablet chewable 25 mg</i>	T1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	T1	
<i>prochlorperazine rectal suppository 25 mg</i>	T1	
<i>ra motion sickness relief oral tablet chewable 25 mg</i>	T1	
<i>sm motion sickness oral tablet 25 mg</i>	T1	
TIGAN INTRAMUSCULAR SOLUTION 100 MG/ML ( <i>trimethobenzamide hcl</i> )	T1	
<i>travel-ease oral tablet 25 mg</i>	T1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	T1	
<b>Anti-Inflammatory Agents (Gi Drugs)</b>		
<i>alosetron hcl oral tablet 0.5 mg, 1 mg</i>	T1	PA
<i>balsalazide disodium oral capsule 750 mg</i>	T1	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	T1	
<i>mesalamine oral capsule delayed release 400 mg</i>	T1	
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	T1	
<i>mesalamine rectal enema 4 gm</i>	T1	
<i>mesalamine rectal suppository 1000 mg</i>	T1	
SFROWASA RECTAL ENEMA 4 GM/60ML ( <i>mesalamine</i> )	T1	
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
<b>Antiulcer Agents And Acid Suppress., Misc</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HELIDAC THERAPY ORAL ( <i>metronid-tetracyc-bis subsal</i> )	T1	
<b>Antiulcer Agents And Acid Suppressants</b>		
<i>aluminum hydroxide gel oral suspension 320 mg/5ml</i>	T1	
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	T1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	T1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	T1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	T1	
<i>antacid calcium oral tablet chewable 500 mg</i>	T1	
<i>antacid calcium rich oral tablet chewable 500 mg</i>	T1	
<i>antacid extra strength oral tablet chewable 750 mg</i>	T1	
ANTACID FLAVOR CHEWS ORAL TABLET CHEWABLE 750 MG ( <i>calcium carbonate antacid</i> )	T1	
<i>antacid maximum oral tablet chewable 1000 mg</i>	T1	
<i>antacid oral tablet chewable 500 mg, 750 mg</i>	T1	
<i>antacid ultra strength oral tablet chewable 1000 mg</i>	T1	
<i>bismuth oral tablet chewable 262 mg</i>	T1	
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	T1	
<i>calcium antacid extra strength oral tablet chewable 750 mg</i>	T1	
<i>calcium antacid oral tablet chewable 500 mg</i>	T1	
<i>calcium carbonate antacid oral suspension 1250 mg/5ml</i>	T1	
<i>calcium carbonate antacid oral tablet 648 mg</i>	T1	
<i>calcium carbonate antacid oral tablet chewable 500 mg</i>	T1	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG ( <i>calcium carbonate antacid</i> )	T1	
<i>childrens pepto oral tablet chewable 400 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>clarithromycin er oral tablet extended release 24 hour 500 mg</i></b>	T1	PA
<b><i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i></b>	T1	PA
<b><i>clarithromycin oral tablet 250 mg, 500 mg</i></b>	T1	
<b><i>cvs antacid extra strength oral tablet chewable 750 mg</i></b>	T1	
<b><i>cvs antacid kids oral tablet chewable 750 mg</i></b>	T1	
<b><i>cvs antacid ultra strength oral tablet chewable 1000 mg</i></b>	T1	
<b><i>cvs anti-diarrheal oral suspension 262 mg/15ml</i></b>	T1	
<b>CVS CHEWY NOT CHALKY FLAVOR ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)</b>	T1	
<b><i>cvs smooth antacid extra st oral tablet chewable 750 mg</i></b>	T1	
<b><i>cvs stomach relief max st oral suspension 525 mg/15ml</i></b>	T1	
<b><i>cvs stomach relief oral suspension 525 mg/30ml</i></b>	T1	
<b><i>cvs stomach relief oral tablet 262 mg</i></b>	T1	
<b><i>cvs stomach relief oral tablet chewable 262 mg</i></b>	T1	
<b><i>diarrhea oral suspension 262 mg/15ml</i></b>	T1	
<b><i>eq antacid extra strength oral tablet chewable 750 mg</i></b>	T1	
<b><i>eq antacid ultra strength oral tablet chewable 1000 mg</i></b>	T1	
<b><i>eq pink-bismuth oral tablet chewable 262 mg</i></b>	T1	
<b><i>eq stomach relief oral suspension 262 mg/15ml</i></b>	T1	
<b><i>eql stomach relief max st oral suspension 525 mg/15ml</i></b>	T1	
<b><i>eql stomach relief oral suspension 262 mg/15ml</i></b>	T1	
<b><i>eql stomach relief oral tablet chewable 262 mg</i></b>	T1	
<b><i>gnp antacid extra strength oral tablet chewable 750 mg</i></b>	T1	
<b><i>gnp antacid oral tablet chewable 500 mg</i></b>	T1	
<b><i>gnp antacid ultra strength oral tablet chewable 1000 mg</i></b>	T1	
<b><i>gnp pink bismuth oral tablet 262 mg</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	T1	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>goodsense antacid oral tablet chewable 750 mg</i>	T1	
<i>goodsense stomach relief oral suspension 525 mg/30ml</i>	T1	
<i>hm antacid extra strength oral tablet chewable 750 mg</i>	T1	
KAOPECTATE EXTRA STRENGTH ORAL SUSPENSION 525 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
KAOPECTATE ORAL SUSPENSION 262 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
<i>magnesium oxide -mg supplement oral tablet 400 (240 mg) mg</i>	T1	
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>pink bismuth oral suspension 262 mg/15ml</i>	T1	
<i>qc antacid extra strength oral tablet chewable 750 mg</i>	T1	
<i>qc antacid oral tablet chewable 500 mg</i>	T1	
<i>qc diarrhea relief oral suspension 262 mg/15ml</i>	T1	
<i>qc stomach relief oral tablet chewable 262 mg</i>	T1	
<i>ra stomach relief oral suspension 262 mg/15ml</i>	T1	
<i>sm antacid oral tablet chewable 500 mg</i>	T1	
<i>sm calcium antacid ex st oral tablet chewable 750 mg</i>	T1	
<i>sm stomach relief oral tablet chewable 262 mg</i>	T1	
<i>smooth antacid extra strength oral tablet chewable 750 mg</i>	T1	
SOOTHE ORAL SUSPENSION 262 MG/15ML ( <i>bismuth subsalicylate</i> )	T1	
SOOTHE ORAL TABLET CHEWABLE 262 MG ( <i>bismuth subsalicylate</i> )	T1	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>stomach relief oral suspension 525 mg/15ml, 525 mg/30ml</i></b>	T1	
<b><i>stomach relief oral tablet 262 mg</i></b>	T1	
<b><i>stomach relief oral tablet chewable 262 mg</i></b>	T1	
<b><i>stomach relief ultra oral suspension 525 mg/15ml</i></b>	T1	
<b><i>tetracycline hcl oral capsule 250 mg, 500 mg</i></b>	T1	
<b>Cathartics And Laxatives</b>		
<b>ACID GONE ORAL SUSPENSION 95-358 MG/15ML (<i>alum hydroxide-mag carbonate</i>)</b>	T1	
<b>ACID GONE ORAL TABLET CHEWABLE 160-105 MG (<i>alum hydroxide-mag carbonate</i>)</b>	T1	
<b><i>antacid extra strength oral tablet chewable 160-105 mg</i></b>	T1	
<b><i>aspirin buf(cacarb-mgcarb-mgo) oral tablet 325 mg</i></b>	T1	
<b><i>bisacodyl ec oral tablet delayed release 5 mg</i></b>	T1	
<b><i>bisacodyl laxative rectal suppository 10 mg</i></b>	T1	
<b><i>bisacodyl oral tablet delayed release 5 mg</i></b>	T1	
<b><i>bisacodyl rectal suppository 10 mg</i></b>	T1	
<b><i>cvs epsom salt oral granules</i></b>	T1	
<b><i>cvs gentle laxative oral tablet delayed release 5 mg</i></b>	T1	
<b><i>cvs gentle laxative rectal suppository 10 mg</i></b>	T1	
<b><i>cvs gentle laxative womens oral tablet delayed release 5 mg</i></b>	T1	
<b><i>cvs heartburn relief ex st oral suspension 254-237.5 mg/5ml</i></b>	T1	
<b><i>cvs heartburn relief oral tablet chewable 160-105 mg</i></b>	T1	
<b><i>cvs magnesium citrate oral solution 1.745 gm/30ml</i></b>	T1	
<b>CVS PURELAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)</b>	T1	
<b><i>cvs senna oral tablet 8.6 mg</i></b>	T1	
<b><i>cvs senna plus oral tablet 8.6-50 mg</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cvs stool softener oral capsule 100 mg, 250 mg, 50 mg</i></b>	T1	
<b><i>cvs stool softener/laxative oral tablet 8.6-50 mg</i></b>	T1	
<b><i>docusate mini rectal enema 283 mg/5ml</i></b>	T1	
<b><i>docusate sodium oral capsule 100 mg, 250 mg</i></b>	T1	
<b><i>docusate sodium oral liquid 100 mg/10ml, 50 mg/5ml</i></b>	T1	
<b><i>docuzen oral tablet 8.6-50 mg</i></b>	T1	
DOK ORAL TABLET 100 MG ( <b><i>docusate sodium</i></b> )	T1	
<b><i>dss oral capsule 100 mg, 250 mg</i></b>	T1	
<b><i>easy-lax oral capsule 100 mg</i></b>	T1	
<b><i>easy-lax plus oral tablet 8.6-50 mg</i></b>	T1	
<b><i>epsom salt oral granules</i></b>	T1	
<b><i>eq gentle laxative oral tablet delayed release 5 mg</i></b>	T1	
<b><i>eq magnesium citrate oral solution 1.745 gm/30ml</i></b>	T1	
<b><i>eq senna-s oral tablet 8.6-50 mg</i></b>	T1	
<b><i>eq stool softener oral capsule 100 mg</i></b>	T1	
<b><i>eq stool softener/laxative oral tablet 8.6-50 mg</i></b>	T1	
<b><i>eq vegetable laxative oral tablet 8.6 mg</i></b>	T1	
<b><i>eql epsom salt granules</i></b>	T1	
<b><i>eql gentle laxative oral tablet delayed release 5 mg</i></b>	T1	
<b><i>eql laxative maximum strength oral tablet 25 mg</i></b>	T1	
<b><i>eql senna laxative oral tablet 8.6 mg</i></b>	T1	
<b><i>eql senna-s oral tablet 8.6-50 mg</i></b>	T1	
<b><i>eql stool softener oral capsule 100 mg</i></b>	T1	
<b><i>gavilax oral packet 17 gm</i></b>	T1	
<b><i>gavilax oral powder 17 gm/scoop</i></b>	T1	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM ( <b><i>peg 3350-kcl-nabcb-nacl-nasulf</i></b> )	T1	
<b><i>peg 3350-kcl-nabcb-nacl-nasulf</i></b> (Gavilyte-G Oral Solution Reconstituted 236 Gm)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gentle laxative oral tablet delayed release 5 mg</i>	T1	
<i>gentle laxative rectal suppository 10 mg</i>	T1	
<i>gentlelax oral powder 17 gm/scoop</i>	T1	
<i>geri-kot oral tablet 8.6 mg</i>	T1	
<i>gnp antacid extra strength oral tablet chewable 160-105 mg</i>	T1	
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	T1	
<i>gnp epsom salt oral granules</i>	T1	
<i>gnp gentle laxative oral tablet delayed release 5 mg</i>	T1	
<i>gnp gentle laxative rectal suppository 10 mg</i>	T1	
<i>gnp magnesium citrate oral solution 1.745 gm/30ml</i>	T1	
<i>gnp senna lax oral tablet 8.6 mg</i>	T1	
<i>gnp senna plus oral tablet 8.6-50 mg</i>	T1	
<i>gnp stool softener ex st oral capsule 250 mg</i>	T1	
<i>gnp stool softener oral capsule 100 mg, 250 mg</i>	T1	
<i>gnp stool softener/laxative oral tablet 8.6-50 mg</i>	T1	
<i>gnp womens gentle laxative oral tablet delayed release 5 mg</i>	T1	
<i>goodsense bisacodyl laxative oral tablet delayed release 5 mg</i>	T1	
<i>goodsense magnesium citrate oral solution 1.745 gm/30ml</i>	T1	
<i>goodsense senna laxative oral tablet 8.6 mg</i>	T1	
<i>goodsense stool softener oral capsule 100 mg</i>	T1	
<i>heartburn antacid ex st oral tablet chewable 160-105 mg</i>	T1	
<i>heartburn relief ex st oral suspension 254-237.5 mg/5ml</i>	T1	
HM CLEARLAX ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	T1	
<i>hm stool softener oral capsule 100 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hm stool softener/laxative oral tablet 8.6-50 mg</i>	T1	
KLS LAXACLEAR ORAL POWDER 17 GM/SCOOP ( <i>polyethylene glycol 3350</i> )	T1	
<i>kp bisacodyl oral tablet delayed release 5 mg</i>	T1	
<i>kp senna oral tablet 8.6 mg</i>	T1	
<i>laxacin oral tablet 8.6-50 mg</i>	T1	
<i>laxative rectal suppository 10 mg</i>	T1	
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	T1	
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml</i>	T1	
<i>natural senna laxative oral tablet 8.6 mg</i>	T1	
ONELAX MAGNESIUM CITRATE ORAL SOLUTION 1.745 GM/30ML ( <i>magnesium citrate</i> )	T1	
ONELAX RECTAL SUPPOSITORY 10 MG ( <i>bisacodyl</i> )	T1	
PEDIA-LAX ORAL LIQUID 50 MG/15ML ( <i>docusate sodium</i> )	T1	
<i>peg 3350 oral packet 17 gm</i>	T1	
<i>peg 3350 oral powder 17 gm/scoop</i>	T1	
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	T1	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	T1	
PLURONIC F127 POWDER ( <i>poloxamer</i> )	T1	
<i>polyethylene glycol 3350 oral packet 17 gm</i>	T1	
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	T1	
<i>qc gentle laxative rectal suppository 10 mg</i>	T1	
<i>qc heartburn antacid oral tablet chewable 160-105 mg</i>	T1	
<i>qc magnesium citrate oral solution 1.745 gm/30ml</i>	T1	
<i>qc natura-lax oral powder 17 gm/scoop</i>	T1	
<i>qc stool softener oral capsule 100 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>qc stool softener pls laxative oral tablet 8.6-50 mg</i>	T1	
<i>qc vegetable laxative oral tablet 8.6 mg</i>	T1	
<i>ra col-rite oral capsule 100 mg, 250 mg</i>	T1	
<i>ra epsom salt granules</i>	T1	
<i>ra epsom salt oral granules</i>	T1	
<i>ra fast relief laxative rectal suppository 10 mg</i>	T1	
<i>ra laxative oral powder 17 gm/scoop</i>	T1	
<i>ra laxative oral tablet delayed release 5 mg</i>	T1	
<i>ra magnesium citrate oral solution 1.745 gm/30ml</i>	T1	
<i>ra p col-rite oral tablet 8.6-50 mg</i>	T1	
<i>ra stool softener oral capsule 100 mg</i>	T1	
<i>ra womens laxative oral tablet delayed release 5 mg</i>	T1	
<i>senexon-s oral tablet 8.6-50 mg</i>	T1	
<i>senna laxative oral tablet 8.6 mg</i>	T1	
<i>senna oral tablet 8.6 mg</i>	T1	
<i>senna plus oral tablet 8.6-50 mg</i>	T1	
<i>senna s oral tablet 8.6-50 mg</i>	T1	
<i>senna-docusate sodium oral tablet 8.6-50 mg</i>	T1	
<i>senna-lax oral tablet 8.6 mg</i>	T1	
<i>senna-plus oral tablet 8.6-50 mg</i>	T1	
<i>senna-s oral tablet 8.6-50 mg</i>	T1	
<i>senna-tabs oral tablet 8.6 mg</i>	T1	
<i>senna-time oral tablet 8.6 mg</i>	T1	
<i>senna-time s oral tablet 8.6-50 mg</i>	T1	
<i>sennosides oral tablet 8.6 mg</i>	T1	
<i>sennosides-docusate sodium oral tablet 8.6-50 mg</i>	T1	
<i>silace oral liquid 150 mg/15ml</i>	T1	
<i>sm epsom salt oral granules</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm gentle laxative oral tablet delayed release 5 mg</i>	T1	
<i>sm senna laxative oral tablet 8.6 mg</i>	T1	
<i>sm senna-s oral tablet 8.6-50 mg</i>	T1	
<i>sm stool softener oral capsule 100 mg</i>	T1	
<i>sm stool softener oral tablet 100 mg</i>	T1	
<i>sm stool softener/laxative oral tablet 8.6-50 mg</i>	T1	
SMOOTH LAX ORAL PACKET 17 GM ( <i>polyethylene glycol 3350</i> )	T1	
<i>sorbitol oral solution 70 %</i>	T1	
<i>sorbitol rectal solution 70 %</i>	T1	
<i>sorbitol solution 70 %</i>	T1	
<i>stimulant laxative oral tablet 8.6-50 mg</i>	T1	
<i>stool softener laxative oral capsule 100 mg</i>	T1	
<i>stool softener oral capsule 100 mg, 250 mg</i>	T1	
<i>stool softener oral liquid 50 mg/5ml</i>	T1	
<i>stool softener oral tablet 100 mg</i>	T1	
<i>stool softener plus laxative oral tablet 8.6-50 mg</i>	T1	
<i>stool softener/laxative oral tablet 50-8.6 mg</i>	T1	
<i>tri-buffered aspirin oral tablet 325 mg</i>	T1	
<i>vegetable lax+stool softener oral tablet 8.6-50 mg</i>	T1	
<b>Chloride Channel Activators</b>		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	T1	PA
<b>Cholelitholytic Agents</b>		
<i>ursodiol oral capsule 300 mg</i>	T1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	T1	
<b>Digestants</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	T1	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT ( <i>pancrelipase (lip-prot-amyl)</i> )	T1	
<b>Gi Drugs, Miscellaneous</b>		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
ALLI ORAL CAPSULE 60 MG ( <i>orlistat</i> )	T1	PA
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-axxq</i> )	T1	PA
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	T1	PA
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG ( <i>vedolizumab</i> )	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	T1	QL (3.2 ML per 28 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL =</b> Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	<b>PA =</b> Prior Authorization
		<b>QL =</b> Quantity Limit
		<b>ST =</b> Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	T1	QL (3.2 ML per 28 days)
IBSRELA ORAL TABLET 50 MG ( <i>tenapanor hcl</i> )	T1	PA
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-dyyb</i> )	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG ( <i>linaclotide</i> )	T1	PA
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	T1	PA
MOTEGRITY ORAL TABLET 1 MG, 2 MG ( <i>prucalopride succinate</i> )	T1	PA
MOVANTIK ORAL TABLET 12.5 MG, 25 MG ( <i>naloxegol oxalate</i> )	T1	PA
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	T1	
RELISTOR ORAL TABLET 150 MG ( <i>methylnaltrexone bromide</i> )	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA

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<b>lowercase bold italics =</b> Generic drugs		<b>Drug Tier</b> T1 = Formulary Medication	<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
SYMPROIC ORAL TABLET 0.2 MG ( <i>naldemedine tosylate</i> )	T1	PA
TRULANCE ORAL TABLET 3 MG ( <i>plecanatide</i> )	T1	PA
<b>Guanylate Cyclase C (Gcc) Recept Agonist</b>		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG ( <i>linaclotide</i> )	T1	PA
TRULANCE ORAL TABLET 3 MG ( <i>plecanatide</i> )	T1	PA
<b>Histamine H2-Antagonists</b>		
<i>acid controller max st oral tablet 20 mg</i>	T1	
<i>acid controller oral tablet 10 mg</i>	T1	
<i>acid reducer maximum strength oral tablet 20 mg</i>	T1	
<i>acid reducer oral tablet 10 mg</i>	T1	
<i>cimetidine 200 oral tablet 200 mg</i>	T1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	T1	
<i>cvs acid controller max st oral tablet 20 mg</i>	T1	
<i>cvs acid controller oral tablet 10 mg</i>	T1	
<i>cvs heartburn relief oral tablet 200 mg</i>	T1	
<i>eq acid reducer oral tablet 10 mg, 200 mg</i>	T1	
<i>eq famotidine max st oral tablet 20 mg</i>	T1	
<i>eq heartburn prevention oral tablet 10 mg, 20 mg</i>	T1	
<i>famotidine maximum strength oral tablet 20 mg</i>	T1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	T1	
<i>famotidine oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>famotidine orig st oral tablet 10 mg</i>	T1	
<i>gnp acid reducer max st oral tablet 20 mg</i>	T1	
<i>gnp acid reducer oral tablet 10 mg</i>	T1	
<i>heartburn relief max st oral tablet 20 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>heartburn relief oral tablet 10 mg</i>	T1	
<i>kls acid controller max st oral tablet 20 mg</i>	T1	
<i>qc acid controller max st oral tablet 20 mg</i>	T1	
<i>qc acid controller oral tablet 10 mg</i>	T1	
<i>ra acid reducer max st oral tablet 20 mg</i>	T1	
<i>ra acid reducer oral tablet 10 mg</i>	T1	
<i>sm acid reducer max st oral tablet 20 mg</i>	T1	
<i>sm acid reducer oral tablet 10 mg, 200 mg</i>	T1	
ZANTAC 360 MAX ST ORAL TABLET 20 MG ( <i>famotidine</i> )	T1	
ZANTAC 360 ORAL TABLET 10 MG ( <i>famotidine</i> )	T1	
<b>Immunomodulatory Agents (56:44)</b>		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG ( <i>vedolizumab</i> )	T1	PA
<b>Lipotropic Agents</b>		
<i>b complex formula 1 (lipotrop) oral tablet</i>	T1	
<i>balance b-100 oral tablet</i>	T1	
<b>Neurokinin-1 Receptor Antagonists</b>		
AKYNZEO ORAL CAPSULE 300-0.5 MG ( <i>netupitant-palonosetron</i> )	T1	PA
<i>aprepitant oral 80 &amp; 125 mg</i>	T1	QL (30 EA per 30 days)
<i>aprepitant oral capsule 125 mg, 80 &amp; 125 mg, 80 mg</i>	T1	QL (30 EA per 30 days)
<i>aprepitant oral capsule 40 mg</i>	T1	QL (1 EA per 30 days)
<b>Opioid Antagonists (56:18)</b>		
MOVANTIK ORAL TABLET 12.5 MG, 25 MG ( <i>naloxegol oxalate</i> )	T1	PA
RELISTOR ORAL TABLET 150 MG ( <i>methylnaltrexone bromide</i> )	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML ( <i>methylnaltrexone bromide</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPROIC ORAL TABLET 0.2 MG ( <i>naldemedine tosylate</i> )	T1	PA
<b>Prokinetic Agents</b>		
<i>metoclopramide hcl injection solution 5 mg/ml</i>	T1	
<i>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</i>	T1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	T1	
<b>Prostaglandins</b>		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	T1	
<b>Protectants</b>		
<i>sucralfate oral suspension 1 gm/10ml</i>	T1	
<i>sucralfate oral tablet 1 gm</i>	T1	
<b>Proton-Pump Inhibitors</b>		
<i>acid reducer oral capsule delayed release 20.6 (20 base) mg</i>	T1	
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 &amp; 500 &amp; 30 mg</i>	T1	PA
<i>cvs esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	
<i>cvs lansoprazole oral tablet delayed release dispersible 15 mg</i>	T1	QL (30 EA per 30 days)
<i>cvs omeprazole magnesium oral capsule delayed release 20 mg, 20.6 mg</i>	T1	
<i>eq lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>eq omeprazole magnesium oral capsule delayed release 20 mg</i>	T1	
<i>eql lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	T1	
<i>gnp esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>gnp omeprazole oral capsule delayed release 20.6 (20 base) mg</i>	T1	
GOODSENSE ESOMEPRAZOLE ORAL CAPSULE DELAYED RELEASE 20 MG ( <i>esomeprazole magnesium</i> )	T1	
<i>goodsense lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>hm esomeprazole magnesium dr oral capsule delayed release 20 mg</i>	T1	
<i>kls esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	
<i>kls lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>kp omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	T1	
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	T1	
<i>lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg</i>	T1	QL (30 EA per 30 days)
<i>omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	T1	
<i>omeprazole oral capsule delayed release 10 mg, 20 mg</i>	T1	
<i>omeprazole oral capsule delayed release 40 mg</i>	T1	QL (60 EA per 30 days)
<i>pantoprazole sodium intravenous solution reconstituted 40 mg</i>	T1	PA
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	T1	
<i>qc esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	
<i>qc lansoprazole oral capsule delayed release 15 mg</i>	T1	
<i>qc omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	T1	
<i>ra esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	T1	
<i>sm esomeprazole magnesium oral capsule delayed release 20 mg</i>	T1	
<i>sm lansoprazole oral capsule delayed release 15 mg</i>	T1	
<b>Heavy Metal Antagonists</b>		
<b>Heavy Metal Antagonists</b>		
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	T1	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	T1	PA
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	T1	PA
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA
FERRIPROX ORAL SOLUTION 100 MG/ML ( <i>deferiprone</i> )	T1	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG ( <i>deferiprone</i> )	T1	PA
<i>penicillamine oral capsule 250 mg</i>	T1	PA
<i>penicillamine oral tablet 250 mg</i>	T1	PA
<i>pentetate calcium trisodium combination solution 200 mg/ml</i>	T1	
<i>pentetate zinc trisodium combination solution 200 mg/ml</i>	T1	
<i>trientine hcl oral capsule 250 mg</i>	T1	PA
<b>Hormones And Synthetic Substitutes</b>		
<b>Adrenals</b>		
<i>ala-cort external cream 1 %</i>	T1	
<i>allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>allergy spray 24 hour nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>anti-itch maximum strength external cream 1 %</i>	T1	
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % ( <i>hydrocortisone</i> )	T1	
AQUANIL HC EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
AQUAPHOR ITCH RELIEF MAX STR EXTERNAL OINTMENT 1 % ( <i>hydrocortisone</i> )	T1	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <i>fluticasone furoate</i> )	T1	
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	T1	
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	T1	
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT ( <i>mometasone furoate</i> )	T1	
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT ( <i>mometasone furoate</i> )	T1	
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <i>mometasone furoate</i> )	T1	
<i>beta hc external lotion 1 %</i>	T1	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	T1	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	T1	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	T1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone valerate external cream 0.1 %</i>	T1	
<i>betamethasone valerate external foam 0.12 %</i>	T1	PA
<i>betamethasone valerate external lotion 0.1 %</i>	T1	
<i>betamethasone valerate external ointment 0.1 %</i>	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT ( <i>budeson-glycopyrrol-formoterol</i> )	T1	PA
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	T1	PA
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	T1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	T1	QL (60 ML per 30 days)
<i>budesonide oral capsule delayed release particles 3 mg</i>	T1	QL (90 EA per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	T1	QL (20.4 GM per 30 days)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylonol</i> )	T1	
CORTIFOAM EXTERNAL FOAM 10 % ( <i>hydrocortisone acetate</i> )	T1	PA
CORTIZONE-10 EXTERNAL OINTMENT 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 FEMININE ITCH EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 INTENSIVE HEALING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 INTENSVE MOISTURE EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 OVERNIGHT EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 OVERNIGHT ITCH EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 PLUS EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIZONE-10 SENSITIVE SKIN EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 SOOTHING ALOE EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 ULTRA SOOTHING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10/ALOE EXTERNAL LIQUID 1 % ( <i>hydrocortisone</i> )	T1	
<i>cvs cortisone maximum strength external cream 1 %</i>	T1	
<i>cvs cortisone maximum strength external gel 1 %</i>	T1	
<i>cvs cortisone maximum strength external ointment 1 %</i>	T1	
<i>cvs fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
DERMAREST ECZEMA EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML ( <i>dexamethasone</i> )	T1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	T1	
<i>dexamethasone oral tablet therapy pack 1.5 mg (51)</i>	T1	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT ( <i>mometasone furo-formoterol fum</i> )	T1	
<i>eq allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>eq hydrocortisone external cream 1 %</i>	T1	
<i>eq hydrocortisone max st external cream 1 %</i>	T1	
<i>eql anti-itch intensive heal external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external ointment 1 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLONASE SENSIMIST CHILDRENS NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
FLONASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	T1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate external cream 0.05 %</i>	T1	
<i>fluticasone propionate external ointment 0.005 %</i>	T1	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 GM per 30 days)
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act</i>	T1	
<i>gnp fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>gnp hydrocortisone external cream 0.5 %</i>	T1	
<i>gnp hydrocortisone max st external ointment 1 %</i>	T1	
<i>gnp hydrocortisone plus external cream 1 %</i>	T1	
<i>gnp hydrocortisone/aloe external cream 1 %</i>	T1	
<i>hm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	T1	
<i>hydrocortisone acetate external cream 1 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone anti-itch external cream 1 %</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 0.5 %, 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external ointment 0.5 %, 1 %, 2.5 %</i>	T1	
<i>hydrocortisone max st external cream 1 %</i>	T1	
<i>hydrocortisone max st external ointment 1 %</i>	T1	
<i>hydrocortisone max st/12 moist external cream 1 %</i>	T1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone/aloe max str external cream 1 %</i>	T1	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
MEDROL ORAL TABLET 2 MG ( <i>methylprednisolone</i> )	T1	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	T1	
PANDEL EXTERNAL CREAM 0.1 % ( <i>hydrocortisone probutate</i> )	T1	PA
PRED MILD OPHTHALMIC SUSPENSION 0.12 % ( <i>prednisolone acetate</i> )	T1	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	T1	
<i>prednisolone oral solution 15 mg/5ml</i>	T1	
<i>prednisolone oral tablet 5 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>prednisolone sodium phosphate ophthalmic solution 1 %</i></b>	T1	
<b><i>prednisolone sodium phosphate oral solution 15 mg/5ml, 6.7 (5 base) mg/5ml</i></b>	T1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML ( <b><i>prednisone</i></b> )	T1	
<b><i>prednisone oral solution 5 mg/5ml</i></b>	T1	
<b><i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i></b>	T1	
<b><i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i></b>	T1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <b><i>hydrocortisone ace-pramoxine</i></b> )	T1	PA
<b><i>hydrocortisone</i></b> (Procto-Med Hc External Cream 2.5 %)	T1	
<b><i>hydrocortisone</i></b> (Proctosol Hc External Cream 2.5 %)	T1	
<b><i>hydrocortisone</i></b> (Proctozone-Hc External Cream 2.5 %)	T1	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT ( <b><i>budesonide</i></b> )	T1	
<b><i>qc anti-itch aloe external cream 1 %</i></b>	T1	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT ( <b><i>beclomethasone diprop hfa</i></b> )	T1	
<b><i>ra anti-itch maximum strength external cream 1 %</i></b>	T1	
<b><i>ra anti-itch maximum strength external ointment 1 %</i></b>	T1	
<b><i>scalp relief maximum strength external solution 1 %</i></b>	T1	
<b><i>sm allergy relief nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 ML per 30 days)
<b><i>sm hydrocortisone external cream 1 %</i></b>	T1	
<b><i>sm hydrocortisone max st external ointment 1 %</i></b>	T1	
<b><i>sm hydrocortisone plus external cream 1 %</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEXACORT EXTERNAL SOLUTION 2.5 % ( <i>hydrocortisone</i> )	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT ( <i>fluticasone-umeclidin-vilant</i> )	T1	PA
VANICREAM HC MAXIMUM STRENGTH EXTERNAL CREAM 1.12 %(1% BASE) ( <i>hydrocortisone acetate</i> )	T1	
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
<b>Alpha-Glucosidase Inhibitors</b>		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	ST
<b>Androgens</b>		
<i>est estrogens-methyltest</i> (Covaryx Hs Oral Tablet 0.625-1.25 Mg)	T1	
<i>est estrogens-methyltest</i> (Covaryx Oral Tablet 1.25-2.5 Mg)	T1	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	T1	PA
<i>est estrogens-methyltest</i> (Eemt Hs Oral Tablet 0.625-1.25 Mg)	T1	
<i>est estrogens-methyltest</i> (Eemt Oral Tablet 1.25-2.5 Mg)	T1	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	T1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	T1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	T1	
<i>methyltestosterone oral capsule 10 mg</i>	T1	PA
<i>testosterone cypionate injection solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)
<i>testosterone cypionate intramuscular solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone transdermal gel 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)</i>	T1	PA
<b>Antiestrogens</b>		
<i>anastrozole oral tablet 1 mg</i>	T1	QL (30 EA per 30 days)
<i>exemestane oral tablet 25 mg</i>	T1	
<i>letrozole oral tablet 2.5 mg</i>	T1	QL (30 EA per 30 days)
<b>Antigonadotropins</b>		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG ( <i>degarelix acetate</i> )	T1	QL (1 EA per 30 days)
ORLISSA ORAL TABLET 150 MG, 200 MG ( <i>elagolix sodium</i> )	T1	PA
<b>Antiparathyroid Agents</b>		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	T1	
<b>Antithyroid Agents</b>		
<i>iodine strong oral solution 5 %</i>	T1	
IOSAT ORAL TABLET 65 MG ( <i>potassium iodide (antidote)</i> )	T1	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T1	
<i>propylthiouracil oral tablet 50 mg</i>	T1	
<b>Biguanides</b>		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	T1	ST
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	T1	
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	T1	PA
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	T1	
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG ( <i>canagliflozin-metformin hcl</i> )	T1	QL (60 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG ( <i>sitagliptin-metformin hcl</i> )	T1	ST

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE = Brand name</b> drugs	<b>Drug Tier</b> <b>T1 = Formulary Medication</b>	<b>PA = Prior Authorization</b> <b>QL = Quantity Limit</b> <b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG ( <i>sitagliptin-metformin hcl</i> )	T1	ST
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	T1	
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	T1	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG ( <i>empagliflozin-metformin hcl</i> )	T1	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	T1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG ( <i>dapagliflozin prop-metformin</i> )	T1	QL (30 EA per 30 days)
Contraceptives		
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
AFTERA ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
AFTERPILL ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	T1	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <i>segesterone-ethinyl estradiol</i> )	T1	
<i>desogestrel-ethinyl estradiol</i> (Apris Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day</i></b> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>briellyn oral tablet 0.4-35 mg-mcg</i></b>	T1	
<b><i>norethindrone</i></b> (Camila Oral Tablet 0.35 Mg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day</i></b> (Camrese Oral Tablet 0.15-0.03 &0.01 Mg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norgestrel-ethinyl estradiol</i></b> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
CURAE ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Daysee Oral Tablet 0.15-0.03 &0.01 Mg)	T1	
<b><i>norethindrone</i></b> (Deblitane Oral Tablet 0.35 Mg)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML ( <b><i>medroxyprogesterone acetate</i></b> )	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML ( <b><i>medroxyprogesterone acetate</i></b> )	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML ( <b><i>medroxyprogesterone acetate</i></b> )	T1	PA
<b><i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Dolishale Oral Tablet 90-20 Mcg)	T1	
<b><i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i></b>	T1	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norgestrel-ethinyl estradiol</i></b> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	
ELLA ORAL TABLET 30 MG ( <b><i>ulipristal acetate</i></b> )	T1	
<b><i>etonogestrel-ethinyl estradiol</i></b> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone</i></b> (Errin Oral Tablet 0.35 Mg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i></b>	T1	
<b><i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Gem mily Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization
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		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>etonogestrel-ethinyl estradiol</i></b> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<b><i>norethindrone</i></b> (Heather Oral Tablet 0.35 Mg)	T1	
HER STYLE ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>norethindrone</i></b> (Incassia Oral Tablet 0.35 Mg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<b><i>norethindrone</i></b> (Jencycla Oral Tablet 0.35 Mg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	<b>PA = Prior Authorization</b>
		<b>QL = Quantity Limit</b>
		<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin-eth estradiol-fe</i></b> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i></b>	T1	
<b><i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i></b>	T1	
<b><i>levonorgestrel oral tablet 1.5 mg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i></b>	T1	
<b><i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/125-30 mcg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)</b>	T1	
<b>LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)</b>	T1	
<b>LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)</b>	T1	
<b><i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 &amp; 0.01 Mg)</b>	T1	
<b><i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)</b>	T1	
<b><i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)</b>	T1	
<b><i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)</b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)</b>	T1	
<b><i>norethindrone</i> (Lyleq Oral Tablet 0.35 Mg)</b>	T1	
<b><i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)</b>	T1	
<b><i>marlissa oral tablet 0.15-30 mg-mcg</i></b>	T1	
<b><i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i></b>	T1	
<b><i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin ace-eth estrad-fe</i></b> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norgestimate-eth estradiol</i></b> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
MY CHOICE ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
MY WAY ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <b><i>estradiol valerate-dienogest</i></b> )	T1	
<b><i>norethindrone-eth estradiol</i></b> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
NEW DAY ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG ( <b><i>etonogestrel</i></b> )	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <b><i>drospirenone-estetrol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<b><i>norethindrone</i></b> (Nora-Be Oral Tablet 0.35 Mg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethindrone oral tablet 0.35 mg</i></b>	T1	
<b><i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i></b>	T1	
<b><i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i></b>	T1	
<b><i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i></b>	T1	
<b><i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i></b>	T1	
<b><i>norethindrone</i> (Norlyda Oral Tablet 0.35 Mg)</b>	T1	
<b><i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)</b>	T1	
<b><i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)</b>	T1	
<b><i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)</b>	T1	
<b><i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)</b>	T1	
<b><i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)</b>	T1	
<b><i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)</b>	T1	
<b><i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet 3-0.03 Mg)</b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPCICON ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
OPILL ORAL TABLET 0.075 MG ( <i>norgestrel</i> )	T1	
OPTION 2 ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
PLAN B ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
REACT ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
<i>norethindrone</i> (Sharobel Oral Tablet 0.35 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG ( <i>levonorgestrel</i> )	T1	
SLYND ORAL TABLET 4 MG ( <i>drospirenone</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norgestimate-eth estradiol</i></b> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Syeda Oral Tablet 3-0.03 Mg)	T1	
TAKE ACTION ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <b><i>levonorgestrel-eth estradiol</i></b> )	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <b><i>levonorgestrel-ethinyl estrad</i></b> )	T1	
<b><i>drospiren-eth estrad-levomefol</i></b> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG ( <b><i>desogestrel-ethinyl estradiol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Vienva Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i></b>	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin-eth estradiol-fe</i></b> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
<b>Dipeptidyl Peptidase-4(Dpp-4) Inhibitors</b>		
<b><i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i></b>	T1	ST
<b><i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i></b>	T1	ST
<b><i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i></b>	T1	ST
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG ( <b><i>sitagliptin-metformin hcl</i></b> )	T1	ST
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG ( <b><i>sitagliptin-metformin hcl</i></b> )	T1	ST
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG ( <b><i>sitagliptin phosphate</i></b> )	T1	ST
<b>Estrogen Agonist-Antagonists</b>		
<b><i>raloxifene hcl oral tablet 60 mg</i></b>	T1	
<b><i>tamoxifen citrate oral tablet 10 mg, 20 mg</i></b>	T1	
<b><i>toremifene citrate oral tablet 60 mg</i></b>	T1	
<b>Estrogens</b>		
<b><i>levonorgestrel-ethinyl estrad</i></b> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>alyacen 1/35 oral tablet 1-35 mg-mcg</i></b>	T1	
<b><i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>levonorgestrel-ethinyl estrad</b> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <b>segesterone-ethinyl estradiol</b> )	T1	
<b>desogestrel-ethinyl estradiol</b> (Apri Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b>norethin-eth estrad triphasic</b> (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	
<b>levonorgest-eth estrad 91-day</b> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b>levonorgestrel-ethinyl estrad</b> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b>norethindrone acet-ethinyl est</b> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b>norethindrone acet-ethinyl est</b> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b>norethin ace-eth estrad-fe</b> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b>norethin ace-eth estrad-fe</b> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b>norethin ace-eth estrad-fe</b> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b>levonorgestrel-ethinyl estrad</b> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b>levonorgestrel-ethinyl estrad</b> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b>desogestrel-ethinyl estradiol</b> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b>norethindrone-eth estradiol</b> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b>norethin ace-eth estrad-fe</b> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>briellyn oral tablet 0.4-35 mg-mcg</i></b>	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY ( <b><i>estradiol-levonorgestrel</i></b> )	T1	PA
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY ( <b><i>estradiol-norethindrone acet</i></b> )	T1	ST
<b><i>est estrogens-methyltest</i></b> (Covaryx Hs Oral Tablet 0.625-1.25 Mg)	T1	
<b><i>est estrogens-methyltest</i></b> (Covaryx Oral Tablet 1.25-2.5 Mg)	T1	
<b><i>norgestrel-ethinyl estradiol</i></b> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Dolishale Oral Tablet 90-20 Mcg)	T1	
<b><i>estradiol</i></b> (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<b><i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i></b>	T1	
<b><i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i></b>	T1	
<b><i>est estrogens-methyltest</i></b> (Eemt Hs Oral Tablet 0.625-1.25 Mg)	T1	
<b><i>est estrogens-methyltest</i></b> (Eemt Oral Tablet 1.25-2.5 Mg)	T1	
<b><i>norgestrel-ethinyl estradiol</i></b> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	
<b><i>etonogestrel-ethinyl estradiol</i></b> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i></b>	T1	
<b><i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i></b>	T1	
<b><i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i></b>	T1	
<b><i>norgestimate-eth estradiol</i></b> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i></b>	T1	
<b><i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i></b>	T1	QL (8 EA per 28 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i></b>	T1	
<b><i>estradiol vaginal cream 0.1 mg/gm</i></b>	T1	
<b><i>estradiol vaginal tablet 10 mcg</i></b>	T1	
<b><i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i></b>	T1	PA
<b><i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i></b>	T1	
<b><i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR ( <b><i>estradiol acetate</i></b> )	T1	PA
<b><i>norethin ace-eth estrad-fe</i></b> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<b><i>norethin ace-eth estrad-fe</i></b> (Gemmy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>etonogestrel-ethinyl estradiol</i></b> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	<b>PA = Prior Authorization</b>
		<b>QL = Quantity Limit</b>
		<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day</i></b> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Jinteli Oral Tablet 1-5 Mg-Mcg)	T1	PA
<b><i>levonorgest-eth estrad 91-day</i></b> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin-eth estradiol-fe</i></b> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i></b>	T1	
<b><i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i></b>	T1	
<b><i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i></b>	T1	
<b><i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG ( <i>norethin-eth estrad-fe biphas</i> )	T1	
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	T1	
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>estradiol</i> (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	T1	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG ( <i>esterified estrogens</i> )	T1	
<i>norethin ace-eth estrad-fe</i> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>estradiol-norethindrone acet</i></b> (Mimvey Oral Tablet 1-0.5 Mg)	T1	PA
<b><i>norgestimate-eth estradiol</i></b> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <b><i>estradiol valerate-dienogest</i></b> )	T1	
<b><i>norethindrone-eth estradiol</i></b> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <b><i>drospirenone-estetrol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<b><i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethindrone-eth estradiol oral tablet 1-5 mg-mcg</i></b>	T1	PA
<b><i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i></b>	T1	
<b><i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i></b>	T1	
<b><i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i></b>	T1	
<b><i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i></b>	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Ocella Oral Tablet 3-0.03 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG ( <b><i>estrogens conjugated</i></b> )	T1	
PREMARIN VAGINAL CREAM 0.625 MG/GM ( <b><i>estrogens, conjugated</i></b> )	T1	
PREMPHASE ORAL TABLET 0.625-5 MG ( <b><i>conj estrog-medroxyprogest ace</i></b> )	T1	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG ( <b><i>conj estrog-medroxyprogest ace</i></b> )	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> <b>T1 =</b> Formulary Medication	<b>PA = Prior Authorization</b>
		<b>QL = Quantity Limit</b>
		<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day</i></b> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Syeda Oral Tablet 3-0.03 Mg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <b><i>levonorgestrel-eth estradiol</i></b> )	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <b><i>levonorgestrel-ethinyl estrad</i></b> )	T1	
<b><i>drospiren-eth estrad-levomefol</i></b> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG ( <b><i>desogestrel-ethinyl estradiol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Vienva Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i></b>	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethindrone-eth estradiol</i></b> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	
<b><i>norethin-eth estradiol-fe</i></b> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<b><i>estradiol</i></b> (Yuvaferm Vaginal Tablet 10 Mcg)	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
<b>Glycogenolytic Agents</b>		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE ( <b><i>glucagon</i></b> )	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE ( <b><i>glucagon</i></b> )	T1	
<b><i>glucagon emergency injection kit 1 mg</i></b>	T1	
<b><i>glucagon emergency injection solution reconstituted 1 mg/ml</i></b>	T1	
<b>Gonadotropins</b>		
ELIGARD SUBCUTANEOUS KIT 22.5 MG ( <b><i>leuprolide acetate (3 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 30 MG ( <b><i>leuprolide acetate (4 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 45 MG ( <b><i>leuprolide acetate (6 month)</i></b> )	T1	
ELIGARD SUBCUTANEOUS KIT 7.5 MG ( <b><i>leuprolide acetate</i></b> )	T1	
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG ( <b><i>leuprolide acetate</i></b> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG ( <i>leuprolide acetate (3 month)</i> )	T1	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG ( <i>leuprolide acetate (4 month)</i> )	T1	PA
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG ( <i>leuprolide acetate</i> )	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG ( <i>leuprolide acetate (3 month)</i> )	T1	PA
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG ( <i>leuprolide acetate (6 month)</i> )	T1	PA
SYNAREL NASAL SOLUTION 2 MG/ML ( <i>nafarelin acetate</i> )	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG ( <i>triptorelin pamoate</i> )	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG ( <i>triptorelin pamoate</i> )	T1	
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG ( <i>goserelin acetate</i> )	T1	
Incretin Mimetics		
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML ( <i>exenatide</i> )	T1	PA
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML ( <i>exenatide</i> )	T1	PA
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML ( <i>semaglutide</i> )	T1	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML ( <i>semaglutide</i> )	T1	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML ( <i>semaglutide</i> )	T1	ST; QL (3 ML per 28 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG ( <i>semaglutide</i> )	T1	ST; QL (30 EA per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML ( <i>dulaglutide</i> )	T1	QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML ( <i>liraglutide</i> )	T1	ST; QL (9 ML per 28 days)
Intermediate-Acting Insulins		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML ( <i>insulin nph human isophane</i> )	T1	QL (30 ML per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML ( <i>insulin nph human isophane</i> )	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML ( <i>insulin nph human isophane</i> )	T1	QL (30 ML per 30 days)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML ( <i>insulin nph human isophane</i> )	T1	QL (30 ML per 30 days)
Long-Acting Insulins		
<i>insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin glargine subcutaneous solution 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin glargine</i> )	T1	QL (30 ML per 30 days)
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin glargine</i> )	T1	QL (30 ML per 30 days)
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin detemir</i> )	T1	QL (30 ML per 30 days)
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML ( <i>insulin detemir</i> )	T1	QL (30 ML per 30 days)
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin glargine-aglr</i> )	T1	QL (30 ML per 30 days)
<b>Meglitinides</b>		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	T1	PA
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	PA
<b>Pituitary</b>		
ACTHAR GEL SUBCUTANEOUS AUTO-INJECTOR 40 UNIT/0.5ML, 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
ACTHAR INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML ( <i>corticotropin</i> )	T1	PA
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	T1	PA
<i>desmopressin acetate injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	T1	PA
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	T1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate spray nasal solution 0.01 %</i>	T1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG ( <i>somatropin</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG ( <b><i>somatropin</i></b> )	T1	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG ( <b><i>somatropin</i></b> )	T1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML ( <b><i>somatropin</i></b> )	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML ( <b><i>somatropin</i></b> )	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML ( <b><i>somatropin</i></b> )	T1	PA
SAIZEN INJECTION SOLUTION RECONSTITUTED 5 MG ( <b><i>somatropin (non-refrigerated)</i></b> )	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG ( <b><i>somatropin (non-refrigerated)</i></b> )	T1	PA
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG ( <b><i>somatropin</i></b> )	T1	PA
<b>Progestins</b>		
<b><i>levonorgestrel-ethinyl estrad</i></b> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
AFTERA ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
AFTERPILL ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>alyacen 1/35 oral tablet 1-35 mg-mcg</i></b>	T1	
<b><i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR ( <b><i>segesterone-ethinyl estradiol</i></b> )	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Apri Oral Tablet 0.15-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin-eth estrad triphasic</i></b> (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>briellyn oral tablet 0.4-35 mg-mcg</i></b>	T1	
<b><i>norethindrone</i></b> (Camila Oral Tablet 0.35 Mg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>levonorgest-eth estrad 91-day</b> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<b>levonorgest-eth estrad 91-day</b> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b>norethin ace-eth estrad-fe</b> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b>levonorgestrel-ethinyl estrad</b> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY ( <b>estradiol-levonorgestrel</b> )	T1	PA
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY ( <b>estradiol-norethindrone acet</b> )	T1	ST
CRINONE VAGINAL GEL 4 %, 8 % ( <b>progesterone</b> )	T1	PA
<b>norgestrel-ethinyl estradiol</b> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
CURAE ORAL TABLET 1.5 MG ( <b>levonorgestrel</b> )	T1	
<b>desogestrel-ethinyl estradiol</b> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b>norethindrone-eth estradiol</b> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b>norethin-eth estrad triphasic</b> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b>levonorgest-eth estrad 91-day</b> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b>norethindrone</b> (Deblitane Oral Tablet 0.35 Mg)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML ( <b>medroxyprogesterone acetate</b> )	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML ( <b>medroxyprogesterone acetate</b> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML ( <i>medroxyprogesterone acetate</i> )	T1	PA
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Oral Tablet 90-20 Mcg)	T1	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	T1	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	T1	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG ( <i>levonorgestrel</i> )	T1	
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	
ELLA ORAL TABLET 30 MG ( <i>ulipristal acetate</i> )	T1	
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	T1	
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	T1	PA
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	T1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin ace-eth estrad-fe</i></b> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<b><i>norethin ace-eth estrad-fe</i></b> (Gem mily Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>etonogestrel-ethinyl estradiol</i></b> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<b><i>norethindrone</i></b> (Heather Oral Tablet 0.35 Mg)	T1	
HER STYLE ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>norethindrone</i></b> (Incassia Oral Tablet 0.35 Mg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<b><i>norethindrone</i></b> (Jencycla Oral Tablet 0.35 Mg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Jinteli Oral Tablet 1-5 Mg-Mcg)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgest-eth estrad 91-day</i></b> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin-eth estradiol-fe</i></b> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>ethynodiol diac-eth estradiol</i></b> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethin ace-eth estrad-fe</i></b> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>levonorgest-eth est &amp; eth est oral tablet 42-21-21-7 days</i></b>	T1	
<b><i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 &amp; 0.01 mg, 0.15-0.03 &amp; 0.01 mg, 0.15-0.03 mg</i></b>	T1	
<b><i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i></b>	T1	
<b><i>levonorgestrel oral tablet 1.5 mg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i></b>	T1	
<b><i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i></b>	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY ( <b><i>levonorgestrel</i></b> )	T1	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG ( <b><i>norethin-eth estrad-fe biphas</i></b> )	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Loryna Oral Tablet 3-0.02 Mg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norgestrel-ethinyl estradiol</i></b> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethindrone</i></b> (Lyleq Oral Tablet 0.35 Mg)	T1	
<b><i>norethindrone</i></b> (Lyza Oral Tablet 0.35 Mg)	T1	
<b><i>marlissa oral tablet 0.15-30 mg-mcg</i></b>	T1	
<b><i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i></b>	T1	
<b><i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i></b>	T1	
<b><i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i></b>	T1	
<b><i>megestrol acetate oral suspension 40 mg/ml</i></b>	T1	
<b><i>megestrol acetate oral tablet 20 mg, 40 mg</i></b>	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethindrone acet-ethinyl est</i></b> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>estradiol-norethindrone acet</i></b> (Mimvey Oral Tablet 1-0.5 Mg)	T1	PA
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norgestimate-eth estradiol</i></b> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
MY CHOICE ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
MY WAY ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG ( <b><i>estradiol valerate-dienogest</i></b> )	T1	
<b><i>norethindrone-eth estradiol</i></b> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
NEW DAY ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG ( <b><i>etonogestrel</i></b> )	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG ( <b><i>drospirenone-estetrol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<b><i>norethindrone</i></b> (Nora-Be Oral Tablet 0.35 Mg)	T1	
<b><i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i></b>	T1	
<b><i>norethindrone acetate oral tablet 5 mg</i></b>	T1	
<b><i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i></b>	T1	
<b><i>norethindrone oral tablet 0.35 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norethindrone-eth estradiol oral tablet 1-5 mg-mcg</i></b>	T1	PA
<b><i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i></b>	T1	
<b><i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i></b>	T1	
<b><i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i></b>	T1	
<b><i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i></b>	T1	
<b><i>norethindrone</i></b> (Norlyda Oral Tablet 0.35 Mg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Ocella Oral Tablet 3-0.03 Mg)	T1	
OPCICON ONE-STEP ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
OPILL ORAL TABLET 0.075 MG ( <b><i>norgestrel</i></b> )	T1	
OPTION 2 ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>desogestrel-ethinyl estradiol</i></b> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethin-eth estrad triphasic</i></b> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
PLAN B ONE-STEP ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
PREMPHASE ORAL TABLET 0.625-5 MG ( <b><i>conj estrogen-medroxyprogesterone</i></b> )	T1	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG ( <b><i>conj estrogen-medroxyprogesterone</i></b> )	T1	
<b><i>progesterone oral capsule 100 mg, 200 mg</i></b>	T1	QL (30 EA per 30 days)
REACT ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
<b><i>norethindrone</i></b> (Sharobel Oral Tablet 0.35 Mg)	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>levonorgest-eth estrad 91-day</i></b> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
SLYND ORAL TABLET 4 MG ( <b><i>drospirenone</i></b> )	T1	
<b><i>norgestimate-eth estradiol</i></b> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levonorgestrel-ethinyl estrad</i></b> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Syeda Oral Tablet 3-0.03 Mg)	T1	
TAKE ACTION ORAL TABLET 1.5 MG ( <b><i>levonorgestrel</i></b> )	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
<b><i>norethin ace-eth estrad-fe</i></b> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norethindron-ethinyl estrad-fe</i></b> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<b><i>levonorg-eth estrad triphasic</i></b> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<b><i>norgestim-eth estrad triphasic</i></b> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR ( <b><i>levonorgestrel-eth estradiol</i></b> )	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG ( <b><i>levonorgestrel-ethinyl estrad</i></b> )	T1	
<b><i>drospiren-eth estrad-levomefol</i></b> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG ( <b><i>desogestrel-ethinyl estradiol</i></b> )	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<b><i>levonorgestrel-ethinyl estrad</i></b> (Vienna Oral Tablet 0.1-20 Mg-Mcg)	T1	
<b><i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i></b>	T1	
<b><i>desogestrel-ethinyl estradiol</i></b> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<b><i>norethindrone-eth estradiol</i></b> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<b><i>norgestimate-eth estradiol</i></b> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<b><i>norethindrone-eth estradiol</i></b> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	
<b><i>norethin-eth estradiol-fe</i></b> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>ethynodiol diac-eth estradiol</i></b> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<b><i>drospirenone-ethinyl estradiol</i></b> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
<b>Rapid-Acting Insulins</b>		
APIDRA INJECTION SOLUTION 100 UNIT/ML ( <b><i>insulin glulisine</i></b> )	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML ( <b><i>insulin glulisine</i></b> )	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML ( <b><i>insulin lispro prot &amp; lispro</i></b> )	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML ( <b><i>insulin lispro prot &amp; lispro</i></b> )	T1	QL (30 ML per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML ( <b><i>insulin lispro prot &amp; lispro</i></b> )	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML ( <b><i>insulin lispro</i></b> )	T1	QL (30 ML per 30 days)
<b><i>insulin asp prot &amp; asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin aspart injection solution 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin aspart prot &amp; aspart subcutaneous suspension (70-30) 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin lispro injection solution 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)
<b><i>insulin lispro prot &amp; lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i></b>	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Short-Acting Insulins</b>		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML ( <i>insulin regular human</i> )	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML ( <i>insulin nph isophane &amp; regular</i> )	T1	QL (30 ML per 30 days)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML ( <i>insulin regular human</i> )	T1	QL (30 ML per 30 days)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML ( <i>insulin regular human</i> )	T1	QL (120 ML per 30 days)
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML ( <i>insulin regular human</i> )	T1	QL (30 ML per 30 days)
<b>Sodium-Gluc Cotransport 2 (Sglt2) Inhib</b>		
FARXIGA ORAL TABLET 10 MG, 5 MG ( <i>dapagliflozin propanediol</i> )	T1	QL (30 EA per 30 days)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG ( <i>canagliflozin-metformin hcl</i> )	T1	QL (60 EA per 30 days)
INVOKANA ORAL TABLET 100 MG, 300 MG ( <i>canagliflozin</i> )	T1	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG ( <i>empagliflozin</i> )	T1	QL (30 EA per 30 days)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG ( <i>empagliflozin-metformin hcl</i> )	T1	QL (60 EA per 30 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		<b>AL = Age Limit</b>
<b>UPPERCASE = Brand name</b> drugs	<b>Drug Tier</b> <b>T1 = Formulary Medication</b>	<b>PA = Prior Authorization</b> <b>QL = Quantity Limit</b> <b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	T1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG ( <i>dapagliflozin prop-metformin</i> )	T1	QL (30 EA per 30 days)
<b>Somatostatin Agonists</b>		
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	T1	
<b>Somatotropin Agonists</b>		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG ( <i>somatropin</i> )	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG ( <i>somatropin</i> )	T1	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG ( <i>somatropin</i> )	T1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML ( <i>somatropin</i> )	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML ( <i>somatropin</i> )	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML ( <i>somatropin</i> )	T1	PA
SAIZEN INJECTION SOLUTION RECONSTITUTED 5 MG ( <i>somatropin (non-refrigerated)</i> )	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG ( <i>somatropin (non-refrigerated)</i> )	T1	PA
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG ( <i>somatropin</i> )	T1	PA
<b>Somatotropin Antagonists</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG ( <i>pegvisomant</i> )	T1	
<b>Sulfonylureas</b>		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	T1	
<i>glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	T1	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	T1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	T1	
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	T1	PA
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	T1	
<b>Thiazolidinediones</b>		
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	T1	ST
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	T1	
<b>Thyroid Agents</b>		
ADTHYZA ORAL TABLET 130 MG, 16.25 MG, 32.5 MG, 65 MG, 97.5 MG ( <i>thyroid</i> )	T1	
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG ( <i>thyroid</i> )	T1	
<i>levothyroxine sodium</i> (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)	T1	
<i>levothyroxine sodium</i> (Levo-T 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)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>levothyroxine sodium 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></b>	T1	
<b><i>levothyroxine sodium</i></b> (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	T1	
<b><i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i></b>	T1	
<b><i>niva thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG ( <b><i>thyroid</i></b> )	T1	
SYNTHROID 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 ( <b><i>levothyroxine sodium</i></b> )	T1	
<b><i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i></b>	T1	
<b><i>levothyroxine sodium</i></b> (Unithroid 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)	T1	
<b>Immunomodulatory Agents (90:00)</b>		
<b>Amino Acid Polymers</b>		
<b><i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i></b>	T1	
<b><i>glatiramer acetate</i></b> (Glatopa Subcutaneous Solution Prefilled Syringe 40 Mg/ML)	T1	
<b>Antimetabolites, Immunosupp Therapy Misc</b>		
<b><i>azathioprine oral tablet 50 mg</i></b>	T1	
<b><i>mycophenolate mofetil oral capsule 250 mg</i></b>	T1	
<b>Calcineurin Inhibitors, Misc (90:28)</b>		
CEQUA OPHTHALMIC SOLUTION 0.09 % ( <b><i>cyclosporine</i></b> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral solution 100 mg/ml</i></b>	T1	
<b><i>cyclosporine ophthalmic emulsion 0.05 %</i></b>	T1	PA
<b><i>cyclosporine oral capsule 100 mg, 25 mg</i></b>	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Solution 100 Mg/ML)	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine modified</i></b> )	T1	
NEORAL ORAL SOLUTION 100 MG/ML ( <b><i>cyclosporine modified</i></b> )	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine</i></b> )	T1	
<b>Disease-Modifying Antirheumat Drugs Misc</b>		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG ( <b><i>vedolizumab</i></b> )	T1	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG ( <b><i>abatacept</i></b> )	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML ( <b><i>abatacept</i></b> )	T1	PA
<b>Disease-Modifying Antirheumatic Drugs</b>		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-axxq</i></b> )	T1	PA
<b><i>hydroxychloroquine sulfate oral tablet 200 mg</i></b>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-dyyb</i></b> )	T1	PA
<b><i>infliximab intravenous solution reconstituted 100 mg</i></b>	T1	PA
<b><i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium oral tablet 2.5 mg</i></b>	T1	
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
<b><i>sulfasalazine oral tablet 500 mg</i></b>	T1	
<b><i>sulfasalazine oral tablet delayed release 500 mg</i></b>	T1	
Fumarates		
<b><i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i></b>	T1	PA
Immunomodulatory Agents (90:00)		
<b><i>cyclophosphamide oral tablet 25 mg, 50 mg</i></b>	T1	
<b><i>mercaptopurine oral tablet 50 mg</i></b>	T1	
Interferons		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML ( <i>interferon beta-1a</i> )	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML ( <i>interferon beta-1a</i> )	T1	
BETASERON SUBCUTANEOUS KIT 0.3 MG ( <i>interferon beta-1b</i> )	T1	
EXTAVIA SUBCUTANEOUS KIT 0.3 MG ( <i>interferon beta-1b</i> )	T1	
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML ( <i>interferon beta-1a</i> )	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG ( <i>interferon beta-1a</i> )	T1	
Interleukin Inhibitor Agents, Misc		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML ( <i>omalizumab</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML ( <b><i>omalizumab</i></b> )	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG ( <b><i>omalizumab</i></b> )	T1	PA
Interleukin-Mediated Agents, Misc		
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML ( <b><i>sarilumab</i></b> )	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML ( <b><i>sarilumab</i></b> )	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML ( <b><i>anakinra</i></b> )	T1	PA
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML ( <b><i>tocilizumab-aazg</i></b> )	T1	PA
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML ( <b><i>tocilizumab-aazg</i></b> )	T1	PA
Janus Kinase Inhibitors, Miscellaneous		
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG ( <b><i>baricitinib</i></b> )	T1	PA
XELJANZ ORAL SOLUTION 1 MG/ML ( <b><i>tofacitinib citrate</i></b> )	T1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG ( <b><i>tofacitinib citrate</i></b> )	T1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG ( <b><i>tofacitinib citrate</i></b> )	T1	PA
Monocarboxylic Acid Amide Agents		
<b><i>leflunomide oral tablet 10 mg, 20 mg</i></b>	T1	
Mtor Inhibitors, Miscellaneous		
<b><i>sirolimus oral solution 1 mg/ml</i></b>	T1	
<b><i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
Phosphodiesterase-4 Inhibitors, Misc		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTEZLA ORAL TABLET 20 MG, 30 MG ( <i>apremilast</i> )	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG ( <i>apremilast</i> )	T1	PA
<b>Sphingosine 1-Phosphate (S1p) Agents</b>		
<i> fingolimod hcl oral capsule 0.5 mg</i>	T1	PA
<b>Tumor Necrosis Factor Inhibitors, Misc</b>		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-axxq</i> )	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <i>etanercept</i> )	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML ( <i>etanercept</i> )	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <i>etanercept</i> )	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>adalimumab-bwwd</i> )	T1	QL (1.6 ML per 28 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs <b>UPPERCASE =</b> Brand name drugs		<b>AL =</b> Age Limit <b>PA =</b> Prior Authorization <b>QL =</b> Quantity Limit <b>ST =</b> Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <i>adalimumab-bwwd</i> )	T1	QL (3.2 ML per 28 days)
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-dyyb</i> )	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
<b>Local Anesthetics (Parenteral)</b>		
<b>Local Anesthetics (Parenteral)</b>		
<i>bupivacaine fisiopharma injection solution 2.5 mg/ml, 5 mg/ml</i>	T1	
<i>bupivacaine hcl (pf) injection solution 0.25 %, 0.5 %, 0.75 %</i>	T1	
<i>bupivacaine hcl injection solution 0.25 %, 0.5 %</i>	T1	
<i>bupivacaine hcl-nacl epidural solution 0.125-0.9 %</i>	T1	
<i>bupivacaine in dextrose intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine spinal intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine-epinephrine (pf) injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>bupivacaine-epinephrine injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chloroprocaine hcl (pf) injection solution 2 %</i>	T1	
<i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i>	T1	
<i>fentanyl-bupivacaine-nacl epidural solution 0.2-0.1-0.9 mg/100ml-%, 0.2-0.125-0.9 mg/100ml-%, 0.5-0.1-0.9 mg/250ml-%, 0.5-0.125-0.9 mg/250ml-%</i>	T1	
<i>lidocaine hcl (pf) injection solution 0.5 %</i>	T1	
<i>lidocaine hcl injection solution 0.5 %, 1 %, 2 %</i>	T1	
<i>lidocaine hcl injection solution prefilled syringe 200 mg/10ml</i>	T1	
<i>lidocaine-epinephrine (pf) injection solution 1 %-1:100000</i>	T1	
<i>lidocaine-epinephrine injection solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000</i>	T1	
POLOCAINE INJECTION SOLUTION 1 %, 2 % ( <i>mepivacaine hcl</i> )	T1	
POLOCAINE-MPF INJECTION SOLUTION 1 %, 1.5 %, 2 % ( <i>mepivacaine hcl</i> )	T1	
<i>ropivacaine hcl injection solution 10 mg/ml, 2 mg/ml, 5 mg/ml, 7.5 mg/ml</i>	T1	
<i>bupivacaine-epinephrine</i> (Sensorcaine/Epinephrine Injection Solution 0.25% -1:200000, 0.5% -1:200000)	T1	
<i>bupivacaine hcl</i> (Sensorcaine-Mpf Injection Solution 0.75 %)	T1	
<i>bupivacaine-epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % ( <i>bupivacaine-epinephrine</i> )	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 ( <i>lidocaine-epinephrine</i> )	T1	
<b>Miscellaneous Therapeutic Agents</b>		
<b>5-Alpha-Reductase Inhibitors</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>finasteride oral tablet 5 mg</i>	T1	
<b>5-Alpha-Reductase Inhibitors (92:04)</b>		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	T1	
<i>finasteride oral tablet 5 mg</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<b>Antidotes (92:12)</b>		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE ( <i>glucagon</i> )	T1	
CHEMET ORAL CAPSULE 100 MG ( <i>succimer</i> )	T1	
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA
<i>glucagon emergency injection kit 1 mg</i>	T1	
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	T1	
IOSAT ORAL TABLET 65 MG ( <i>potassium iodide</i> ( <i>antidote</i> ))	T1	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	T1	PA
<i>leucovorin calcium oral tablet 5 mg</i>	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	QL (2 ML per 180 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML ( <i>naloxone hcl</i> )	T1	QL (1 ML per 180 days)
Antigout Agents		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
<i>colchicine oral capsule 0.6 mg</i>	T1	PA
<i>colchicine oral tablet 0.6 mg</i>	T1	QL (30 EA per 30 days)
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>probenecid oral tablet 500 mg</i>	T1	
Bone Resorption Inhibitors		
<i>alendronate sodium oral solution 70 mg/75ml</i>	T1	QL (75 ML per 30 days)
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>estradiol</i></b> (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<b><i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i></b>	T1	
<b><i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i></b>	T1	QL (8 EA per 28 days)
<b><i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i></b>	T1	
<b><i>estradiol vaginal cream 0.1 mg/gm</i></b>	T1	
<b><i>estradiol vaginal tablet 10 mcg</i></b>	T1	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR ( <b><i>estradiol acetate</i></b> )	T1	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT ( <b><i>alendronate-cholecalciferol</i></b> )	T1	PA
<b><i>ibandronate sodium oral tablet 150 mg</i></b>	T1	QL (1 EA per 28 days)
<b><i>estradiol</i></b> (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG ( <b><i>esterified estrogens</i></b> )	T1	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG ( <b><i>estrogens conjugated</i></b> )	T1	
PREMARIN VAGINAL CREAM 0.625 MG/GM ( <b><i>estrogens, conjugated</i></b> )	T1	
<b><i>raloxifene hcl oral tablet 60 mg</i></b>	T1	
<b><i>risedronate sodium oral tablet 5 mg</i></b>	T1	QL (30 EA per 30 days)
<b><i>estradiol</i></b> (Yuvafem Vaginal Tablet 10 Mcg)	T1	
<b><i>zoledronic acid intravenous concentrate 4 mg/5ml</i></b>	T1	QL (0.51 ML per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs <b>UPPERCASE =</b> Brand name drugs		<b>AL =</b> Age Limit <b>PA =</b> Prior Authorization <b>QL =</b> Quantity Limit <b>ST =</b> Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Cariostatic Agents</b>		
<i>sodium fluoride</i> (Denta 5000 Plus Dental Cream 1.1 %)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PERIOMED MOUTH/THROAT CONCENTRATE 0.63 % ( <i>stannous fluoride</i> )	T1	
PREVIDENT DENTAL GEL 1.1 % ( <i>sodium fluoride</i> )	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	T1	
<b>Complement Inhibitors</b>		
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT ( <i>c1 esterase inhibitor (human)</i> )	T1	PA
<b>Complement Inhibitors (92:32)</b>		
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT ( <i>c1 esterase inhibitor (human)</i> )	T1	PA
<b>Disease-Modifying Antirheumatic Agents</b>		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i></b>	T1	QL (2 EA per 28 days)
<b><i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i></b>	T1	QL (2 EA per 28 days)
<b><i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i></b>	T1	QL (4 EA per 28 days)
<b><i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i></b>	T1	QL (4 EA per 28 days)
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-axxq</i></b> )	T1	PA
<b><i>azathioprine oral tablet 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral solution 100 mg/ml</i></b>	T1	
<b><i>cyclosporine oral capsule 100 mg, 25 mg</i></b>	T1	
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <b><i>etanercept</i></b> )	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML ( <b><i>etanercept</i></b> )	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <b><i>etanercept</i></b> )	T1	PA
<b><i>cyclosporine modified</i></b> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Solution 100 Mg/ML)	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (3.2 ML per 28 days)

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>hydroxychloroquine sulfate oral tablet 200 mg</i></b>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-dyyb</i></b> )	T1	PA
<b><i>infliximab intravenous solution reconstituted 100 mg</i></b>	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML ( <b><i>sarilumab</i></b> )	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML ( <b><i>sarilumab</i></b> )	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML ( <b><i>anakinra</i></b> )	T1	PA
<b><i>leflunomide oral tablet 10 mg, 20 mg</i></b>	T1	
<b><i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium oral tablet 2.5 mg</i></b>	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine modified</i></b> )	T1	
NEORAL ORAL SOLUTION 100 MG/ML ( <b><i>cyclosporine modified</i></b> )	T1	
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG ( <b><i>baricitinib</i></b> )	T1	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG ( <b><i>abatacept</i></b> )	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML ( <b><i>abatacept</i></b> )	T1	PA
OTEZLA ORAL TABLET 30 MG ( <b><i>apremilast</i></b> )	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG ( <b><i>apremilast</i></b> )	T1	PA
<b><i>penicillamine oral capsule 250 mg</i></b>	T1	PA
<b><i>penicillamine oral tablet 250 mg</i></b>	T1	PA

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG ( <i>cyclosporine</i> )	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
XELJANZ ORAL SOLUTION 1 MG/ML ( <i>tofacitinib citrate</i> )	T1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG ( <i>tofacitinib citrate</i> )	T1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG ( <i>tofacitinib citrate</i> )	T1	PA
<b>Immunomodulatory Agents</b>		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML ( <i>interferon gamma-1b</i> )	T1	
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i></b>	T1	QL (4 EA per 28 days)
<b><i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i></b>	T1	QL (4 EA per 28 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML ( <b><i>interferon beta-1a</i></b> )	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML ( <b><i>interferon beta-1a</i></b> )	T1	
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-axxq</i></b> )	T1	PA
<b><i>azathioprine oral tablet 50 mg</i></b>	T1	
BETASERON SUBCUTANEOUS KIT 0.3 MG ( <b><i>interferon beta-1b</i></b> )	T1	
<b><i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral solution 100 mg/ml</i></b>	T1	
<b><i>cyclosporine oral capsule 100 mg, 25 mg</i></b>	T1	
<b><i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i></b>	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML ( <b><i>etanercept</i></b> )	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML ( <b><i>etanercept</i></b> )	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML ( <b><i>etanercept</i></b> )	T1	PA
EXTAVIA SUBCUTANEOUS KIT 0.3 MG ( <b><i>interferon beta-1b</i></b> )	T1	
<b><i>fingolimod hcl oral capsule 0.5 mg</i></b>	T1	PA
<b><i>cyclosporine modified</i></b> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Solution 100 Mg/ML)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i></b>	T1	
<b><i>glatiramer acetate</i></b> (Glatopa Subcutaneous Solution Prefilled Syringe 40 Mg/ML)	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML ( <b><i>adalimumab-bwwd</i></b> )	T1	QL (3.2 ML per 28 days)
<b><i>hydroxychloroquine sulfate oral tablet 200 mg</i></b>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-dyyb</i></b> )	T1	PA
<b><i>infliximab intravenous solution reconstituted 100 mg</i></b>	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML ( <b><i>anakinra</i></b> )	T1	PA
<b><i>leflunomide oral tablet 10 mg, 20 mg</i></b>	T1	
<b><i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i></b>	T1	PA
<b><i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium oral tablet 2.5 mg</i></b>	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine modified</i></b> )	T1	
NEORAL ORAL SOLUTION 100 MG/ML ( <b><i>cyclosporine modified</i></b> )	T1	
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG ( <b><i>abatacept</i></b> )	T1	PA

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML ( <i>abatacept</i> )	T1	PA
OTEZLA ORAL TABLET 20 MG, 30 MG ( <i>apremilast</i> )	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG ( <i>apremilast</i> )	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML ( <i>peginterferon alfa-2a</i> )	T1	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG ( <i>pomalidomide</i> )	T1	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML ( <i>interferon beta-1a</i> )	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG ( <i>interferon beta-1a</i> )	T1	
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG ( <i>lenalidomide</i> )	T1	PA
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG ( <i>cyclosporine</i> )	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML ( <i>adalimumab-ryvk</i> )	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML ( <i>golimumab</i> )	T1	PA
<i>sulfasalazine oral tablet 500 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>sulfasalazine oral tablet delayed release 500 mg</i></b>	T1	
THALOMID ORAL CAPSULE 100 MG, 50 MG ( <i>thalidomide</i> )	T1	PA
<b>Immunosuppressive Agents</b>		
<b><i>azathioprine oral tablet 50 mg</i></b>	T1	
<b><i>cyclophosphamide oral tablet 25 mg, 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>cyclosporine modified oral solution 100 mg/ml</i></b>	T1	
<b><i>cyclosporine oral capsule 100 mg, 25 mg</i></b>	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<b><i>cyclosporine modified</i></b> (Gengraf Oral Solution 100 Mg/ML)	T1	
<b><i>leflunomide oral tablet 10 mg, 20 mg</i></b>	T1	
<b><i>mercaptopurine oral tablet 50 mg</i></b>	T1	
<b><i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i></b>	T1	
<b><i>methotrexate sodium oral tablet 2.5 mg</i></b>	T1	
<b><i>mycophenolate mofetil oral capsule 250 mg</i></b>	T1	
<b><i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i></b>	T1	
<b><i>mycophenolate mofetil oral tablet 500 mg</i></b>	T1	
<b><i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i></b>	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine modified</i></b> )	T1	
NEORAL ORAL SOLUTION 100 MG/ML ( <b><i>cyclosporine modified</i></b> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>pimecrolimus external cream 1 %</i></b>	T1	PA
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG ( <b><i>tacrolimus</i></b> )	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG ( <b><i>cyclosporine</i></b> )	T1	
<b><i>sirolimus oral solution 1 mg/ml</i></b>	T1	
<b><i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i></b>	T1	
<b><i>tacrolimus external ointment 0.03 %, 0.1 %</i></b>	T1	QL (30 GM per 30 days)
<b><i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i></b>	T1	
Other Miscellaneous Therapeutic Agents		
<b><i>betaine oral powder</i></b>	T1	
<b><i>bp vit 3 oral capsule 1 mg</i></b>	T1	
<b><i>calcium d-glucarate oral capsule 500 mg</i></b>	T1	
<b><i>complete natal dha oral 29-1-200 &amp; 200 mg</i></b>	T1	
<b><i>cvs fish oil oral capsule 1000 mg</i></b>	T1	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG ( <b><i>cysteamine bitartrate</i></b> )	T1	
<b><i>dalfampridine er oral tablet extended release 12 hour 10 mg</i></b>	T1	PA
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML ( <b><i>sodium hyaluronate (viscosup)</i></b> )	T1	
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT ( <b><i>abobotulinumtoxina</i></b> )	T1	PA
ELMIRON ORAL CAPSULE 100 MG ( <b><i>pentosan polysulfate sodium</i></b> )	T1	PA
<b><i>eqf fish oil oral capsule 1000 mg</i></b>	T1	
EVOTAZ ORAL TABLET 300-150 MG ( <b><i>atazanavir-cobicistat</i></b> )	T1	
<b><i>fish oil concentrate oral capsule 1000 mg, 300 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fish oil omega-3 oral capsule 1000 mg</i>	T1	
<i>fish oil oral capsule 1000 mg</i>	T1	
<i>fish oil oral capsule delayed release 1000 mg</i>	T1	
<i>gnp fish oil oral capsule 1000 mg</i>	T1	
<i>gnp fish oil oral capsule delayed release 1000 mg</i>	T1	
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML ( <i>sodium hyaluronate (viscosup)</i> )	T1	
<i>levocarnitine oral tablet 330 mg</i>	T1	
<i>levocarnitine sf oral solution 1 gm/10ml</i>	T1	
LODOCO ORAL TABLET 0.5 MG ( <i>colchicine</i> )	T1	PA
<i>metyrosine oral capsule 250 mg</i>	T1	
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	T1	
<i>odorless coated fish oil oral capsule delayed release 1000 mg</i>	T1	
<i>omega 3 oral capsule 1000 mg</i>	T1	
<i>omega-3 fatty acids oral capsule 1000 mg</i>	T1	
<i>omega-3 fish oil oral capsule 1000 mg</i>	T1	
<i>omega-3 oral capsule 1000 mg</i>	T1	
<i>prenatal gummies/dha &amp; fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	T1	
PREZCOBIX ORAL TABLET 800-150 MG ( <i>darunavir-cobicistat</i> )	T1	
<i>sm fish oil oral capsule 1000 mg</i>	T1	
<i>sm fish oil oral capsule delayed release 1000 mg</i>	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG ( <i>elviteg-cobic-emtricit-tenofdf</i> )	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG ( <i>darun-cobic-emtricit-tenofaf</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYBOST ORAL TABLET 150 MG ( <i>cobicistat</i> )	T1	
<i>urin ds oral tablet 81.6 mg</i>	T1	
<i>urneva oral capsule 120 mg</i>	T1	
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT ( <i>incobotulinumtoxina</i> )	T1	PA
Protective Agents		
<i>adapalene external gel 0.1 %</i>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>cvs adapalene external gel 0.1 %</i>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	T1	PA
MESNEX ORAL TABLET 400 MG ( <i>mesna</i> )	T1	
Nonhormonal Contraceptives		
Nonhormonal Contraceptives		
<i>aimsco lubricated</i>	T1	
CAYA VAGINAL DIAPHRAGM ( <i>diaphragm arc-spring</i> )	T1	
<i>condoms</i>	T1	
DUREX EXTRA SENSITIVE THIN DEVICE ( <i>condoms latex lubricated</i> )	T1	
DUREX REALFEEL DEVICE ( <i>condoms non-latex lubricated</i> )	T1	
ENCARE VAGINAL SUPPOSITORY 100 MG ( <i>nonoxynol-9</i> )	T1	
FANTASY LUBRICATED ( <i>condoms latex lubricated</i> )	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FANTASY LUBRICATED/SPERMICIDE ( <i>condoms latex lubricated</i> )	T1	
FC2 FEMALE CONDOM ( <i>condoms - female</i> )	T1	
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM ( <i>cervical caps</i> )	T1	
KAMELEON LUBRICATED ( <i>condoms latex lubricated</i> )	T1	
<i>kimono</i>	T1	
KIMONO COLORS DEVICE ( <i>condoms latex lubricated</i> )	T1	
KIMONO MAXX-LARGE FLARE ( <i>condoms latex lubricated</i> )	T1	
<i>kimono micro thin</i>	T1	
<i>kimono micro thin plus</i>	T1	
<i>kimono plus</i>	T1	
<i>kimono ps</i>	T1	
<i>kimono ps plus</i>	T1	
<i>kimono sensation</i>	T1	
<i>kimono sensation plus</i>	T1	
KIMONO SPECIAL DEVICE ( <i>condoms latex lubricated</i> )	T1	
<i>maxx</i>	T1	
<i>maxx plus</i>	T1	
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM ( <i>diaphragms</i> )	T1	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % ( <i>nonoxynol-9</i> )	T1	
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE ( <i>copper</i> )	T1	
PHEXXI VAGINAL GEL 1.8-1-0.4 % ( <i>lactic ac-citric ac-pot bitart</i> )	T1	
REALITY LATEX CONDOMS ( <i>condoms latex lubricated</i> )	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REALITY LATEX/ULTRA TEXTURED DEVICE ( <i>condoms latex lubricated</i> )	T1	
REALITY LATEX/ULTRA THIN DEVICE ( <i>condoms latex lubricated</i> )	T1	
TODAY SPONGE VAGINAL 1000 MG ( <i>nonoxynol-9</i> )	T1	
TRUSTEX COLOR CONDOMS + LUBE ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUB/RIBBED/STUDED ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUB/SPERMICIDE EX ST ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUB/SPERMICIDE XL ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUBRICATED ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUBRICATED EX LARGE ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUBRICATED EXTRA ST ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX LUBRICATED/SPERMICIDE ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX NATURAL CONDOMS + LUBE ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX NON-LUBRICATED ( <i>condoms latex non-lubricated</i> )	T1	
TRUSTEX RIA LUB/SPERMICIDE ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX RIA LUBRICATED ( <i>condoms latex lubricated</i> )	T1	
TRUSTEX RIA NON-LUBRICATED ( <i>condoms latex non-lubricated</i> )	T1	
TRUSTEX-NONOXYNOL-9/RIB/STUD ( <i>condoms latex lubricated</i> )	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % <i>(nonoxynol-9)</i>	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % <i>(nonoxynol-9)</i>	T1	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % <i>(diaphragm wide seal)</i>	T1	
<b>Oxytocics</b>		
<b>Oxytocics</b>		
<i>methylergonovine maleate injection solution 0.2 mg/ml</i>	T1	
<i>methylergonovine maleate oral tablet 0.2 mg</i>	T1	QL (28 EA per 7 days)
<i>mifepristone oral tablet 200 mg</i>	T1	
<i>oxytocin injection solution 10 unit/ml</i>	T1	
<b>Pharmaceutical Aids</b>		
<b>Pharmaceutical Aids</b>		
<i>bacteriostatic water(benz alc) injection solution</i>	T1	
<i>sterile water for injection injection solution</i>	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Respiratory Tract Agents</b>		
<b>Alpha And Beta Adrenergic Agonist(Respr)</b>		
<i>12 hour decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>cvs 12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
<i>cvs nasal decongestant oral tablet 30 mg</i>	T1	
<i>epinephrine (anaphylaxis) injection solution 1 mg/ml, 30 mg/30ml</i>	T1	
<i>epinephrine hcl (nasal) nasal solution 0.1 %</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	T1	QL (4 EA per 180 days)
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
<i>eql nasal decongestant oral tablet 30 mg</i>	T1	
<i>gnp nasal decongestant oral tablet 30 mg</i>	T1	
<i>gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg</i>	T1	
<i>kp pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	T1	
<i>meijer nasal decongestant oral tablet 30 mg</i>	T1	
<i>nasal decongestant d oral tablet 30 mg</i>	T1	
<i>nasal decongestant oral tablet 30 mg</i>	T1	
<i>pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg</i>	T1	
<i>pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	T1	
<i>qc nasal decongestant pe oral tablet 30 mg</i>	T1	
<i>qc suphedrine maximum strength oral tablet extended release 12 hour 120 mg</i>	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra sinus/congestion relief oral tablet extended release 12 hour 120 mg</i>	T1	
<i>ra suphedrine oral tablet 30 mg</i>	T1	
<i>ra suphedrine oral tablet extended release 12 hour 120 mg</i>	T1	
<i>sinus 12 hour oral tablet extended release 12 hour 120 mg</i>	T1	
<i>sm nasal decongestant max st oral tablet 30 mg</i>	T1	
<i>sm nasal decongestant oral tablet extended release 12 hour 120 mg</i>	T1	
SUDOGEST ORAL TABLET 60 MG ( <i>pseudoephedrine hcl</i> )	T1	
<i>suphedrine 12hour oral tablet extended release 12 hour 120 mg</i>	T1	
WAL-PHED 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 120 MG ( <i>pseudoephedrine hcl</i> )	T1	
WAL-PHED D ORAL TABLET 30 MG ( <i>pseudoephedrine hcl</i> )	T1	
<b>Anticholinergic Agents (Respir.Tract)</b>		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic ointment 1 %</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT ( <i>ipratropium bromide hfa</i> )	T1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT ( <i>ipratropium-albuterol</i> )	T1	
<i>ipratropium bromide inhalation solution 0.02 %</i>	T1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	T1	

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<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT ( <i>tiotropium bromide monohydrate</i> )	T1	QL (4 GM per 30 days)
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	T1	
Anti-Inflammatory Agents (Respiratory)		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML ( <i>mepolizumab</i> )	T1	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML ( <i>mepolizumab</i> )	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG ( <i>mepolizumab</i> )	T1	PA
Antitussives		
<i>actidom dmx oral liquid 10-30-200 mg/5ml</i>	T1	
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>benzonatate oral capsule 100 mg, 200 mg</i>	T1	
<i>biodesp dm oral syrup 5-15-100 mg/5ml</i>	T1	
<i>bio-dtuss dmx oral liquid 30-1-20 mg/5ml</i>	T1	
<i>bio-rytuss oral liquid 5-2-10 mg/5ml</i>	T1	
<i>chest congestion relief dm oral syrup 10-100 mg/5ml</i>	T1	
<i>childrens cough oral liquid 5-100 mg/5ml</i>	T1	
<i>childrens mucus relief cough oral liquid 5-100 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	T1	
<i>coditussin ac oral liquid 200-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cough &amp; chest congestion dm oral liquid 5-100 mg/5ml</i>	T1	
<i>cough &amp; congestion kids oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs chest congest/cough child oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs cold &amp; cough childrens oral solution 2.5-5 mg/5ml</i>	T1	
<i>cvs cough &amp; chest congestion oral liquid 20-400 mg/20ml</i>	T1	
<i>cvs dm maximum adult oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs mucus dm extended release oral tablet extended release 12 hour 30-600 mg</i>	T1	QL (120 EA per 30 days)
<i>cvs mucus dm extended release oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>cvs tussin dm max st oral liquid 20-400 mg/20ml</i>	T1	
DELSYM CGH/CHEST CONG DM CHILD ORAL LIQUID 5-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	
<i>despec dm oral syrup 5-10-100 mg/5ml</i>	T1	
<i>despec dm-g oral syrup 5-10-100 mg/5ml</i>	T1	
<i>despec eda oral liquid 2.5-5-50 mg/ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml</i></b>	T1	
DIABETIC TUSSIN DM MAX ST ORAL LIQUID 10-200 MG/5ML ( <b><i>dextromethorphan-guaifenesin</i></b> )	T1	
<b><i>diphen oral tablet 25 mg</i></b>	T1	
<b><i>diphenhist oral capsule 25 mg</i></b>	T1	
<b><i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i></b>	T1	
<b><i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>diphenhydramine hcl oral tablet 25 mg</i></b>	T1	
<b><i>diphenhydramine hcl oral tablet chewable 12.5 mg</i></b>	T1	
<b><i>dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg</i></b>	T1	
<b><i>dometuss-dmx oral liquid 10-30-200 mg/5ml</i></b>	T1	
<b><i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i></b>	T1	
<b><i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>eq allergy relief oral capsule 25 mg</i></b>	T1	
<b><i>eq allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>eq cough childrens oral liquid 5-100 mg/5ml</i></b>	T1	
<b><i>eq mucus relief dm oral tablet extended release 12 hour 30-600 mg</i></b>	T1	QL (120 EA per 30 days)
<b><i>eq tussin dm cough/chest oral syrup 10-100 mg/5ml</i></b>	T1	
<b><i>eql allergy oral tablet 25 mg</i></b>	T1	
<b><i>eql allergy relief oral tablet 25 mg</i></b>	T1	
<b><i>eql childrens allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>eql nighttime sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>eql sleep aid oral capsule 50 mg</i></b>	T1	
<b><i>eql tussin dm cough/chest cong oral syrup 100-10 mg/5ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>g tussin ac oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
GILTUSS ALLERGY COUGH & CONGES ORAL LIQUID 5-2-10 MG/5ML ( <i>phenylephrine-chlorphen-dm</i> )	T1	
<i>glenmax peb dm oral liquid 5-2-10 mg/5ml</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	
<i>gnp allergy relief oral tablet 25 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	T1	
<i>gnp tussin cf cough &amp; cold oral syrup 5-10-100 mg/5ml</i>	T1	
<i>gnp tussin dm cough oral liquid 100-10 mg/5ml</i>	T1	
<i>gnp tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>goodsense tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>goodsense tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>g-supress dx pediatric oral liquid 2.5-5-50 mg/ml</i>	T1	
G-TRON PED ORAL LIQUID 10-15-350 MG/5ML ( <i>phenylephrine-dm-gg</i> )	T1	
<i>guaiaitussin ac oral syrup 100-10 mg/5ml</i>	T1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>guaifenesin-codeine oral solution 200-20 mg/10ml</i>	T1	
<i>guaifenesin-dm oral syrup 100-10 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	T1	QL (45 EA per 30 days); AL (Min 18 Years)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	T1	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	T1	
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>maxi-tuss gmx oral liquid 10-200 mg/5ml</i>	T1	
<i>maxi-tuss jr oral liquid 2.5-5 mg/5ml</i>	T1	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>mucus relief cough childrens oral liquid 5-100 mg/5ml</i>	T1	
<i>mucus relief dm max oral liquid 20-400 mg/20ml, 5-100 mg/5ml</i>	T1	
<i>mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>mucus relief dm oral liquid 20-400 mg/20ml</i>	T1	
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	T1	QL (120 EA per 30 days)
<i>mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>neotuss oral liquid 30-200 mg/5ml</i>	T1	
<i>night time sleep aid oral tablet 25 mg</i>	T1	
<i>nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pharbedryl oral capsule 25 mg, 50 mg</i>	T1	
<i>pres gen pediatric oral liquid 2.5-5-75 mg/5ml</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>qc complete allergy medicine oral tablet 25 mg</i>	T1	
<i>qc sleep aid max st oral capsule 50 mg</i>	T1	
<i>qc tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>ra allergy medication oral capsule 25 mg</i>	T1	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy medication oral tablet 25 mg</i>	T1	
<i>ra allergy oral tablet 25 mg</i>	T1	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>ra tussin cgh/chest congest dm oral liquid 100-10 mg/5ml</i>	T1	
<i>ra tussin dm oral liquid 100-10 mg/5ml</i>	T1	
<i>robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml</i>	T1	
ROBAFEN DM CGH/CHEST CONGEST ORAL LIQUID 10-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROBITUSSIN CHILD COUGH/COLD CF ORAL LIQUID 2.5-5-50 MG/5ML ( <i>phenylephrine-dm-gg</i> )	T1	
SCOT-TUSSIN DM ORAL LIQUID 2-15 MG/5ML ( <i>chlorpheniramine-dm</i> )	T1	
SCOT-TUSSIN SENIOR ORAL LIQUID 15-200 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>sm tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>sm tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>sm tussin dm oral syrup 100-10 mg/5ml</i>	T1	
<i>sorbutuss nr oral liquid 10-100 mg/5ml</i>	T1	
<i>supress-dx pediatric oral liquid 2.5-5-50 mg/ml</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
TUSNEL ORAL TABLET 60-30-400 MG ( <i>pseudoephedrine-dm-gg</i> )	T1	
<i>tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>tussin dm oral syrup 100-10 mg/5ml</i>	T1	
<i>virtussin a/c oral solution 100-10 mg/5ml</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	

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		<b>Coverage Requirements and Limits</b>
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>

<b>Prescription Drug Name</b>	<b>Drug Tier</b>	<b>Coverage Requirements and Limits</b>
<b><i>wal-som maximum strength oral capsule 50 mg</i></b>	T1	
WAL-TUSSIN COUGH/CHEST DM ORAL SYRUP 100-10 MG/5ML ( <b><i>dextromethorphan-guaifenesin</i></b> )	T1	
<b>Corticosteroids (Respiratory Tract)</b>		
<b><i>allergy relief nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 ML per 30 days)
<b><i>allergy spray 24 hour nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 ML per 30 days)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <b><i>fluticasone furoate</i></b> )	T1	
<b><i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i></b>	T1	QL (120 ML per 30 days)
<b><i>budesonide inhalation suspension 1 mg/2ml</i></b>	T1	QL (60 ML per 30 days)
<b><i>budesonide nasal suspension 32 mcg/act</i></b>	T1	QL (8.43 ML per 30 days)
<b><i>cvs budesonide nasal suspension 32 mcg/act</i></b>	T1	QL (8.43 ML per 30 days)
<b><i>cvs fluticasone propionate nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 ML per 30 days)
<b><i>cvs nasal allergy spray nasal aerosol 55 mcg/act</i></b>	T1	QL (16.9 ML per 30 days)
<b><i>eq allergy relief nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 ML per 30 days)
<b><i>eq nasal allergy nasal aerosol 55 mcg/act</i></b>	T1	QL (16.9 ML per 30 days)
FLONASE SENSIMIST CHILDRENS NASAL SUSPENSION 27.5 MCG/SPRAY ( <b><i>fluticasone furoate</i></b> )	T1	QL (18.6 ML per 30 days)
FLONASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY ( <b><i>fluticasone furoate</i></b> )	T1	QL (18.6 ML per 30 days)
<b><i>flunisolide nasal solution 25 mcg/act (0.025%)</i></b>	T1	PA
<b><i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i></b>	T1	
<b><i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i></b>	T1	
<b><i>fluticasone propionate nasal suspension 50 mcg/act</i></b>	T1	QL (18.2 GM per 30 days)
<b><i>gnp 24 hour nasal allergy nasal aerosol 55 mcg/act</i></b>	T1	QL (16.9 ML per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp budesonide nasal spray nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>gnp fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>goodsense nasal allergy spray nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>nasal allergy 24 hour nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT ( <i>budesonide</i> )	T1	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	T1	
<i>ra budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>ra nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>sm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<b>Endothelin Receptor Antagonists</b>		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	T1	PA
<b>Expectorants</b>		
<i>actidom dmx oral liquid 10-30-200 mg/5ml</i>	T1	
<i>biodesp dm oral syrup 5-15-100 mg/5ml</i>	T1	
<i>chest congestion relief dm oral syrup 10-100 mg/5ml</i>	T1	
<i>chest congestion relief oral liquid 100 mg/5ml</i>	T1	
<i>chest congestion relief oral tablet 400 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>childrens cough oral liquid 5-100 mg/5ml</i>	T1	
<i>childrens mucus relief cough oral liquid 5-100 mg/5ml</i>	T1	
<i>coditussin ac oral liquid 200-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>cough &amp; chest congestion dm oral liquid 5-100 mg/5ml</i>	T1	
<i>cough &amp; congestion kids oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs chest congest/cough child oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs chest congestion relief oral tablet 400 mg</i>	T1	
<i>cvs cough &amp; chest congestion oral liquid 20-400 mg/20ml</i>	T1	
<i>cvs dm maximum adult oral liquid 5-100 mg/5ml</i>	T1	
<i>cvs mucus d extended release oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>cvs mucus d max st er oral tablet extended release 12 hour 1200-120 mg</i>	T1	QL (60 EA per 30 days)
<i>cvs mucus dm extended release oral tablet extended release 12 hour 30-600 mg</i>	T1	QL (120 EA per 30 days)
<i>cvs mucus dm extended release oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>cvs mucus extended release oral tablet extended release 12 hour 1200 mg</i>	T1	QL (60 EA per 30 days)
<i>cvs tussin adult chest congest oral liquid 100 mg/5ml</i>	T1	
<i>cvs tussin dm max st oral liquid 20-400 mg/20ml</i>	T1	
DELSYM CGH/CHEST CONG DM CHILD ORAL LIQUID 5-100 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	
<i>despec dm oral syrup 5-10-100 mg/5ml</i>	T1	
<i>despec dm-g oral syrup 5-10-100 mg/5ml</i>	T1	
<i>despec eda oral liquid 2.5-5-50 mg/ml</i>	T1	
<i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIABETIC TUSSIN DM MAX ST ORAL LIQUID 10-200 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	
<i>dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>dometuss-dmx oral liquid 10-30-200 mg/5ml</i>	T1	
<i>ed bron gp oral liquid 5-100 mg/5ml</i>	T1	
<i>eq cough childrens oral liquid 5-100 mg/5ml</i>	T1	
<i>eq mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	T1	QL (120 EA per 30 days)
<i>eq tussin dm cough/chest oral syrup 10-100 mg/5ml</i>	T1	
<i>eql tussin dm cough/chest cong oral syrup 100-10 mg/5ml</i>	T1	
<i>eql tussin mucus/chest congest oral liquid 100 mg/5ml</i>	T1	
<i>g tussin ac oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>geri-tussin oral liquid 100 mg/5ml</i>	T1	
<i>gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>gnp mucus er oral tablet extended release 12 hour 1200 mg</i>	T1	QL (60 EA per 30 days)
<i>gnp mucus relief oral tablet 400 mg</i>	T1	
<i>gnp tab tussin oral tablet 400 mg</i>	T1	
<i>gnp tussin cf cough &amp; cold oral syrup 5-10-100 mg/5ml</i>	T1	
<i>gnp tussin dm cough oral liquid 100-10 mg/5ml</i>	T1	
<i>gnp tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>gnp tussin mucus &amp; chest cong oral liquid 100 mg/5ml</i>	T1	
<i>goodsense tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>goodsense tussin dm max oral liquid 20-400 mg/20ml</i>	T1	
<i>g-supress dx pediatric oral liquid 2.5-5-50 mg/ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
G-TRON PED ORAL LIQUID 10-15-350 MG/5ML ( <i>phenylephrine-dm-gg</i> )	T1	
<i>guaiaatussin ac oral syrup 100-10 mg/5ml</i>	T1	
<i>guaifenesin oral liquid 100 mg/5ml</i>	T1	
<i>guaifenesin oral tablet 200 mg, 400 mg</i>	T1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>guaifenesin-codeine oral solution 200-20 mg/10ml</i>	T1	
<i>guaifenesin-dm oral syrup 100-10 mg/5ml</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
IOSAT ORAL TABLET 65 MG ( <i>potassium iodide</i> ( <i>antidote</i> ))	T1	
<i>maxi-tuss ac oral solution 100-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>maxi-tuss gmx oral liquid 10-200 mg/5ml</i>	T1	
<i>maxi-tuss pe max oral liquid 5-100 mg/5ml</i>	T1	
MUCINEX FAST-MAX CHEST CONG MS ORAL LIQUID 400 MG/20ML ( <i>guaifenesin</i> )	T1	
<i>mucosa oral tablet 400 mg</i>	T1	
<i>mucus relief chest congestion oral tablet 400 mg</i>	T1	
<i>mucus relief cough childrens oral liquid 5-100 mg/5ml</i>	T1	
<i>mucus relief d oral tablet extended release 12 hour 120-1200 mg</i>	T1	QL (60 EA per 30 days)
<i>mucus relief d oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>mucus relief dm max oral liquid 20-400 mg/20ml, 5-100 mg/5ml</i>	T1	
<i>mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>mucus relief dm oral liquid 20-400 mg/20ml</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	T1	QL (120 EA per 30 days)
<i>mucus relief max st oral tablet extended release 12 hour 1200 mg</i>	T1	QL (60 EA per 30 days)
<i>mucus relief oral tablet 400 mg</i>	T1	
<i>mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg</i>	T1	
<i>neotuss oral liquid 30-200 mg/5ml</i>	T1	
<i>potassium iodide oral solution 1 gm/ml</i>	T1	
<i>pres gen pediatric oral liquid 2.5-5-75 mg/5ml</i>	T1	
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 120-1200 mg</i>	T1	QL (60 EA per 30 days)
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 60-600 mg</i>	T1	QL (120 EA per 30 days)
<i>qc medifin 400 oral tablet 400 mg</i>	T1	
<i>qc mucus relief er oral tablet extended release 12 hour 1200 mg</i>	T1	QL (60 EA per 30 days)
<i>qc tussin cf oral liquid 5-10-100 mg/5ml</i>	T1	
<i>qc tussin expectorant adult oral liquid 100 mg/5ml</i>	T1	
<i>qc tussin mucus/congestion oral liquid 100 mg/5ml</i>	T1	
<i>ra mucus relief d max strength oral tablet extended release 12 hour 120-1200 mg</i>	T1	QL (60 EA per 30 days)
<i>ra mucus relief d oral tablet extended release 12 hour 600-60 mg</i>	T1	QL (120 EA per 30 days)
<i>ra tussin cgh/chest congest dm oral liquid 100-10 mg/5ml</i>	T1	
<i>ra tussin chest congestion oral liquid 100 mg/5ml</i>	T1	
<i>ra tussin dm oral liquid 100-10 mg/5ml</i>	T1	
<i>ra tussin oral liquid 100 mg/5ml</i>	T1	
<i>refenesen 400 oral tablet 400 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml</i></b>	T1	
ROBAFEN DM CGH/CHEST CONGEST ORAL LIQUID 10-100 MG/5ML ( <b><i>dextromethorphan-guaifenesin</i></b> )	T1	
ROBITUSSIN CHILD COUGH/COLD CF ORAL LIQUID 2.5-5-50 MG/5ML ( <b><i>phenylephrine-dm-gg</i></b> )	T1	
<b><i>scot-tussin expectorant oral liquid 100 mg/5ml</i></b>	T1	
SCOT-TUSSIN SENIOR ORAL LIQUID 15-200 MG/5ML ( <b><i>dextromethorphan-guaifenesin</i></b> )	T1	
<b><i>siltussin sa oral liquid 100 mg/5ml</i></b>	T1	
<b><i>sm chest congestion relief oral tablet 400 mg</i></b>	T1	
<b><i>sm mucus relief max strength oral tablet extended release 12 hour 1200 mg</i></b>	T1	QL (60 EA per 30 days)
<b><i>sm tussin cf oral liquid 5-10-100 mg/5ml</i></b>	T1	
<b><i>sm tussin dm max oral liquid 20-400 mg/20ml</i></b>	T1	
<b><i>sm tussin dm oral syrup 100-10 mg/5ml</i></b>	T1	
<b><i>sm tussin mucus+chest congest oral liquid 100 mg/5ml</i></b>	T1	
<b><i>sorbutuss nr oral liquid 10-100 mg/5ml</i></b>	T1	
<b><i>supress-dx pediatric oral liquid 2.5-5-50 mg/ml</i></b>	T1	
TUSNEL ORAL TABLET 60-30-400 MG ( <b><i>pseudoephedrine-dm-gg</i></b> )	T1	
TUSNEL-EX ORAL LIQUID 100 MG/5ML ( <b><i>guaifenesin</i></b> )	T1	
<b><i>tussin cf oral liquid 5-10-100 mg/5ml</i></b>	T1	
<b><i>tussin dm max oral liquid 20-400 mg/20ml</i></b>	T1	
<b><i>tussin dm oral syrup 100-10 mg/5ml</i></b>	T1	
<b><i>tussin mucus &amp; chest congest oral liquid 100 mg/5ml</i></b>	T1	
<b><i>tussin mucus+chest congestion oral liquid 100 mg/5ml</i></b>	T1	
<b><i>virtussin a/c oral solution 100-10 mg/5ml</i></b>	T1	
WAL-TUSSIN CHEST CONGESTION ORAL LIQUID 100 MG/5ML ( <b><i>guaifenesin</i></b> )	T1	

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**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-TUSSIN COUGH/CHEST DM ORAL SYRUP 100-10 MG/5ML ( <i>dextromethorphan-guaifenesin</i> )	T1	
<b>First Generation Antihist.(Respir Tract)</b>		
<i>aler-cap oral capsule 25 mg</i>	T1	
<i>aller-chlor oral tablet 4 mg</i>	T1	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy oral tablet 4 mg</i>	T1	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>allergy relief oral capsule 25 mg</i>	T1	
<i>allergy relief oral tablet 25 mg, 4 mg</i>	T1	
BANOPHEN ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>chlorhist oral tablet 4 mg</i>	T1	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	T1	
<i>chlorpheniramine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>complete allergy medicine oral capsule 25 mg</i>	T1	
<i>complete allergy relief oral tablet 25 mg</i>	T1	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	T1	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	T1	
<i>cvs allergy relief oral capsule 25 mg</i>	T1	
<i>cvs allergy relief oral tablet 25 mg</i>	T1	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs sleep-aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	
<i>diphen oral tablet 25 mg</i>	T1	
<i>diphenhist oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	T1	
<i>diphenhydramine hcl oral tablet 25 mg</i>	T1	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	T1	
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	T1	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>eq allergy relief oral capsule 25 mg</i>	T1	
<i>eq allergy relief oral tablet 25 mg</i>	T1	
<i>eql allergy oral tablet 25 mg</i>	T1	
<i>eql allergy relief oral tablet 25 mg</i>	T1	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>eql sleep aid oral capsule 50 mg</i>	T1	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	T1	
<i>geri-dryl oral tablet 25 mg</i>	T1	
<i>gnp allergy oral capsule 25 mg</i>	T1	
<i>gnp allergy oral tablet 25 mg</i>	T1	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	T1	
<i>gnp allergy relief oral capsule 25 mg</i>	T1	
<i>gnp allergy relief oral tablet 25 mg, 4 mg</i>	T1	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>gnp childrens allergy oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>gnp sleep aid nighttime oral tablet 25 mg</i></b>	T1	
<b><i>gnp sleep aid oral tablet 25 mg</i></b>	T1	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML <b><i>(diphenhydramine hcl)</i></b>	T1	
<b><i>liquid allergy relief oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>m-dryl oral liquid 12.5 mg/5ml</i></b>	T1	
MICLARA LQ ORAL LIQUID 1.25 MG/5ML <b><i>(triprolidine hcl)</i></b>	T1	
<b><i>night time sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>nighttime sleep aid oral tablet 25 mg</i></b>	T1	
<b><i>pharbechlor oral tablet 4 mg</i></b>	T1	
<b><i>pharbedryl oral capsule 25 mg, 50 mg</i></b>	T1	
<b><i>promethazine hcl oral solution 6.25 mg/5ml</i></b>	T1	
<b><i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i></b>	T1	
<b><i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i></b>	T1	
<b><i>promethazine hcl</i></b> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG <b><i>(promethazine hcl)</i></b>	T1	
<b><i>qc allergy childrens oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>qc chlor-pheniramine oral tablet 4 mg</i></b>	T1	
<b><i>qc complete allergy medicine oral tablet 25 mg</i></b>	T1	
<b><i>qc sleep aid max st oral capsule 50 mg</i></b>	T1	
<b><i>ra allergy medication oral capsule 25 mg</i></b>	T1	
<b><i>ra allergy medication oral liquid 12.5 mg/5ml</i></b>	T1	
<b><i>ra allergy medication oral tablet 25 mg</i></b>	T1	
<b><i>ra allergy oral tablet 25 mg</i></b>	T1	
<b><i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ra allergy relief oral capsule 25 mg</i>	T1	
<i>ra allergy relief oral tablet 4 mg</i>	T1	
<i>ra chlorpheniramine maleate oral tablet 4 mg</i>	T1	
<i>ra complete allergy oral tablet 25 mg</i>	T1	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	T1	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>ra sleep aid oral capsule 50 mg</i>	T1	
<i>ra sleep aid oral tablet 25 mg</i>	T1	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	T1	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	T1	
<i>sleep aid (doxylamine) oral tablet 25 mg</i>	T1	
<i>sleep aid oral tablet 25 mg</i>	T1	
<i>sleep tabs oral tablet 25 mg</i>	T1	
<i>sleep-aid oral capsule 50 mg</i>	T1	
<i>sleep-aid oral tablet 25 mg</i>	T1	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	T1	
<i>sm allergy relief oral tablet 25 mg</i>	T1	
<i>sm sleep aid oral tablet 25 mg</i>	T1	
<i>total allergy oral tablet 25 mg</i>	T1	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG ( <i>diphenhydramine hcl</i> )	T1	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML ( <i>diphenhydramine hcl</i> )	T1	
WAL-FINATE ORAL TABLET 4 MG ( <i>chlorpheniramine maleate</i> )	T1	
<i>wal-som maximum strength oral capsule 50 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>wal-som oral tablet 25 mg</b>	T1	
<b>Interleukin Antagonists</b>		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML ( <b><i>dupilumab</i></b> )	T1	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML ( <b><i>benralizumab</i></b> )	T1	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 30 MG/ML ( <b><i>benralizumab</i></b> )	T1	PA
<b>Leukotriene Modifiers</b>		
<b>montelukast sodium oral packet 4 mg</b>	T1	PA
<b>montelukast sodium oral tablet 10 mg</b>	T1	
<b>montelukast sodium oral tablet chewable 4 mg, 5 mg</b>	T1	
<b>zafirlukast oral tablet 10 mg, 20 mg</b>	T1	PA
<b>Mast-Cell Stabilizers</b>		
ALOCRILOPHthalmic SOLUTION 2 % ( <b><i>nedocromil sodium</i></b> )	T1	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % ( <b><i>lodoxamide tromethamine</i></b> )	T1	PA
<b>cromolyn sodium inhalation nebulization solution 20 mg/2ml</b>	T1	
<b>cromolyn sodium ophthalmic solution 4 %</b>	T1	
<b>cromolyn sodium oral concentrate 100 mg/5ml</b>	T1	
<b>Mucolytic Agents</b>		
<b>acetylcysteine inhalation solution 10 %, 20 %</b>	T1	
<b>sodium chloride</b> (Nebusal Inhalation Nebulization Solution 3 %)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML ( <b><i>dornase alfa</i></b> )	T1	PA
<b>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %</b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Nasal Preparations (Steroids)</b>		
<i>allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>allergy spray 24 hour nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>cvs budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>cvs fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>cvs nasal allergy spray nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>eq allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>eq nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
FLONASE SENSIMIST CHILDRENS NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
FLONASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY ( <i>fluticasone furoate</i> )	T1	QL (18.6 ML per 30 days)
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 GM per 30 days)
<i>gnp 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>gnp budesonide nasal spray nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>gnp fluticasone propionate nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>goodsense nasal allergy spray nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm 24 hour nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>hm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>nasal allergy 24 hour nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>ra budesonide nasal suspension 32 mcg/act</i>	T1	QL (8.43 ML per 30 days)
<i>ra nasal allergy nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)
<i>sm allergy relief nasal suspension 50 mcg/act</i>	T1	QL (18.2 ML per 30 days)
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	T1	QL (16.9 ML per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Orally Inhaled Preparations (Steroids)</b>		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT ( <i>fluticasone furoate</i> )	T1	
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	T1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	T1	QL (60 ML per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT ( <i>budesonide</i> )	T1	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT ( <i>beclomethasone diprop hfa</i> )	T1	
<b>Phosphodiesterase-5 Inhibitors (Respir)</b>		
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	PA
<b>Prostacyclin &amp; Prostacyclin Derivatives</b>		
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG ( <i>treprostinil diolamine</i> )	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
VENTAVIS INHALATION SOLUTION 20 MCG/ML ( <i>iloprost</i> )	T1	PA
<b>Pulmonary Surfactants</b>		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5ML, 240 MG/3ML ( <i>poractant alfa</i> )	T1	
INFASURF INTRATRACHEAL SUSPENSION 35-0.9 MG/ML-% ( <i>calfactant in nacl</i> )	T1	
<b>Respiratory Tract Agents, Miscellaneous</b>		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML ( <i>omalizumab</i> )	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML ( <i>omalizumab</i> )	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG ( <i>omalizumab</i> )	T1	PA
<b>Second Generation Antihist(Respir Tract)</b>		
<i>12hr allergy relief oral tablet 60 mg</i>	T1	ST
<i>24hr allergy relief oral tablet 180 mg</i>	T1	ST
<i>allergy 24-hr oral tablet 180 mg</i>	T1	ST
<i>allergy relief cetirizine oral tablet 5 mg</i>	T1	PA
<i>allergy relief oral tablet 180 mg, 60 mg</i>	T1	ST
<i>azelastine hcl nasal solution 0.1 %, 0.15 %, 137 mcg/spray</i>	T1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	T1	QL (6 ML per 30 days)
<i>cetirizine hcl childrens oral solution 5 mg/5ml</i>	T1	
<i>cetirizine hcl oral tablet 5 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs allergy relief oral tablet 180 mg, 60 mg</i>	T1	ST
<i>cvs allergy relief oral tablet dispersible 10 mg</i>	T1	
<i>desloratadine oral tablet 5 mg</i>	T1	PA
<i>desloratadine oral tablet dispersible 5 mg</i>	T1	PA
<i>eq allergy relief oral tablet 180 mg</i>	T1	ST
<i>eql allergy relief oral tablet 180 mg</i>	T1	ST
<i>fexofenadine hcl oral tablet 180 mg, 60 mg</i>	T1	ST
<i>gnp allergy relief oral tablet 180 mg</i>	T1	ST
<i>gnp loratadine oral tablet dispersible 10 mg</i>	T1	
<i>goodsense aller-ease oral tablet 180 mg</i>	T1	ST
<i>hm fexofenadine hcl oral tablet 180 mg</i>	T1	ST
KLS ALLER-FEX ORAL TABLET 180 MG ( <i>fexofenadine hcl</i> )	T1	ST
<i>loratadine oral tablet dispersible 10 mg</i>	T1	
<i>mm fexofenadine hcl oral tablet 180 mg</i>	T1	ST
<i>ra allergy relief oral tablet 180 mg</i>	T1	ST
<i>sm allergy relief oral tablet 60 mg</i>	T1	ST
<i>sm fexofenadine hcl oral tablet 180 mg</i>	T1	ST
<b>Select.Beta-2-Adrenergic Agonist(Respir)</b>		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	T1	QL (2 GM per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i>	T1	
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml</i>	T1	PA
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	T1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	T1	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics</b> =		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE</b> = Brand name	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT ( <i>salmeterol xinafoate</i> )	T1	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	T1	
<b>Vasodilating Agents (Respiratory Tract)</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG ( <i>riociguat</i> )	T1	PA
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG ( <i>macitentan</i> )	T1	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG ( <i>treprostinil diolamine</i> )	T1	PA
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG ( <i>bosentan</i> )	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML ( <i>treprostinil</i> )	T1	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG ( <i>selexipag</i> )	T1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG ( <i>selexipag</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VENTAVIS INHALATION SOLUTION 20 MCG/ML ( <i>iloprost</i> )	T1	PA
<b>Vasodilating Agents, Misc</b>		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG ( <i>riociguat</i> )	T1	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG ( <i>selexipag</i> )	T1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG ( <i>selexipag</i> )	T1	PA
<b>Xanthine Derivatives</b>		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
<b>Skin And Mucous Membrane Agents</b>		
<b>Adrenergic Agonists</b>		
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	T1	PA
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	T1	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
<b>Allylamines (Skin And Mucous Membrane)</b>		
<i>naftifine hcl external cream 1 %</i>	T1	
<b>Antibacterials (84:04)</b>		
<i>sulfacetamide sodium-sulfur</i> (Avar-E Emollient External Cream 10-5 %)	T1	
<i>avidoxy oral tablet 100 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZELEX EXTERNAL CREAM 20 % ( <i>azelaic acid</i> )	T1	
<i>bacitracin external ointment 500 unit/gm</i>	T1	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	T1	
<i>bacitracin zinc external ointment 500 unit/gm</i>	T1	
<i>bacitracin zinc-aloe external ointment 500 unit/gm</i>	T1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
BACITRAYCIN PLUS EXTERNAL OINTMENT 500 UNIT/GM ( <i>bacitracin</i> )	T1	
CLEOCIN VAGINAL SUPPOSITORY 100 MG ( <i>clindamycin phosphate</i> )	T1	ST
<i>clindamycin phosphate</i> (Clindacin Etz External Swab 1 %)	T1	
<i>clindamycin phosphate</i> (Clindacin-P External Swab 1 %)	T1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	T1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	T1	PA
<i>clindamycin phosphate external gel 1 %</i>	T1	
<i>clindamycin phosphate external lotion 1 %</i>	T1	
<i>clindamycin phosphate external solution 1 %</i>	T1	
<i>clindamycin phosphate external swab 1 %</i>	T1	
<i>clindamycin phosphate vaginal cream 2 %</i>	T1	
<i>cvs bacitracin zinc external ointment 500 unit/gm</i>	T1	
<i>cvs poly bacitracin external ointment 500-10000 unit/gm</i>	T1	
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
<i>double antibiotic external ointment 500-10000 unit/gm</i>	T1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline hyclate oral tablet 100 mg</i>	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b> Generic drugs		AL = Age Limit
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	T1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	T1	
<i>eq bacitracin zinc external ointment 500 unit/gm</i>	T1	
<i>ery external pad 2 %</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
<i>gentamicin sulfate external cream 0.1 %</i>	T1	
<i>gentamicin sulfate external ointment 0.1 %</i>	T1	
<i>gnp bacitracin zinc external ointment 500 unit/gm</i>	T1	
<i>levofloxacin oral solution 25 mg/ml</i>	T1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	T1	QL (30 EA per 30 days)
<i>mafenide acetate external packet 5 %</i>	T1	
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	T1	QL (30 EA per 30 days)
<i>mupirocin external ointment 2 %</i>	T1	
<i>neomycin sulfate oral tablet 500 mg</i>	T1	
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ophthalmic Ointment 1 %)	T1	
OVACE PLUS EXTERNAL CREAM 10 % ( <i>sulfacetamide sodium</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>poly bacitracin external ointment 500-10000 unit/gm</i>	T1	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	T1	
<i>qc bacitracin external ointment 500 unit/gm</i>	T1	
<i>ra bacitracin zinc first aid external ointment 500 unit/gm</i>	T1	
<i>ra double antibiotic external ointment 500-10000 unit/gm</i>	T1	
<i>sm antibiotic external ointment 500 unit/gm</i>	T1	
<i>sm double antibiotic external ointment 500-10000 unit/gm</i>	T1	
<i>sodium sulfacetamide external shampoo 10 %</i>	T1	
<i>sss 10-5 external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	T1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	T1	
<i>wal-sporin external ointment 500-100000 unit/gm</i>	T1	
<b>Antifulgals (Skin, Mucous Membrane), Misc</b>		
EXODERM EXTERNAL LOTION 25-1 % ( <i>sod thiosulfate-salicylic acid</i> )	T1	
<i>gentian violet external solution 1 %, 2 %</i>	T1	
<i>gnp gentian violet external solution 1 %</i>	T1	
<b>Antiproliferants</b>		
<i>bexarotene oral capsule 75 mg</i>	T1	PA
<i>fluorouracil external cream 5 %</i>	T1	
<i>fluorouracil external solution 2 %, 5 %</i>	T1	
<i>imiquimod external cream 5 %</i>	T1	
<b>Antipruritics And Local Anesthetics</b>		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASPERFLEX LIDOCAINE EXTERNAL CREAM 4 % <i>(lidocaine)</i>	T1	QL (60 GM per 30 days)
<i>calahist external lotion 1-8 %</i>	T1	
<i>calamine plus external lotion 1-8 %</i>	T1	
CETACAINE EXTERNAL AEROSOL 2-2-14 % ( <i>butamben-tetracaine-benzocaine</i> )	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylonol</i> )	T1	
CRYODOSE TA EXTERNAL AEROSOL ( <i>pentafluoroprop-tetrafluoroeth</i> )	T1	
<i>cvs calamine plus external lotion 1-8 %</i>	T1	
<i>cvs lidocaine maximum strength external cream 4 %</i>	T1	QL (60 GM per 30 days)
<i>doxepin hcl external cream 5 %</i>	T1	
<i>eql calamine medicated external lotion 1-8 %</i>	T1	
<i>ethyl chloride external aerosol</i>	T1	
GEBAUERS PAIN EASE EXTERNAL AEROSOL ( <i>pentafluoroprop-tetrafluoroeth</i> )	T1	
GEBAUERS SPRAY AND STRETCH EXTERNAL AEROSOL ( <i>pentafluoroprop-tetrafluoroeth</i> )	T1	
<i>lidocaine hcl</i> (Glydo External Prefilled Syringe 2 %)	T1	
<i>gnp caldyphen external lotion 1-8 %</i>	T1	
<i>gnp lidocaine pain relieving external cream 4 %</i>	T1	QL (60 GM per 30 days)
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>lidocaine external cream 4 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine external ointment 5 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine external patch 5 %</i>	T1	PA
<i>lidocaine hcl external cream 3 %</i>	T1	QL (85 GM per 30 days)
<i>lidocaine hcl external cream 4 %</i>	T1	QL (60 GM per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	T1	
<i>lidocaine pain relief max st external cream 4 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine plus external cream 4 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace rectal kit 3-0.5 %</i>	T1	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine-hydrocortisone ace</i> (Lidocort External Cream 3-0.5 %)	T1	
<i>lidopin external cream 3 %</i>	T1	QL (85 GM per 30 days)
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % ( <i>pramoxine-hc</i> )	T1	
PRAMOSONE EXTERNAL OINTMENT 1-1 %, 1-2.5 % ( <i>pramoxine-hc</i> )	T1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	T1	PA
REGENECARE EXTERNAL GEL 2 % ( <i>lidocaine-collagen-aloe vera</i> )	T1	
<i>sm caldyphen clear external lotion 1-0.1 %</i>	T1	
<i>sm caldyphen external lotion 1-8 %</i>	T1	
<i>zionodil external lotion 3 %</i>	T1	
<b>Antivirals (Skin And Mucous Membrane)</b>		
<i>acyclovir external cream 5 %</i>	T1	PA
<i>acyclovir external ointment 5 %</i>	T1	PA
<i>acyclovir oral capsule 200 mg</i>	T1	
<i>acyclovir oral suspension 200 mg/5ml</i>	T1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	T1	
<i>docosanol external cream 10 %</i>	T1	QL (2 GM per 30 days)
<i>gnp docosanol external cream 10 %</i>	T1	QL (2 GM per 30 days)

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Astringents (84:12)</b>		
<i>calahist external lotion 1-8 %</i>	T1	
<i>calamine external lotion 8-8 %</i>	T1	
<i>calamine plus external lotion 1-8 %</i>	T1	
<i>calamine-zinc oxide external lotion 8-8 %</i>	T1	
<i>calamine-zinc oxide external suspension 8-8 %</i>	T1	
<i>cvs calamine plus external lotion 1-8 %</i>	T1	
DRYSOL EXTERNAL SOLUTION 20 % ( <i>aluminum chloride</i> )	T1	
<i>eql calamine medicated external lotion 1-8 %</i>	T1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T1	
<i>gnp calamine external lotion 8-8 %</i>	T1	
<i>gnp caldyphen external lotion 1-8 %</i>	T1	
<i>goodsense calamine external suspension 8-8 %</i>	T1	
<i>qc calamine external lotion</i>	T1	
<i>sm calamine external lotion</i>	T1	
<i>sm caldyphen external lotion 1-8 %</i>	T1	
XERAC AC EXTERNAL SOLUTION 6.25 % ( <i>aluminum chloride in alcohol</i> )	T1	
<b>Astringents, Anti-Infective</b>		
<i>benzalkonium chloride external concentrate 50 %</i>	T1	
<i>benzalkonium chloride external solution , 50 %</i>	T1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>gentian violet external solution 1 %, 2 %</i>	T1	
<i>gnp gentian violet external solution 1 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
IODOFLEX EXTERNAL PAD 0.9 % ( <i>cadexomer iodine</i> )	T1	
<i>iodosorb external gel 0.9 %</i>	T1	

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**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>chlorhexidine gluconate</i></b> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<b><i>selenium sulfide external lotion 2.5 %</i></b>	T1	
<b><i>selenium sulfide external shampoo 2.25 %</i></b>	T1	
<b><i>silver sulfadiazine external cream 1 %</i></b>	T1	
<b>Azoles (Skin And Mucous Membrane)</b>		
<b><i>3 day vaginal vaginal cream 2 %</i></b>	T1	
<b><i>antifungal (clotrimazole) external cream 1 %</i></b>	T1	
<b><i>anti-fungal external cream 1 %</i></b>	T1	
<b><i>antifungal external cream 2 %</i></b>	T1	
<b><i>antifungal external powder 2 %</i></b>	T1	
<b><i>athletes foot (clotrimazole) external cream 1 %</i></b>	T1	
<b><i>athletes foot external powder 2 %</i></b>	T1	
<b><i>athletes foot powder spray external aerosol powder 2 %</i></b>	T1	
<b><i>baza antifungal external cream 2 %</i></b>	T1	
<b><i>clotrimazole 3 vaginal cream 2 %</i></b>	T1	
<b><i>clotrimazole af external cream 1 %</i></b>	T1	
<b><i>clotrimazole anti-fungal external cream 1 %</i></b>	T1	
<b><i>clotrimazole external cream 1 %</i></b>	T1	
<b><i>clotrimazole external solution 1 %</i></b>	T1	
<b><i>clotrimazole mouth/throat troche 10 mg</i></b>	T1	
<b><i>clotrimazole vaginal cream 1 %</i></b>	T1	
<b><i>clotrimazole-7 vaginal cream 1 %</i></b>	T1	
<b><i>clotrimazole-betamethasone external cream 1-0.05 %</i></b>	T1	
<b><i>clotrimazole-betamethasone external lotion 1-0.05 %</i></b>	T1	
<b><i>cvs athletes foot external aerosol powder 2 %</i></b>	T1	
<b><i>cvs clotrimazole 3 vaginal cream 2 %</i></b>	T1	
<b><i>cvs clotrimazole external cream 1 %</i></b>	T1	
<b><i>cvs clotrimazole external solution 1 %</i></b>	T1	

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**Coverage Requirements and Limits**  
AL = Age Limit  
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cv</i> s <i>itch relief external cream 1 %</i>	T1	
<i>cv</i> s <i>miconazole 1 combo pack vaginal kit 1200 &amp; 2 mg &amp; %</i>	T1	QL (30 EA per 30 days)
<i>cv</i> s <i>miconazole 3 combo pack vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	
<i>cv</i> s <i>miconazole 3 combo-supp vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	QL (1 EA per 2 days)
<i>cv</i> s <i>miconazole 7 vaginal cream 2 %</i>	T1	
<i>cv</i> s <i>ringworm external cream 1 %</i>	T1	
<i>cv</i> s <i>tioconazole 1 vaginal ointment 6.5 %</i>	T1	
<i>e</i> conazole nitrate external cream 1 %	T1	
<i>e</i> q antifungal external cream 1 %	T1	
<i>e</i> q athletes foot external cream 1 %	T1	
<i>e</i> q jock itch external cream 1 %	T1	
<i>e</i> q miconazole 1 vaginal kit 1200 & 2 mg & %	T1	QL (30 EA per 30 days)
<i>e</i> ql miconazole 7 vaginal cream 2 %	T1	
<i>g</i> np athletes foot external cream 1 %	T1	
<i>g</i> np clotrimazole 3 vaginal cream 2 %	T1	
<i>g</i> np miconazole 1 vaginal kit 1200 & 2 mg & %	T1	QL (30 EA per 30 days)
<i>g</i> np miconazole 3 vaginal kit 200 & 2 mg-% (9gm)	T1	QL (1 EA per 2 days)
<i>g</i> np miconazole 7 vaginal cream 2 %	T1	
<i>g</i> np miconazorb af external powder 2 %	T1	
<i>g</i> oodsense athletes foot external cream 1 %	T1	
GYNAZOLE-1 VAGINAL CREAM 2 % ( <i>butoconazole nitrate (1 dose)</i> )	T1	
<i>j</i> ock itch external cream 1 %	T1	
<i>j</i> ock itch relief external cream 1 %	T1	
<i>k</i> etoconazole external cream 2 %	T1	
<i>k</i> etoconazole external shampoo 2 %	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICATIN EXTERNAL CREAM 2 % ( <i>miconazole nitrate</i> )	T1	
<i>miconazole 1 vaginal kit 1200 &amp; 2 mg &amp; %</i>	T1	QL (30 EA per 30 days)
<i>miconazole 3 combo-supp vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	QL (1 EA per 2 days)
<i>miconazole 3 vaginal suppository 200 mg</i>	T1	
<i>miconazole 7 vaginal cream 2 %</i>	T1	
<i>miconazole 7 vaginal suppository 100 mg</i>	T1	
<i>miconazole antifungal external cream 2 %</i>	T1	
<i>miconazole nitrate external cream 2 %</i>	T1	
<i>miconazole nitrate vaginal cream 2 %</i>	T1	
MICOTRIN AC EXTERNAL CREAM 1 % ( <i>clotrimazole</i> )	T1	
MICOTRIN AP EXTERNAL POWDER 2 % ( <i>miconazole nitrate</i> )	T1	
MONISTAT 7 COMBO PACK APP VAGINAL KIT 100 & 2 MG-% (9GM) ( <i>miconazole nitrate</i> )	T1	
<i>qc 3 day vaginal cream 4 %</i>	T1	
<i>qc clotrimazole vaginal cream 1 %</i>	T1	
<i>qc miconazole 7 vaginal cream 2 %</i>	T1	
<i>ra atheletes foot external aerosol powder 2 %</i>	T1	
<i>ra athletes foot external cream 1 %</i>	T1	
<i>ra clotrimazole 7 vaginal cream 1 %</i>	T1	
<i>ra clotrimazole external cream 1 %</i>	T1	
<i>ra jock itch external cream 1 %</i>	T1	
<i>ra miconazole 3 combo pack app vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	
<i>ra miconazole 3 combo pack vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	QL (1 EA per 2 days)
<i>ra miconazole 7 vaginal cream 2 %</i>	T1	
<i>ra tioconazole 1 vaginal ointment 6.5 %</i>	T1	
<i>sm 3-day vaginal vaginal cream 2 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sm antifungal clotrimazole external cream 1 %</i>	T1	
<i>sm antifungal miconazole external cream 2 %</i>	T1	
<i>sm clotrimazole vaginal vaginal cream 1 %</i>	T1	
<i>sm miconazole 3 applicator vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	
<i>sm miconazole 3 vaginal kit 200 &amp; 2 mg-% (9gm)</i>	T1	QL (1 EA per 2 days)
<i>sm miconazole 7 vaginal cream 2 %</i>	T1	
<i>sm miconazole 7 vaginal suppository 100 mg</i>	T1	
<i>sm tioconazole-1 vaginal ointment 6.5 %</i>	T1	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	T1	
<i>terconazole vaginal suppository 80 mg</i>	T1	PA
<i>tioconazole-1 vaginal ointment 6.5 %</i>	T1	
<i>tm-clotrimazole external cream 1 %</i>	T1	
<b>Basic Lotions And Liniments</b>		
<i>cvs moisturizing external lotion</i>	T1	
<b>Basic Ointments And Protectants</b>		
<i>calamine external lotion 8-8 %</i>	T1	
<i>calamine-zinc oxide external lotion 8-8 %</i>	T1	
<i>calamine-zinc oxide external suspension 8-8 %</i>	T1	
<i>calcipotriene external cream 0.005 %</i>	T1	PA
<i>calcipotriene external ointment 0.005 %</i>	T1	PA
<i>calcipotriene external solution 0.005 %</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
CORTIZONE-10 INTENSIVE HEALING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 PLUS EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIZONE-10/ALOE EXTERNAL LIQUID 1 % <i>(hydrocortisone)</i>	T1	
<i>gnp calamine external lotion 8-8 %</i>	T1	
<i>gnp hydrocortisone/aloe external cream 1 %</i>	T1	
<i>goodsense calamine external suspension 8-8 %</i>	T1	
<i>hydrocortisone external cream 0.5 %, 1 %</i>	T1	
<i>hydrocortisone/aloe max str external cream 1 %</i>	T1	
<i>qc anti-itch aloe external cream 1 %</i>	T1	
REGENECARE EXTERNAL GEL 2 % ( <i>lidocaine-collagen-aloe vera</i> )	T1	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM <i>(collagenase)</i>	T1	
<i>sm calamine external lotion</i>	T1	
<i>sm hydrocortisone plus external cream 1 %</i>	T1	
<b>Benzylamines (Skin And Mucous Membrane)</b>		
<i>butenafine hcl external cream 1 %</i>	T1	
<i>cvs butenafine hcl external cream 1 %</i>	T1	
<b>Cell Stimulants And Proliferants</b>		
<i>finasteride oral tablet 5 mg</i>	T1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	T1	
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin oral capsule 10 mg</i>	T1	PA
<b>Corticosteroids (Skin, Mucous Membrane)</b>		

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ala-cort external cream 1 %</i>	T1	
<i>alclometasone dipropionate external cream 0.05 %</i>	T1	PA
<i>alclometasone dipropionate external ointment 0.05 %</i>	T1	PA
<i>anti-itch maximum strength external cream 1 %</i>	T1	
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % ( <i>hydrocortisone</i> )	T1	
APEXICON E EXTERNAL CREAM 0.05 % ( <i>diflorasone diacet emoll base</i> )	T1	PA
AQUANIL HC EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
AQUAPHOR ITCH RELIEF MAX STR EXTERNAL OINTMENT 1 % ( <i>hydrocortisone</i> )	T1	
<i>benzoyl perox-hydrocortisone external lotion 5-0.5 %</i>	T1	
<i>beta hc external lotion 1 %</i>	T1	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	T1	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	T1	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	T1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	T1	
<i>betamethasone valerate external cream 0.1 %</i>	T1	
<i>betamethasone valerate external foam 0.12 %</i>	T1	PA
<i>betamethasone valerate external lotion 0.1 %</i>	T1	
<i>betamethasone valerate external ointment 0.1 %</i>	T1	
<i>budesonide rectal foam 2 mg</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>clobetasol propionate e external cream 0.05 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobetasol propionate external cream 0.05 %</i>	T1	
<i>clobetasol propionate external foam 0.05 %</i>	T1	
<i>clobetasol propionate external gel 0.05 %</i>	T1	
<i>clobetasol propionate external lotion 0.05 %</i>	T1	
<i>clobetasol propionate external ointment 0.05 %</i>	T1	
<i>clobetasol propionate external shampoo 0.05 %</i>	T1	PA
<i>clobetasol propionate external solution 0.05 %</i>	T1	
<i>clocortolone pivalate external cream 0.1 %</i>	T1	PA
<i>clobetasol propionate</i> (Clodan External Shampoo 0.05 %)	T1	PA
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	T1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylenol</i> )	T1	
CORTIFOAM EXTERNAL FOAM 10 % ( <i>hydrocortisone acetate</i> )	T1	PA
CORTIZONE-10 EXTERNAL OINTMENT 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 FEMININE ITCH EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 INTENSIVE HEALING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 INTENSIVE MOISTURE EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 OVERNIGHT EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 OVERNIGHT ITCH EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 PLUS EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 SENSITIVE SKIN EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORTIZONE-10 SOOTHING ALOE EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10 ULTRA SOOTHING EXTERNAL CREAM 1 % ( <i>hydrocortisone</i> )	T1	
CORTIZONE-10/ALOE EXTERNAL LIQUID 1 % ( <i>hydrocortisone</i> )	T1	
<i>cvs cortisone maximum strength external cream 1 %</i>	T1	
<i>cvs cortisone maximum strength external gel 1 %</i>	T1	
<i>cvs cortisone maximum strength external ointment 1 %</i>	T1	
DERMAREST ECZEMA EXTERNAL LOTION 1 % ( <i>hydrocortisone</i> )	T1	
<i>desonide external cream 0.05 %</i>	T1	
<i>desonide external lotion 0.05 %</i>	T1	PA
<i>desonide external ointment 0.05 %</i>	T1	
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	T1	PA
<i>desoximetasone external gel 0.05 %</i>	T1	PA
<i>desoximetasone external ointment 0.25 %</i>	T1	PA
<i>diflorasone diacetate external ointment 0.05 %</i>	T1	PA
<i>eq hydrocortisone external cream 1 %</i>	T1	
<i>eq hydrocortisone max st external cream 1 %</i>	T1	
<i>eql anti-itch intensive heal external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external cream 1 %</i>	T1	
<i>eql anti-itch maximum strength external ointment 1 %</i>	T1	
<i>fluocinolone acetonide body external oil 0.01 %</i>	T1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	T1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	T1	
<i>fluocinolone acetonide external solution 0.01 %</i>	T1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	T1	
<i>fluocinonide emulsified base external cream 0.05 %</i>	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

**lowercase bold italics =**  
Generic drugs  
**UPPERCASE =** Brand name drugs

**Drug Tier**  
T1 = Formulary Medication

**Coverage Requirements and Limits**  
AL = Age Limit  
PA = Prior Authorization  
QL = Quantity Limit  
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinonide external cream 0.05 %, 0.1 %</i>	T1	
<i>fluocinonide external gel 0.05 %</i>	T1	
<i>fluocinonide external ointment 0.05 %</i>	T1	
<i>fluocinonide external solution 0.05 %</i>	T1	
<i>flurandrenolide external cream 0.05 %</i>	T1	PA
<i>flurandrenolide external lotion 0.05 %</i>	T1	PA
<i>fluticasone propionate external cream 0.05 %</i>	T1	
<i>fluticasone propionate external ointment 0.005 %</i>	T1	
<i>gnp hydrocortisone external cream 0.5 %</i>	T1	
<i>gnp hydrocortisone max st external ointment 1 %</i>	T1	
<i>gnp hydrocortisone plus external cream 1 %</i>	T1	
<i>gnp hydrocortisone/aloe external cream 1 %</i>	T1	
<i>halcinonide external cream 0.1 %</i>	T1	PA
<i>halobetasol propionate external cream 0.05 %</i>	T1	
<i>halobetasol propionate external ointment 0.05 %</i>	T1	
HALOG EXTERNAL OINTMENT 0.1 % ( <i>halcinonide</i> )	T1	PA
HALOG EXTERNAL SOLUTION 0.1 % ( <i>halcinonide</i> )	T1	PA
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	T1	
<i>hydrocortisone acetate external cream 1 %</i>	T1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone anti-itch external cream 1 %</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 0.5 %, 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external ointment 0.5 %, 1 %, 2.5 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone max st external cream 1 %</i>	T1	
<i>hydrocortisone max st external ointment 1 %</i>	T1	
<i>hydrocortisone max st/12 moist external cream 1 %</i>	T1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone/aloë max str external cream 1 %</i>	T1	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace rectal kit 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace</i> (Lidocort External Cream 3-0.5 %)	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	T1	
<i>triamcinolone acetamide</i> (Oralene Mouth/Throat Paste 0.1 %)	T1	
PANDEL EXTERNAL CREAM 0.1 % ( <i>hydrocortisone probutate</i> )	T1	PA
PRAMOSONE EXTERNAL CREAM 1-1 % ( <i>pramoxine-hc</i> )	T1	
PRAMOSONE EXTERNAL OINTMENT 1-1 %, 1-2.5 % ( <i>pramoxine-hc</i> )	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % ( <i>hydrocortisone ace-pramoxine</i> )	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
<i>qc anti-itch aloe external cream 1 %</i>	T1	
<i>ra anti-itch maximum strength external cream 1 %</i>	T1	
<i>ra anti-itch maximum strength external ointment 1 %</i>	T1	
<i>scalp relief maximum strength external solution 1 %</i>	T1	
<i>sm hydrocortisone external cream 1 %</i>	T1	
<i>sm hydrocortisone max st external ointment 1 %</i>	T1	
<i>sm hydrocortisone plus external cream 1 %</i>	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % ( <i>hydrocortisone</i> )	T1	
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	T1	PA
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	T1	
<i>triamcinolone in absorbase external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide</i> (Triderm External Cream 0.5 %)	T1	
VANICREAM HC MAXIMUM STRENGTH EXTERNAL CREAM 1.12 %(1% BASE) ( <i>hydrocortisone acetate</i> )	T1	
<b>Hydroxypyridones (Skin, Mucous Membrane)</b>		
<i>ciclopirox</i> (Ciclodan External Solution 8 %)	T1	
<i>ciclopirox external gel 0.77 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ciclopirox external shampoo 1 %</i>	T1	
<i>ciclopirox external solution 8 %</i>	T1	
<i>ciclopirox olamine external cream 0.77 %</i>	T1	
<i>ciclopirox olamine external suspension 0.77 %</i>	T1	
<b>Immunomodulatory Agents (84:06)</b>		
<i>pimecrolimus external cream 1 %</i>	T1	PA
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML ( <i>brodalumab</i> )	T1	PA
<i>sirolimus oral solution 1 mg/ml</i>	T1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)
<b>Janus Kinase Inhibitors (84:06)</b>		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG ( <i>ruxolitinib phosphate</i> )	T1	PA
<b>Keratolytic Agents</b>		
<i>isotretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>acitretin oral capsule 10 mg, 25 mg</i>	T1	
<i>adapalene external gel 0.1 %</i>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	T1	PA
<i>sulfacetamide sodium-sulfur</i> (Avar-E Emollient External Cream 10-5 %)	T1	
<i>isotretinoin</i> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
CONDYLOX EXTERNAL GEL 0.5 % ( <i>podofilox</i> )	T1	QL (7 GM per 365 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs adapalene external gel 0.1 %</i>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
EXODERM EXTERNAL LOTION 25-1 % ( <i>sod thiosulfate-salicylic acid</i> )	T1	
<i>gormel external cream 20 %</i>	T1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	T1	PA
<i>podofilox external solution 0.5 %</i>	T1	
<i>salicylic acid external shampoo 6 %</i>	T1	
<i>salimez external cream 6 %</i>	T1	
<i>selenium sulfide external shampoo 2.25 %</i>	T1	
<i>sss 10-5 external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	T1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	T1	
<i>tazarotene external cream 0.05 %, 0.1 %</i>	T1	
<i>tazarotene external gel 0.05 %, 0.1 %</i>	T1	
<i>urea 20 intensive hydrating external cream 20 %</i>	T1	
<i>ureacin-20 external cream 20 %</i>	T1	
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
<b>Keratoplastic Agents</b>		
<i>coal tar external solution 20 %</i>	T1	
<i>coal tar extract solution 20 %</i>	T1	
<i>coal tar solution , 20 %</i>	T1	
TARSUM RELIEF EXTERNAL SHAMPOO 2 % ( <i>coal tar extract</i> )	T1	
X-SEB T PLUS EXTERNAL SHAMPOO 10 % ( <i>coal tar extract</i> )	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Drug Tier</b> T1 = Formulary Medication	<b>Coverage Requirements and Limits</b>
<b>UPPERCASE =</b> Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>Local Anti-Infectives, Miscellaneous</b>		
<i>acne foaming wash external liquid 10 %</i>	T1	
<i>acne medication 10 external gel 10 %</i>	T1	
<i>acne medication 10 external lotion 10 %</i>	T1	
<i>acne medication 2.5 external gel 2.5 %</i>	T1	
<i>acne medication 5 external gel 5 %</i>	T1	
<i>acne medication 5 external lotion 5 %</i>	T1	
<i>acne treatment external bar 10 %</i>	T1	
<i>acne treatment external gel 10 %</i>	T1	
<i>acne-clear external gel 10 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>benzalkonium chloride external concentrate 50 %</i>	T1	
<i>benzalkonium chloride external solution , 50 %</i>	T1	
<i>benzoyl perox-hydrocortisone external lotion 5-0.5 %</i>	T1	
<i>benzoyl peroxide external gel 10 %, 2.5 %, 5 %</i>	T1	
<i>benzoyl peroxide external liquid 10 %</i>	T1	
<i>benzoyl peroxide wash external liquid 10 %, 5 %</i>	T1	
<i>bp wash external liquid 10 %, 2.5 %, 5 %</i>	T1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML ( <i>hc-pramoxine-chloroxylenol</i> )	T1	
<i>cvs acne cleansing external bar 10 %</i>	T1	
<i>cvs acne control cleanser external cream 10 %</i>	T1	
<i>cvs acne treatment external cream 10 %</i>	T1	
<i>cvs acne treatment external gel 10 %</i>	T1	
<i>cvs advanced 3-in-1 cleanser external liquid 5 %</i>	T1	
<i>cvs creamy acne face wash external liquid 4 %</i>	T1	PA
<i>cvs foaming acne face wash external liquid 10 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs targeted acne spot external cream 2.5 %</i>	T1	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % ( <i>sulfuric acid-sulf phenolics</i> )	T1	
FEM PH VAGINAL GEL 0.9-0.025 % ( <i>acetic acid-oxyquinoline</i> )	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>hydrogen peroxide solution 30 %</i>	T1	
IODOFLEX EXTERNAL PAD 0.9 % ( <i>cadexomer iodine</i> )	T1	
<i>iodosorb external gel 0.9 %</i>	T1	
<i>mafenide acetate external packet 5 %</i>	T1	
MEDPURA BENZOYL PEROXIDE EXTERNAL GEL 10 %, 5 % ( <i>benzoyl peroxide</i> )	T1	
MEDPURA BENZOYL PEROXIDE EXTERNAL LIQUID 10 %, 5 % ( <i>benzoyl peroxide</i> )	T1	
PANOXYL CREAMY WASH EXTERNAL LIQUID 4 % ( <i>benzoyl peroxide</i> )	T1	PA
PANOXYL FOAMING WASH EXTERNAL LIQUID 10 % ( <i>benzoyl peroxide</i> )	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<i>ra daylogic acne foaming wash external foam 10 %</i>	T1	
<i>selenium sulfide external lotion 2.5 %</i>	T1	
<i>selenium sulfide external shampoo 2.25 %</i>	T1	
<i>silver sulfadiazine external cream 1 %</i>	T1	
<b>Nonsteroidal Anti-Inflammat.Agents(Skin)</b>		
<i>arthritis pain reliever external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>cvs diclofenac sodium external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>diclofenac sodium external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>eq arthritis pain external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>gnp arthritis pain external gel 1 %</i>	T1	QL (300 GM per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>goodsense arthritis pain external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>kls diclofenac sodium external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>qc diclofenac sodium external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>sm arthritis pain external gel 1 %</i>	T1	QL (300 GM per 30 days)
Pigmenting Agents		
UVADEX EXTRACORPOREAL SOLUTION 20 MCG/ML ( <i>methoxsalen (photopheresis)</i> )	T1	
Polyenes (Skin And Mucous Membrane)		
<i>nystatin</i> (Nyamyc External Powder 100000 Unit/Gm)	T1	
<i>nystatin external cream 100000 unit/gm</i>	T1	
<i>nystatin external ointment 100000 unit/gm</i>	T1	
<i>nystatin external powder 100000 unit/gm</i>	T1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	T1	
Scabicides And Pediculicides		
<i>bedding spray lice treatment aerosol 0.5 %</i>	T1	
<i>cvs lice killing external shampoo 0.33-4 %</i>	T1	
<i>cvs lice treatment external liquid 1 %</i>	T1	
<i>cvs lice-bedbug-mite aerosol 0.5 %</i>	T1	
<i>eql lice killing max st external shampoo 0.33-4 %</i>	T1	
<i>gnp lice treatment external liquid 1 %</i>	T1	
<i>gnp lice treatment external shampoo 0.33-4 %</i>	T1	
<i>goodsense lice killing external liquid 1 %</i>	T1	
<i>lice killing external shampoo 4-0.33 %</i>	T1	
<i>lice killing maximum strength external shampoo 0.33-4 %</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lice treatment external liquid 1 %</i>	T1	
<i>permethrin external cream 5 %</i>	T1	
<i>ra lice maximum strength external shampoo 0.33-4 %</i>	T1	
<i>sm bedding lice treatment aerosol 0.5 %</i>	T1	
<i>sm lice killing max strength external shampoo 0.33-4 %</i>	T1	
<i>spinosad external suspension 0.9 %</i>	T1	PA
<i>stop lice aerosol 0.5 %</i>	T1	
<b>Skin And Mucous Membrane Agents, Misc.</b>		
<i>isotretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>acitretin oral capsule 10 mg, 25 mg</i>	T1	
<i>adapalene external gel 0.1 %</i>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	T1	PA
<i>arthritis pain reliever external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>arthritis pain relieving external cream 0.075 %</i>	T1	
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-axxq</i> )	T1	PA
AZELEX EXTERNAL CREAM 20 % ( <i>azelaic acid</i> )	T1	
<i>calcipotriene external cream 0.005 %</i>	T1	PA
<i>calcipotriene external ointment 0.005 %</i>	T1	PA
<i>calcipotriene external solution 0.005 %</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>calcitriol external ointment 3 mcg/gm</i>	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>capsaicin external cream 0.025 %, 0.075 %, 0.1 %</i></b>	T1	
<b><i>capsaicin hp external cream 0.1 %</i></b>	T1	
<b><i>capsaicin pain relief external cream 0.1 %</i></b>	T1	
<b><i>isotretinoin</i></b> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
CONDYLOX EXTERNAL GEL 0.5 % ( <b><i>podofilox</i></b> )	T1	QL (7 GM per 365 days)
<b><i>cvs adapalene external gel 0.1 %</i></b>	T1	QL (15 GM per 30 days); AL (Max 40 Years)
<b><i>cvs capsaicin hp external cream 0.1 %</i></b>	T1	
<b><i>cvs diclofenac sodium external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
<b><i>diclofenac sodium external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML ( <b><i>dupilumab</i></b> )	T1	PA
<b><i>eq arthritis pain external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
FEM PH VAGINAL GEL 0.9-0.025 % ( <b><i>acetic acid-oxyquinoline</i></b> )	T1	
<b><i>fluorouracil external cream 5 %</i></b>	T1	
<b><i>fluorouracil external solution 2 %, 5 %</i></b>	T1	
<b><i>gnp arthritis pain external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
<b><i>goodsense arthritis pain external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
<b><i>imiquimod external cream 5 %</i></b>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <b><i>infliximab-dyyb</i></b> )	T1	PA
<b><i>infliximab intravenous solution reconstituted 100 mg</i></b>	T1	PA
<b><i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i></b>	T1	PA
<b><i>kls diclofenac sodium external gel 1 %</i></b>	T1	QL (300 GM per 30 days)
ORAMAGICRX MOUTH/THROAT SUSPENSION RECONSTITUTED ( <b><i>oral wound care products</i></b> )	T1	
OTEZLA ORAL TABLET 20 MG, 30 MG ( <b><i>apremilast</i></b> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG ( <i>apremilast</i> )	T1	PA
<i>pimecrolimus external cream 1 %</i>	T1	PA
<i>podofilox external solution 0.5 %</i>	T1	
<i>qc diclofenac sodium external gel 1 %</i>	T1	QL (300 GM per 30 days)
RADIAPLEXRX EXTERNAL GEL ( <i>wound dressings</i> )	T1	
REGENECARE EXTERNAL GEL 2 % ( <i>lidocaine-collagen-aloe vera</i> )	T1	
REGRANEX EXTERNAL GEL 0.01 % ( <i>becaplermin</i> )	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG ( <i>infliximab-abda</i> )	T1	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM ( <i>collagenase</i> )	T1	
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML ( <i>brodalumab</i> )	T1	PA
<i>sm arthritis pain external gel 1 %</i>	T1	QL (300 GM per 30 days)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)
<i>tazarotene external cream 0.05 %, 0.1 %</i>	T1	
<i>tazarotene external gel 0.05 %, 0.1 %</i>	T1	
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
ZOSTRIX HP EXTERNAL CREAM 0.1 % ( <i>capsaicin</i> )	T1	
<b>Thiocarbamates(Skin And Mucous Membrane)</b>		
<i>antifungal (tolnaftate) external cream 1 %</i>	T1	
<i>athletes foot powder spray external aerosol powder 1 %</i>	T1	
<i>cvs athletes foot (tolnaftate) external aerosol powder 1 %</i>	T1	
<i>cvs athletes foot (tolnaftate) external cream 1 %</i>	T1	
<i>cvs foot &amp; sneaker external aerosol powder 1 %</i>	T1	
<i>eq athletes foot (tolnaftate) external cream 1 %</i>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp tolnaftate external cream 1 %</i>	T1	
<i>jock itch spray powder external aerosol powder 1 %</i>	T1	
MICOTRIN AL EXTERNAL SOLUTION 1 % ( <i>tolnaftate</i> )	T1	
<i>odor control foot &amp; sneaker external aerosol powder 1 %</i>	T1	
<i>qc antifungal (tolnaftate) external cream 1 %</i>	T1	
<i>qc tolnaftate external cream 1 %</i>	T1	
<i>ra foot care (tolnaftate) external cream 1 %</i>	T1	
<i>ra jock itch max st external aerosol powder 1 %</i>	T1	
<i>sm antifungal tolnaftate external cream 1 %</i>	T1	
<i>tm-tolnaftate external solution 1 %</i>	T1	
<i>tolnaftate antifungal external cream 1 %</i>	T1	
<i>tolnaftate external aerosol powder 1 %</i>	T1	
<i>tolnaftate external cream 1 %</i>	T1	
<i>tolnaftate external powder 1 %</i>	T1	
<b>Smooth Muscle Relaxants</b>		
<b>Antimuscarinics</b>		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	T1	PA
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	T1	PA
<i>flavoxate hcl oral tablet 100 mg</i>	T1	PA
GELNIQUE TRANSDERMAL GEL 10 % ( <i>oxybutynin chloride</i> )	T1	PA
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	T1	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	T1	
<i>oxybutynin chloride oral tablet 5 mg</i>	T1	
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR ( <i>oxybutynin</i> )	T1	PA

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		<b>AL = Age Limit</b>
Generic drugs		<b>PA = Prior Authorization</b>
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	<b>QL = Quantity Limit</b>
drugs	<b>T1 = Formulary Medication</b>	<b>ST = Step Therapy</b>
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	T1	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	T1	ST; QL (30 EA per 30 days)
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	T1	ST
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	T1	PA
<i>tropium chloride oral tablet 20 mg</i>	T1	PA
VESICARE LS ORAL SUSPENSION 5 MG/5ML ( <i>solifenacin succinate</i> )	T1	PA
Respiratory Smooth Muscle Relaxants		
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG ( <i>theophylline</i> )	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Selective Beta-3-Adrenergic Agonists		
GEMTESA ORAL TABLET 75 MG ( <i>vibegron</i> )	T1	PA
<i>mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg</i>	T1	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML ( <i>mirabegron</i> )	T1	PA
Vitamins		
Multivitamin Preparations		
<i>actical oral capsule</i>	T1	
<i>b complex formula 1 (lipotrop) oral tablet</i>	T1	
<i>b complex-c oral tablet</i>	T1	
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i><b>b complex-c-folic acid oral tablet</b></i>	T1	
<i><b>balance b-100 oral tablet</b></i>	T1	
<i><b>balance b-50 oral tablet</b></i>	T1	
<i><b>b-complex (folic acid) oral tablet</b></i>	T1	
<i><b>b-complex/vitamin c oral tablet</b></i>	T1	
<i><b>b-complex-c oral tablet</b></i>	T1	
<i><b>calcium for women oral tablet chewable 500-100-40</b></i>	T1	
<i><b>calcium/c/d oral tablet chewable 500-10-250 mg-mg-unit</b></i>	T1	
<i><b>centravites 50 plus oral tablet</b></i>	T1	
<i><b>childrens chew multivitamin oral tablet chewable</b></i>	T1	
<i><b>childrens chewable vitamins oral tablet chewable</b></i>	T1	
<i><b>classic prenatal oral tablet 28-0.8 mg</b></i>	T1	
<i><b>complete natal dha oral 29-1-200 &amp; 200 mg</b></i>	T1	
<i><b>cvs b complex plus c oral tablet</b></i>	T1	
<i><b>cvs one daily essential oral tablet</b></i>	T1	
<i><b>cvs super b complex/c oral tablet</b></i>	T1	
<i><b>daily value multivitamin oral tablet</b></i>	T1	
<i><b>daily vite oral tablet</b></i>	T1	
<i><b>daily vites oral tablet</b></i>	T1	
<i><b>daily-vite multivitamin oral tablet</b></i>	T1	
<i><b>daily-vite oral tablet</b></i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG ( <i><b>b complex-c-biotin-e-min-fa</b></i> )	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG ( <i><b>b complex-c-folic acid</b></i> )	T1	
DIALYVITE/ZINC ORAL TABLET ( <i><b>b complex-c-zn-folic acid</b></i> )	T1	
ELITE-OB ORAL TABLET 50-1.25 MG ( <i><b>prenatal vit-iron carbonyl-fa</b></i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	
<i>essential one daily multivit oral tablet</i>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE ( <i>pediatric multiple vitamins</i> )	T1	
<i>folbee plus oral tablet</i>	T1	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	T1	
GERITOL TONIC ORAL LIQUID ( <i>iron-vitamins</i> )	T1	
<i>gnp essential one daily oral tablet</i>	T1	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE ( <i>pediatric multivit-minerals</i> )	T1	
<i>high potency multivitamin oral tablet</i>	T1	
<i>hylavite oral tablet</i>	T1	
<i>kobee oral tablet</i>	T1	
<i>m-natal plus oral tablet 27-1 mg</i>	T1	
<i>multiple vitamins oral tablet</i>	T1	
<i>multiple vitamins-iron oral tablet chewable 15 mg</i>	T1	
<i>multivitamin adult oral tablet</i>	T1	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	T1	
<i>multivitamin childrens oral tablet chewable</i>	T1	
<i>multivitamin oral tablet</i>	T1	
<i>multi-vitamin oral tablet</i>	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
<i>nephro vitamins oral tablet 0.8 mg</i>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	T1	
NUTRIVIT ORAL LIQUID ( <i>b complex-lysine-min-fe-fa</i> )	T1	
ONE-A-DAY ESSENTIAL ORAL TABLET ( <i>multiple vitamin</i> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>one-daily multi-vitamin oral tablet</i></b>	T1	
<b><i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i></b>	T1	
<b><i>prenatal gummies/dha &amp; fa oral tablet chewable 0.4-32.5 mg</i></b>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG ( <b><i>prenatal mv-min-fe fum-fa-dha</i></b> )	T1	
<b><i>prenatal one daily oral tablet 27-0.8 mg</i></b>	T1	
<b><i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i></b>	T1	
<b><i>prenatal plus oral tablet 27-1 mg</i></b>	T1	
<b><i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i></b>	T1	
<b><i>prenatal vitamins oral tablet 28-0.8 mg</i></b>	T1	
<b><i>prenatal/iron oral tablet , 28-0.8 mg</i></b>	T1	
<b><i>qc prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>quintabs oral tablet</i></b>	T1	
<b><i>ra balanced b-100 oral tablet</i></b>	T1	
<b><i>ra prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>b complex-c-folic acid</i></b> (Renal Oral Capsule 1 Mg)	T1	
<b><i>renal vitamin oral tablet 0.8 mg</i></b>	T1	
<b><i>rena-vite oral tablet</i></b>	T1	
<b><i>rena-vite rx oral tablet 1 mg</i></b>	T1	
<b><i>reno caps oral capsule 1 mg</i></b>	T1	
<b><i>sm b super vitamin complex oral tablet</i></b>	T1	
<b><i>sm vitamin b complex/vitamin c oral tablet</i></b>	T1	
<b><i>stress formula oral tablet</i></b>	T1	
<b><i>super b complex/fa/vit c oral tablet</i></b>	T1	
<b><i>super b/c oral capsule</i></b>	T1	
<b><i>super b-complex + vitamin c oral tablet</i></b>	T1	
<b><i>super b-complex/vit c/fa oral tablet</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>support oral liquid</i></b>	T1	
SUPPORT-500 ORAL CAPSULE ( <b><i>multiple vitamins-minerals</i></b> )	T1	
TAB-A-VITE ORAL TABLET ( <b><i>multiple vitamin</i></b> )	T1	
THERA ORAL TABLET ( <b><i>multiple vitamin</i></b> )	T1	
<b><i>thrivite rx oral tablet 29-1 mg</i></b>	T1	
<b><i>triphrocaps oral capsule 1 mg</i></b>	T1	
<b><i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i></b>	T1	
<b><i>tri-vite/fluoride oral solution 0.25 mg/ml</i></b>	T1	
<b><i>v-c forte oral capsule</i></b>	T1	
<b><i>multiple vitamins-minerals</i></b> (Vic-Forte Oral Capsule)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE ( <b><i>pediatric multivit-minerals</i></b> )	T1	
<b><i>vitamins acd-fluoride oral solution 0.25 mg/ml</i></b>	T1	
<b><i>wescaps oral capsule 1 mg</i></b>	T1	
<b><i>westab plus oral tablet 27-1 mg</i></b>	T1	
<b>Vitamin A</b>		
AQUASOL A INTRAMUSCULAR SOLUTION 50000 UNIT/ML ( <b><i>vitamin a</i></b> )	T1	
<b><i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i></b>	T1	
<b><i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i></b>	T1	
<b><i>tri-vite/fluoride oral solution 0.25 mg/ml</i></b>	T1	
<b><i>vitamins acd-fluoride oral solution 0.25 mg/ml</i></b>	T1	
<b>Vitamin B Complex</b>		
<b><i>b complex-c oral tablet</i></b>	T1	
<b><i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i></b>	T1	
<b><i>b complex-c-folic acid oral tablet</i></b>	T1	
<b><i>b-12 oral tablet 1000 mcg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
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drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-12 oral tablet extended release 1000 mcg</i>	T1	
<i>b-12 tr oral tablet extended release 1000 mcg</i>	T1	
<i>b-2 oral tablet 100 mg</i>	T1	
<i>b6 natural oral tablet 100 mg</i>	T1	
<i>b-6 oral tablet 100 mg, 250 mg, 50 mg</i>	T1	
<i>balance b-50 oral tablet</i>	T1	
<i>b-complex (folic acid) oral tablet</i>	T1	
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>b-complex-c oral tablet</i>	T1	
<i>bp vit 3 oral capsule 1 mg</i>	T1	
<i>childrens chew multivitamin oral tablet chewable</i>	T1	
<i>childrens chewable vitamins oral tablet chewable</i>	T1	
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 &amp; 200 mg</i>	T1	
<i>cvs b complex plus c oral tablet</i>	T1	
<i>cvs b6 oral tablet 100 mg</i>	T1	
<i>cvs super b complex/c oral tablet</i>	T1	
<i>cvs vitamin b12 oral tablet 1000 mcg</i>	T1	
<i>cvs vitamin b-12 oral tablet 1000 mcg</i>	T1	
<i>cvs vitamin b12 oral tablet extended release 1000 mcg</i>	T1	
<i>cvs vitamin b-2 oral tablet 100 mg</i>	T1	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG ( <i>b complex-c-biotin-e-min-fa</i> )	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	T1	
DIALYVITE/ZINC ORAL TABLET ( <i>b complex-c-zn-folic acid</i> )	T1	
<i>cyanocobalamin</i> (Dodex Injection Solution 1000 Mcg/MI)	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
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drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i></b>	T1	
ELITE-OB ORAL TABLET 50-1.25 MG ( <b><i>prenatal vit-iron carbonyl-fa</i></b> )	T1	
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 250 MG, 750 MG ( <b><i>niacin</i></b> )	T1	
<b><i>eq1 b-6 oral tablet 100 mg</i></b>	T1	
<b><i>eq1 prenatal formula oral tablet 28-0.8 mg</i></b>	T1	
<b><i>fe c tab plus oral tablet 100-250-0.025-1 mg</i></b>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE ( <b><i>pediatric multiple vitamins</i></b> )	T1	
<b><i>folbee oral tablet 2.5-25-1 mg</i></b>	T1	
<b><i>folbee plus oral tablet</i></b>	T1	
FOLBIC ORAL TABLET 2.5-25-2 MG ( <b><i>fa-pyridoxine-cyanocobalamin</i></b> )	T1	
<b><i>folic acid injection solution 5 mg/ml</i></b>	T1	
<b><i>folic acid oral tablet 1 mg, 400 mcg</i></b>	T1	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG ( <b><i>ferrous sulfate-c-folic acid</i></b> )	T1	
<b><i>folplex 2.2 oral tablet 2.2-25-0.5 mg</i></b>	T1	
FOLTRATE ORAL TABLET 500-1 MCG-MG ( <b><i>cobalamin combinations</i></b> )	T1	
<b><i>full spectrum b/vitamin c oral tablet 0.8 mg</i></b>	T1	
<b><i>gnp prenatal oral tablet 28-0.8 mg</i></b>	T1	
<b><i>gnp vitamin b-12 oral tablet extended release 1000 mcg</i></b>	T1	
<b><i>gnp vitamin b-6 oral tablet 100 mg</i></b>	T1	
<b><i>hematinic plus vit/minerals oral tablet 106-1 mg</i></b>	T1	
<b><i>hematinic/folic acid oral tablet 324-1 mg</i></b>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG ( <b><i>fe fum-vit c-vit b12-fa</i></b> )	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>hydroxocobalamin acetate intramuscular solution 1000 mcg/ml</i></b>	T1	
<b><i>hylavite oral tablet</i></b>	T1	
<b><i>iron polysacch cmplx-b12-fa</i></b> (Iferex 150 Forte Oral Capsule 150-25-1 Mg-Mcg-Mg)	T1	
<b><i>iron 100 plus oral tablet 100-250-0.025-1 mg</i></b>	T1	
<b><i>kobee oral tablet</i></b>	T1	
<b><i>kp folic acid oral tablet 1 mg</i></b>	T1	
<b><i>kp niacin oral tablet 500 mg</i></b>	T1	
<b><i>kp vitamin b-12 oral tablet 1000 mcg</i></b>	T1	
<b><i>kp vitamin b-6 oral tablet 100 mg</i></b>	T1	
<b><i>leucovorin calcium oral tablet 5 mg</i></b>	T1	
<b><i>l-methyl-mc oral tablet 6-1-50-5 mg</i></b>	T1	
METAFOLBIC ORAL TABLET 6-1-50-5 MG ( <b><i>l-methylfolate-b12-b6-b2</i></b> )	T1	
<b><i>m-natal plus oral tablet 27-1 mg</i></b>	T1	
MTX SUPPORT ORAL TABLET ( <b><i>cobalamin combinations</i></b> )	T1	
<b><i>multivitamin childrens (w/ fa) oral tablet chewable</i></b>	T1	
<b><i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i></b>	T1	
<b><i>nephro vitamins oral tablet 0.8 mg</i></b>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG ( <b><i>b complex-c-folic acid</i></b> )	T1	
<b><i>neurin-sl sublingual tablet sublingual 600-600 mcg</i></b>	T1	
<b><i>niacin (antihyperlipidemic) oral tablet 500 mg</i></b>	T1	
<b><i>niacin er oral capsule extended release 250 mg, 500 mg</i></b>	T1	
<b><i>niacin er oral tablet extended release 1000 mg, 250 mg, 500 mg, 750 mg</i></b>	T1	
<b><i>niacin oral tablet 100 mg, 250 mg, 50 mg, 500 mg</i></b>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>niacinamide oral tablet 500 mg</i>	T1	PA
NIVA-FOL ORAL TABLET 2.5-25-2 MG ( <i>fa-pyridoxine-cyanocobalamin</i> )	T1	
NUTRIVIT ORAL LIQUID ( <i>b complex-lysine-min-fe-fa</i> )	T1	
<i>poly-iron 150 forte oral capsule 150-25-1 mg-mcg-mg</i>	T1	
<i>prenatal gummies/dha &amp; fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG ( <i>prenatal mv-min-fe fum-fa-dha</i> )	T1	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	T1	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i>	T1	
<i>prenatal plus oral tablet 27-1 mg</i>	T1	
<i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i>	T1	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	T1	
<i>prenatal/iron oral tablet , 28-0.8 mg</i>	T1	
PROFERRIN-FORTE ORAL TABLET 12-1 MG ( <i>fe heme polypeptide-folic acid</i> )	T1	
<i>pyridoxine hcl injection solution 100 mg/ml</i>	T1	
<i>pyridoxine hcl oral tablet 50 mg</i>	T1	
<i>qc prenatal oral tablet 28-0.8 mg</i>	T1	
<i>ra balanced b-100 oral tablet</i>	T1	
<i>ra niacin oral tablet 100 mg, 500 mg</i>	T1	
<i>ra prenatal oral tablet 28-0.8 mg</i>	T1	
<i>ra vitamin b-12 tr oral tablet extended release 1000 mcg</i>	T1	
<i>ra vitamin b-6 oral tablet 100 mg, 50 mg</i>	T1	
<i>b complex-c-folic acid</i> (Renal Oral Capsule 1 Mg)	T1	
<i>renal vitamin oral tablet 0.8 mg</i>	T1	
<i>rena-vite oral tablet</i>	T1	
<i>rena-vite rx oral tablet 1 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>reno caps oral capsule 1 mg</i>	T1	
<i>riboflavin oral tablet 400 mg</i>	T1	
<i>sm b super vitamin complex oral tablet</i>	T1	
<i>sm vitamin b complex/vitamin c oral tablet</i>	T1	
<i>sm vitamin b6 oral tablet 100 mg</i>	T1	
<i>super b complex/fa/vit c oral tablet</i>	T1	
<i>super b/c oral capsule</i>	T1	
<i>super b-complex + vitamin c oral tablet</i>	T1	
<i>super b-complex/vit c/fa oral tablet</i>	T1	
<i>sv vitamin b-12 er oral tablet extended release 1000 mcg</i>	T1	
<i>thiamine hcl injection solution 100 mg/ml, 200 mg/2ml</i>	T1	
<i>thrivite rx oral tablet 29-1 mg</i>	T1	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	T1	
<i>triphrocaps oral capsule 1 mg</i>	T1	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
<i>vitamin b-12 er oral tablet extended release 1000 mcg</i>	T1	
<i>vitamin b-12 oral tablet 1000 mcg</i>	T1	
<i>vitamin b-2 oral tablet 100 mg</i>	T1	
<i>vitamin b-6 oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>vitamin b6 oral tablet 100 mg, 250 mg, 50 mg</i>	T1	
<i>wescaps oral capsule 1 mg</i>	T1	
<i>westab max oral tablet 2.5-25-2 mg</i>	T1	
<i>westab one oral tablet 2.5-25-1 mg</i>	T1	
<i>westab plus oral tablet 27-1 mg</i>	T1	
<b>Vitamin C</b>		
<i>ascorbic acid injection solution 500 mg/ml</i>	T1	
<i>b complex-c oral tablet</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
<i>b complex-c-folic acid oral tablet</i>	T1	
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>b-complex-c oral tablet</i>	T1	
<i>calcium/c/d oral tablet chewable 500-10-250 mg-mg-unit</i>	T1	
<i>childrens chew multivitamin oral tablet chewable</i>	T1	
<i>childrens chewable vitamins oral tablet chewable</i>	T1	
<i>cvs b complex plus c oral tablet</i>	T1	
<i>cvs super b complex/c oral tablet</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG ( <i>b complex-c-biotin-e-min-fa</i> )	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	T1	
DIALYVITE/ZINC ORAL TABLET ( <i>b complex-c-zn-folic acid</i> )	T1	
<i>fe c tab plus oral tablet 100-250-0.025-1 mg</i>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE ( <i>pediatric multiple vitamins</i> )	T1	
<i>folbee plus oral tablet</i>	T1	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG ( <i>ferrous sulfate-c-folic acid</i> )	T1	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE ( <i>pediatric multivit-minerals</i> )	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG ( <i>fe fum-vit c-vit b12-fa</i> )	T1	
<i>hylavite oral tablet</i>	T1	
<i>iron 100 plus oral tablet 100-250-0.025-1 mg</i>	T1	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nephro vitamins oral tablet 0.8 mg</i>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG ( <i>b complex-c-folic acid</i> )	T1	
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>b complex-c-folic acid</i> (Renal Oral Capsule 1 Mg)	T1	
<i>renal vitamin oral tablet 0.8 mg</i>	T1	
<i>rena-vite oral tablet</i>	T1	
<i>rena-vite rx oral tablet 1 mg</i>	T1	
<i>reno caps oral capsule 1 mg</i>	T1	
<i>sm b super vitamin complex oral tablet</i>	T1	
<i>sm vitamin b complex/vitamin c oral tablet</i>	T1	
<i>super b complex/fa/vit c oral tablet</i>	T1	
<i>super b/c oral capsule</i>	T1	
<i>super b-complex + vitamin c oral tablet</i>	T1	
<i>super b-complex/vit c/fa oral tablet</i>	T1	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	T1	
<i>triphrocaps oral capsule 1 mg</i>	T1	
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE ( <i>pediatric multivit-minerals</i> )	T1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	T1	
<i>wescaps oral capsule 1 mg</i>	T1	
Vitamin D		
<i>600+d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>aqueous vitamin d oral liquid 10 mcg/ml</i>	T1	QL (100 ML per 30 days)
BPROTECTED PEDIA D-VITE ORAL LIQUID 10 MCG/ML ( <i>cholecalciferol</i> )	T1	QL (100 ML per 30 days)

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIDOL ORAL SOLUTION 200 MCG/ML ( <i>ergocalciferol</i> )	T1	
<i>cal-citrate plus vitamin d oral tablet 250-2.5 mg-mcg</i>	T1	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	T1	
<i>calcitriol oral solution 1 mcg/ml</i>	T1	
<i>calcium + vitamin d3 oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	T1	
<i>calcium 1000 + d oral tablet 1000-20 mg-mcg</i>	T1	
<i>calcium 500 + d oral tablet 500-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 500 + d3 oral tablet 500-15 mg-mcg</i>	T1	
<i>calcium 500/d oral tablet 500-5 mg-mcg</i>	T1	
<i>calcium 500+d high potency oral tablet 500-10 mg-mcg</i>	T1	
<i>calcium 500+d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 500+d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>calcium 600 + d oral tablet 600-5 mg-mcg</i>	T1	
<i>calcium 600 +d high potency oral tablet 600-10 mg-mcg</i>	T1	
<i>calcium 600/vitamin d oral tablet 600-10 mg-mcg</i>	T1	
<i>calcium 600/vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>calcium 600+d high potency oral tablet 600-10 mg-mcg</i>	T1	
<i>calcium 600+d oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	T1	
<i>calcium 600+d3 oral tablet 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i>	T1	
<i>calcium carb-cholecalciferol oral tablet 500-10 mg-mcg, 500-5 mg-mcg, 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i>	T1	
<i>calcium carb-cholecalciferol oral tablet chewable 500-10 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcium carbonate-vitamin d oral capsule 600-5 mg-mcg</i>	T1	
<i>calcium carbonate-vitamin d oral tablet 600-5 mg-mcg</i>	T1	
<i>calcium citrate + d oral tablet 250-5 mg-mcg, 315-5 mg-mcg</i>	T1	
<i>calcium citrate + d3 maximum oral tablet 315-6.25 mg-mcg</i>	T1	
<i>calcium citrate + d3 oral tablet 200-6.25 mg-mcg, 315-5 mg-mcg</i>	T1	
<i>calcium citrate malate-vit d oral tablet 250-2.5 mg-mcg</i>	T1	
<i>calcium citrate+d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	T1	
<i>calcium citrate-vitamin d oral tablet 200-3.125 mg-mcg, 315-5 mg-mcg</i>	T1	
<i>calcium citrate-vitamin d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>calcium for women oral tablet chewable 500-100-40</i>	T1	
<i>calcium high potency/vitamin d oral tablet 600-5 mg-mcg</i>	T1	
<i>calcium oral tablet chewable 500-2.5 mg-mcg</i>	T1	
<i>calcium plus vitamin d oral tablet 500-5 mg-mcg</i>	T1	
<i>calcium plus vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>calcium/c/d oral tablet chewable 500-10-250 mg-mg-unit</i>	T1	
<i>calcium+d3 oral tablet 500-10 mg-mcg, 500-15 mg-mcg, 600-20 mg-mcg</i>	T1	
<i>calcium-vitamin d3 oral capsule 600-10 mg-mcg</i>	T1	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg</i>	T1	
CITRACAL MAXIMUM ORAL TABLET 315-6.25 MG-MCG ( <i>calcium citrate-vitamin d</i> )	T1	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	T1	
<i>coral calcium oral capsule 185-50-100 mg-mg-unit</i>	T1	
<i>cvs calcium + d3 oral tablet 600-20 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
<b>lowercase bold italics =</b>		AL = Age Limit
Generic drugs		PA = Prior Authorization
<b>UPPERCASE = Brand name</b>	<b>Drug Tier</b>	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs calcium 600 &amp; vitamin d3 oral tablet 600-20 mg-mcg</i>	T1	
<i>cvs calcium 600+d oral tablet 600-20 mg-mcg</i>	T1	
<i>cvs calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	T1	
<i>cvs d3 oral capsule 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	T1	
<i>cvs vitamin d3 oral tablet chewable 25 mcg (1000 ut)</i>	T1	
<i>d 1000 oral capsule 25 mcg (1000 ut)</i>	T1	
<i>d 1000 oral tablet chewable 25 mcg (1000 ut)</i>	T1	
<i>d 10000 oral capsule 250 mcg (10000 ut)</i>	T1	
<i>d-1000 extra strength oral tablet 25 mcg (1000 ut)</i>	T1	
<i>d2000 ultra strength oral capsule 50 mcg (2000 ut)</i>	T1	
<i>d3 2000 oral capsule 50 mcg (2000 ut)</i>	T1	
<i>d3 adult oral tablet chewable 25 mcg (1000 ut)</i>	T1	
<i>d3 high potency oral capsule 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	T1	
<i>d3 high potency oral tablet 10 mcg (400 unit)</i>	T1	
<i>d3 oral tablet 50 mcg (2000 ut)</i>	T1	
<i>d3 super strength oral capsule 50 mcg (2000 ut)</i>	T1	
<i>d3-1000 oral capsule 25 mcg (1000 ut)</i>	T1	
<i>d3-1000 oral tablet 25 mcg (1000 ut)</i>	T1	
<i>d-400 oral tablet 10 mcg (400 unit)</i>	T1	
<i>d-5000 oral tablet 125 mcg (5000 ut)</i>	T1	
DECARA ORAL CAPSULE 1.25 MG (50000 UT) ( <i>cholecalciferol</i> )	T1	
<i>delta d3 oral tablet 10 mcg (400 unit)</i>	T1	
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T1	
<i>d-vite pediatric oral liquid 10 mcg/ml</i>	T1	QL (100 ML per 30 days)
<i>eq calcium 500+d oral tablet 500-5 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>eq calcium 600+d oral tablet 600-20 mg-mcg</i></b>	T1	
<b><i>eq calcium citrate+d oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>eql calcium citrate/vitamin d oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>eql calcium citrate/vitamin d3 oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>eql calcium/vitamin d oral tablet 600-10 mg-mcg</i></b>	T1	
<b><i>eql calcium/vitamin d3 oral tablet 600-20 mg-mcg</i></b>	T1	
<b><i>eql vitamin d3 oral capsule 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i></b>	T1	
<b><i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i></b>	T1	
<b><i>ergocalciferol oral solution 200 mcg/ml</i></b>	T1	
<b>FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (alendronate-cholecalciferol)</b>	T1	PA
<b><i>gnp calcium 500 +d3 oral tablet 500-15 mg-mcg</i></b>	T1	
<b><i>gnp calcium 600 +d3 oral tablet 600-20 mg-mcg</i></b>	T1	
<b><i>gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>gnp d 1000 oral capsule 25 mcg (1000 ut)</i></b>	T1	
<b><i>gnp d 2000 oral tablet chewable 25 mcg (1000 ut)</i></b>	T1	
<b><i>gnp vitamin d maximum strength oral tablet 50 mcg (2000 ut)</i></b>	T1	
<b><i>gnp vitamin d oral tablet 25 mcg (1000 ut)</i></b>	T1	
<b><i>gnp vitamin d oral tablet chewable 10 mcg (400 unit)</i></b>	T1	
<b><i>gnp vitamin d3 extra strength oral tablet 25 mcg (1000 ut)</i></b>	T1	
<b><i>gnp vitamin d3 oral tablet 10 mcg (400 unit)</i></b>	T1	
<b><i>kp calcium citrate+d oral tablet 315-6.25 mg-mcg</i></b>	T1	
<b><i>kp vitamin d oral capsule 25 mcg (1000 ut)</i></b>	T1	
<b><i>kp vitamin d3 oral capsule 25 mcg (1000 ut)</i></b>	T1	
<b><i>liquid calcium/vitamin d oral capsule 600-5 mg-mcg</i></b>	T1	

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<b>lowercase bold italics =</b> Generic drugs		<b>Coverage Requirements and Limits</b> AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
<b>UPPERCASE =</b> Brand name drugs	<b>Drug Tier</b> T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTIMAL D3 ORAL CAPSULE 1.25 MG (50000 UT) ( <i>cholecalciferol</i> )	T1	
OYSCO 500+D ORAL TABLET 500-5 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	T1	
<i>oyster shell calcium + d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium + d3 oral tablet 500-10 mg-mcg</i>	T1	
<i>oyster shell calcium plus d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium w/d oral tablet 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/vit d3 oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>oyster shell calcium/vitamin d oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg</i>	T1	
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>pharmacist choice d-vitamin oral liquid 400 unit/ml</i>	T1	QL (100 ML per 30 days)
<i>ra calcium 600/vit d/minerals oral tablet 600-200 mg-unit</i>	T1	
<i>ra calcium 600/vitamin d-3 oral tablet 600-10 mg-mcg</i>	T1	
<i>ra calcium cit plus vit d-3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>ra calcium cit-vit d-3 petites oral tablet 200-6.25 mg-mcg</i>	T1	
RA HI CAL ORAL TABLET 500-5 MG-MCG ( <i>calcium carb-cholecalciferol</i> )	T1	
<i>ra vitamin d-3 oral capsule 50 mcg (2000 ut)</i>	T1	
<i>ra vitamin d-3 oral tablet 25 mcg (1000 ut)</i>	T1	
<i>sm calcium citrate+/vit d3 oral tablet 315-6.25 mg-mcg</i>	T1	
<i>sm calcium citrate+/vit d3 max oral tablet 315-6.25 mg-mcg</i>	T1	
<i>sm calcium/vitamin d oral tablet 500-5 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b><i>sm vitamin d3 oral capsule 50 mcg, 50 mcg (2000 ut)</i></b>	T1	
<b><i>sm vitamin d3 oral tablet 25 mcg (1000 ut)</i></b>	T1	
THERA-D 2000 ORAL TABLET 50 MCG (2000 UT) <b><i>(cholecalciferol)</i></b>	T1	
THERA-D RAPID REPLETION ORAL TABLET 50 MCG (2000 UT) <b><i>(cholecalciferol)</i></b>	T1	
<b><i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i></b>	T1	
<b><i>tri-vite/fluoride oral solution 0.25 mg/ml</i></b>	T1	
VITAJOY DAILY D GUMMIES ORAL TABLET CHEWABLE 25 MCG (1000 UT) <b><i>(cholecalciferol)</i></b>	T1	
<b><i>vitamin d (cholecalciferol) oral capsule 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i></b>	T1	
<b><i>vitamin d (cholecalciferol) oral tablet 10 mcg (400 unit), 25 mcg (1000 ut)</i></b>	T1	
<b><i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i></b>	T1	
<b><i>vitamin d high potency oral capsule 25 mcg (1000 ut)</i></b>	T1	
<b><i>vitamin d infant oral liquid 10 mcg/ml</i></b>	T1	QL (100 ML per 30 days)
<b><i>vitamin d oral capsule 50 mcg (2000 ut)</i></b>	T1	
<b><i>vitamin d oral liquid 10 mcg/ml</i></b>	T1	QL (100 ML per 30 days)
<b><i>vitamin d oral tablet 25 mcg (1000 ut), 50 mcg (2000 ut)</i></b>	T1	
VITAMIN D-1000 MAX ST ORAL TABLET 25 MCG (1000 UT) <b><i>(cholecalciferol)</i></b>	T1	
<b><i>vitamin d2 oral tablet 10 mcg (400 unit)</i></b>	T1	
<b><i>vitamin d3 adult gummies oral tablet chewable 25 mcg (1000 ut)</i></b>	T1	
<b><i>vitamin d3 extra strength oral tablet chewable 25 mcg (1000 ut)</i></b>	T1	
<b><i>vitamin d3 gummies adult oral tablet chewable 25 mcg (1000 ut)</i></b>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
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<i>vitamin d3 oral capsule 1.25 mg (50000 ut), 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	T1	
<i>vitamin d-3 oral capsule 25 mcg (1000 ut)</i>	T1	
<i>vitamin d3 oral liquid 10 mcg/ml</i>	T1	QL (100 ML per 30 days)
<i>vitamin d3 oral liquid 125 mcg/ml</i>	T1	
<i>vitamin d3 oral tablet 10 mcg (400 unit), 25 mcg, 25 mcg (1000 ut), 50 mcg (2000 ut), 75 mcg (3000 ut)</i>	T1	
<i>vitamin d3 oral tablet chewable 10 mcg (400 unit), 25 mcg (1000 ut)</i>	T1	
<i>vitamin d3 super strength oral capsule 50 mcg (2000 ut)</i>	T1	
<i>vitamin d3 super strength oral tablet 50 mcg (2000 ut)</i>	T1	
<i>vitamin d3 ultra potency oral tablet 1250 mcg</i>	T1	
<i>vitamins acd-fluoride oral solution 0.25 mg/ml</i>	T1	
YUMVS VITAMIN D3 ORAL TABLET CHEWABLE 25 MCG (1000 UT) ( <i>cholecalciferol</i> )	T1	
<b>Vitamin E</b>		
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG ( <i>b complex-c-biotin-e-min-fa</i> )	T1	
<b>Vitamin K Activity</b>		
<i>calcium for women oral tablet chewable 500-100-40</i>	T1	
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	

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