meridianhealth

2021

Medicaid Formulary

ILLINOIS

2021 Illinois Medicaid Formulary

Version 236

Updated:
02/26/2021

This formulary is up to date through its date of publication, 02/26/2021.

Introduction

MeridianHealth (Meridian) is pleased to give an updated 2021 Medicaid formulary as a reference and tool for providers, pharmacists, and patients. The purpose of the Meridian formulary is to help providers choose clinically fit and cost-effective products for their patients. This document has facts about the drugs we cover in this plan.

The MeridianRx Pharmacy and Therapeutics (P&T) Committee

The MeridianRx P&T Committee is made up of providers, pharmacists, and health professionals. The clinical information within the formulary mainly came from medical literature and is reviewed and approved by the P&T Committee.

Notice

The information contained in this formulary is given by Meridian, only for the convenience of medical providers. This formulary is not meant to be a substitute for the knowledge, expertise, skill, and judgment of the medical provider in his or her choice of prescription drugs. Meridian assumes no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should see the drug manufacturer's product literature or standard references for more detailed information.

Preface

The Meridian formulary is organized in sections. Each section includes therapeutic groups named by either drug class or disease state. Brand and common names are included as a reference to help in product recognition. Brand name drugs are capitalized (e.g., CONCERTA) and generic drugs are listed in lower-case italics (e.g., *methylphenidate HCL*).

Meridian will not cover prescription drugs that are prescribed for experimental, investigational, or non-FDA approved indications, dosages, or routes of administration.

Formulary Components

The Meridian formulary contains covered medications without authorization, medications that must meet step therapy protocol, medications that need prior authorization, specialty medications, and medications that have quantity limits. Members will not be charged a co-pay when Meridian covers a medication.

Generic Substitution

Meridian is a mandatory generic plan. The Illinois Department of Healthcare and Family Services (HFS) has mandated that some brand medications are to be covered over the generic medication. Generic medication will be dispensed when available.

Covered Medications without Authorization

Meridian covers many medications without requiring authorization. These medications include many prescription and over-the-counter medications (with a valid prescription).

Tier Descriptions

Tier Number	Tier Name	Tier Description
1	Preferred	The Illinois Department of Healthcare and Family Service (HFS) preferred drug list (PDL) mandated coverage. No prior authorization required. Products may have quantity limitations, gender restrictions, specialty restrictions, and/or age limitations.
2	Preferred with Prior Authorization	HFS PDL mandated coverage. Prior authorization required. In some cases, will need the trial and failure of preferred agent(s). Products may also have additional approval criteria, quantity limitations, gender restrictions, specialty restrictions, and/or age limitations.
3	Non-Preferred	HFS PDL mandated coverage. Prior authorization required. In most cases will need the trial and failure of two or more preferred agent(s). Products may also have additional approval criteria, quantity limitations, gender restrictions, and/or age limitations.
4	Supplemental Coverage	Additional products that Meridian covers for the benefit of its members. Some products may require prior authorization, have quantity limitations, gender restrictions, step therapy, specialty restrictions, and/or age limitations.

Non-Covered Benefits

Non-covered benefits include medications used for cosmetic purposes, to promote fertility, for sexual dysfunction, for experimental or investigational purposes, or medications that are not licensed for use in the United States.

Prior Authorization (PA)

Drugs indicated with "PA" need prior authorization for coverage. Details of PA criteria are listed next to the drug name. Please call the MeridianRx Help Desk at **855-580-1688** or fax a completed prior authorization form to **855-580-1695**. All prior authorization requests will be reviewed within 24 hours.

Please note: A prior authorization is NOT required on any anticonvulsant medications for members with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be given at point of sale or within records.

Step Therapy (ST)
Drugs with an "ST" need step therapy for coverage. The required step is listed next to the drug name.

Specialty Medications (SP)
All specialty medications noted as “SP” are to be filled at contracted, in-network specialty pharmacies.

Quantity Limits (QL)
Drugs with a "QL" have a set quantity limit imposed. These limits are based on FDA-recommended dosing guidelines. The quantity limit is listed next to the drug name. All medications have a maximum of 30 days per prescription.

Fill Limit (FL)
Drugs indicated with an "FL" have a set fill limit imposed. The fill limit is listed next to the drug name. These medications are limited to a number of fills in a set amount of time.

Day Supply Limit (DS)
Drugs indicated with a "DS" have a set day supply limit imposed. The day supply limit is listed next to the drug name. These medications are limited to a certain day supply in a set amount of time.

Gender Restriction (GR)
Drugs indicated with a "GR" have a set gender restriction imposed. The gender restriction is listed next to the drug name. These medications are limited to either males or females.

Age Limit (AL)
Drugs indicated with an "AL" have a set age limit imposed. The age limit is listed next to the drug name. These medications are limited to a specific age range.

Benefit Exception
To request non-formulary medication(s), fax a completed Formulary Exception form asking for an exception to the formulary. This request needs to have relevant clinical documentation showing trial and failure of all formulary agents. It should also have information showing the medication is the standard of care for the indication provided (peer-reviewed journal articles may be required).

Please call the MeridianRx Help Desk at **855-580-1688** or fax a completed Formulary Exception form to **855-580-1695**.

Pharmacy Benefit Management

Meridian uses MeridianRx to manage each member's pharmacy benefit. MeridianRx provides Meridian with a pharmacy network, pharmacy claims management services, and claims adjudication. This formulary is up to date through the date of publication. Please notify MeridianRx of any mistakes in the formulary. A copy of this formulary can be mailed upon request.

Contact MeridianRx Help Desk at **855-580-1688** or email **info@meridianrx.com.**

UM Criteria Legend

UM Criteria Code	UM Criteria Description
SP	Specialty Medication
PA	Prior Authorization Required
ST	Step Therapy Required
FL	Fill Limit
QL	Quantity Limit
DS	Days Supply Limit
GR	Gender Restriction
AL	Age Limit

Drug List

Covered Prescription Drugs

ADHD / ANTI-NARCOLEPSY AGENTS : AMPHETAMINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
dextroamp-amphet er 10 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphet er 15 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphet er 20 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphet er 25 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphet er 30 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphet er 5 mg cap (ADDERALL XR)	QL	Limited to 30 EA per 30 days.
dextroamp-amphetam 12.5 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetam 7.5 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetamin 10 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetamin 15 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetamin 20 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetamin 30 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
dextroamp-amphetamine 5 mg tab (ADDERALL)	QL	Limited to 90 EA per 30 days.
VYVANSE 10 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 10 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 20 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 20 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 30 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 30 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 40 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 40 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 50 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 50 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 60 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
VYVANSE 60 MG CHEWABLE TABLET *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : AMPHETAMINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
VYVANSE 70 MG CAPSULE *(lisdexamfetamine dimesylate)*	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADDERALL 10 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL 12.5 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL 15 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL 20 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL 30 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL 7.5 MG TABLET *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADDERALL XR 10 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADDERALL XR 15 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADDERALL XR 20 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADDERALL XR 25 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADDERALL XR 30 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADDERALL XR 5 MG CAPSULE *(use dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADZENYS ER 1.25 MG/ML SUSP *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 12.5 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 15.7 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 18.8 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 3.1 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 6.3 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADZENYS XR-ODT 9.4 MG TABLET *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : AMPHETAMINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amphetamine er 1.25 mg/ml susp (ADZENYS ER)	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
amphetamine sulfate 10 mg tab (EVEKEO)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
amphetamine sulfate 5 mg tab (EVEKEO)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DESOXYN 5 MG TABLET *(methamphetamine hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DEXEDRINE SPANSULE 10 MG *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DEXEDRINE SPANSULE 15 MG *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DEXEDRINE SPANSULE 5 MG *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine 10 mg tab (DEXAMPEX)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine 10 mg tab (ZENZEDI)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine 5 mg tab (DEXEDRINE)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine 5 mg tab (ZENZEDI)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine 5 mg/5 ml (LIQUADD)	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
dextroamphetamine er 10 mg cap (DEXEDRINE)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine er 15 mg cap (DEXEDRINE)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
dextroamphetamine er 5 mg cap (DEXEDRINE)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DYANAVEL XR 2.5 MG/ML SUSP *(amphetamine)*	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
EVEKEO 10 MG TABLET *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EVEKEO 5 MG TABLET *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EVEKEO ODT 10 MG *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EVEKEO ODT 15 MG *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EVEKEO ODT 20 MG *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EVEKEO ODT 5 MG *(amphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methamphetamine 5 mg tablet (DESOXYN)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
MYDAYIS ER 12.5 MG CAPSULE *(dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
MYDAYIS ER 25 MG CAPSULE *(dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
MYDAYIS ER 37.5 MG CAPSULE *(dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
MYDAYIS ER 50 MG CAPSULE *(dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
PROCENTRA 5 MG/5 ML SOLUTION *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : AMPHETAMINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ZENZEDI 10 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 15 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 2.5 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 20 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 30 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 5 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZENZEDI 7.5 MG TABLET *(dextroamphetamine sulfate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.

ADHD / ANTI-NARCOLEPSY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clonidine hcl er 0.1 mg tablet (KAPVAY)	QL	Limited to 120 EA per 30 days.
guanfacine hcl er 1 mg tablet (INTUNIV)	QL	Limited to 30 EA per 30 days.
guanfacine hcl er 2 mg tablet (INTUNIV)	QL	Limited to 30 EA per 30 days.
guanfacine hcl er 3 mg tablet (INTUNIV)	QL	Limited to 30 EA per 30 days.
guanfacine hcl er 4 mg tablet (INTUNIV)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
atomoxetine hcl 10 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 100 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 18 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 25 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 40 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 60 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
atomoxetine hcl 80 mg capsule (STRATTERA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
INTUNIV ER 1 MG TABLET *(use guanfacine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
INTUNIV ER 2 MG TABLET *(use guanfacine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
INTUNIV ER 3 MG TABLET *(use guanfacine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
INTUNIV ER 4 MG TABLET *(use guanfacine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 10 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 100 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
STRATTERA 18 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 25 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 40 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 60 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STRATTERA 80 MG CAPSULE *(atomoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SUNOSI 150 MG TABLET *(solriamfetol hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization required. Limited to 30 EA per 30 days.
SUNOSI 75 MG TABLET *(solriamfetol hcl)*	PA,QL,SP	Restricted to specialty pharmacies. Prior Authorization required. Limited to 60 EA per 30 days.
WAKIX 17.8 MG TABLET *(pitolisant hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
WAKIX 4.45 MG TABLET *(pitolisant hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

ADHD / ANTI-NARCOLEPSY AGENTS : STIMULANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CONCERTA ER 18 MG TABLET *(methylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
CONCERTA ER 27 MG TABLET *(methylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
CONCERTA ER 36 MG TABLET *(methylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
CONCERTA ER 54 MG TABLET *(methylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
dexmethylphenidate 10 mg tab (FOCALIN)	QL	Limited to 90 EA per 30 days.
dexmethylphenidate 2.5 mg tab (FOCALIN)	QL	Limited to 90 EA per 30 days.
dexmethylphenidate 5 mg tab (FOCALIN)	QL	Limited to 90 EA per 30 days.
FOCALIN XR 10 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 15 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 20 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 25 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 30 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 35 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 40 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
FOCALIN XR 5 MG CAPSULE *(dexmethylphenidate hcl)*	QL	Limited to 30 EA per 30 days.
methylphenidate 10 mg tablet (RITALIN)	QL	Limited to 90 EA per 30 days.
methylphenidate 20 mg tablet (RITALIN)	QL	Limited to 60 EA per 30 days.
methylphenidate 5 mg tablet (RITALIN)	QL	Limited to 90 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : STIMULANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
methylphenidate er 10 mg tab (METADATE ER)	QL	Limited to 30 EA per 30 days.
methylphenidate er 20 mg tab (RITALIN-SR)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADHANSIA XR 25 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADHANSIA XR 35 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ADHANSIA XR 45 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADHANSIA XR 55 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADHANSIA XR 70 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ADHANSIA XR 85 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 10 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 15 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 20 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 30 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 40 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 50 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
APTENSIO XR 60 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
armodafinil 150 mg tablet (NUVIGIL)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
armodafinil 200 mg tablet (NUVIGIL)	PA	Prior Authorization required.
armodafinil 250 mg tablet (NUVIGIL)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
armodafinil 50 mg tablet (NUVIGIL)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
COTEMPLA XR-ODT 17.3 MG TABLET *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
COTEMPLA XR-ODT 25.9 MG TABLET *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
COTEMPLA XR-ODT 8.6 MG TABLET *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DAYTRANA 10 MG/9 HR PATCH *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DAYTRANA 15 MG/9 HR PATCH *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DAYTRANA 20 MG/9 HOUR PATCH *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DAYTRANA 30 MG/9 HOUR PATCH *(methylphenidate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 10 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : STIMULANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
dexmethylphenidate er 15 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 20 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 25 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 30 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 35 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 40 mg cp (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
dexmethylphenidate er 5 mg cap (FOCALIN XR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
FOCALIN 10 MG TABLET *(use dexmethylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
FOCALIN 2.5 MG TABLET *(use dexmethylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
FOCALIN 5 MG TABLET *(use dexmethylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
JORNAY PM 100 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
JORNAY PM 20 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JORNAY PM 40 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JORNAY PM 60 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
JORNAY PM 80 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
METHYLIN 10 MG/5 ML SOLUTION *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
METHYLIN 5 MG/5 ML SOLUTION *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
methylphenidate 10 mg chew tab (METHYLIN)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate 10 mg/5 ml sol (METHYLIN)	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
methylphenidate 2.5 mg chew tb (METHYLIN)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate 5 mg chew tab (METHYLIN)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate 5 mg/5 ml soln (METHYLIN)	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
methylphenidate cd 10 mg cap (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate cd 20 mg cap (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate cd 30 mg cap (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate cd 40 mg cap (METADATE CD)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate cd 50 mg cap (METADATE CD)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : STIMULANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
methylphenidate cd 60 mg cap (METADATE CD)	PA	Prior Authorization required.
methylphenidate er 10 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 15 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 18 mg tab (CONCERTA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 18 mg tab (CONCERTA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 20 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 27 mg tab (CONCERTA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 27 mg tab (CONCERTA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 30 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 36 mg tab (CONCERTA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 36 mg tab (CONCERTA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 40 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 50 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 54 mg tab (CONCERTA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 54 mg tab (CONCERTA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er 60 mg cap (APTENSIO XR)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
methylphenidate er 72 mg tab (RELEXXII)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er(cd) 10mg cp (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(cd) 20mg cp (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(cd) 30mg cp (METADATE CD)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(cd) 40mg cp (METADATE CD)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate er(cd) 50mg cp (METADATE CD)	PA	Prior Authorization required.
methylphenidate er(cd) 60mg cp (METADATE CD)	PA	Prior Authorization required.
methylphenidate er(la) 10mg cp (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(la) 20mg cp (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(la) 30mg cp (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate er(la) 40mg cp (RITALIN LA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate la 10 mg cap (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate la 20 mg cap (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate la 30 mg cap (RITALIN LA)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
methylphenidate la 40 mg cap (RITALIN LA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.
methylphenidate la 60 mg cap (RITALIN LA)	PA	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ADHD / ANTI-NARCOLEPSY AGENTS : STIMULANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
modafinil 100 mg tablet (PROVIGIL)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
modafinil 200 mg tablet (PROVIGIL)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
NUVIGIL 150 MG TABLET *(armodafinil)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
NUVIGIL 200 MG TABLET *(armodafinil)*	PA	Prior Authorization required.
NUVIGIL 250 MG TABLET *(armodafinil)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
NUVIGIL 50 MG TABLET *(armodafinil)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
PROVIGIL 100 MG TABLET *(modafinil)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
PROVIGIL 200 MG TABLET *(modafinil)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
QUILLICHEW ER 20 MG CHEW TAB *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
QUILLICHEW ER 30 MG CHEW TAB *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
QUILLICHEW ER 40 MG CHEW TAB *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
QUILLIVANT XR 25 MG/5 ML SUSP *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 450 mL per 30 days.
RELEXXII ER 72 MG TABLET *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
RITALIN 10 MG TABLET *(use methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
RITALIN 20 MG TABLET *(use methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RITALIN 5 MG TABLET *(use methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
RITALIN LA 10 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RITALIN LA 20 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RITALIN LA 30 MG CAPSULE *(methylphenidate hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RITALIN LA 40 MG CAPSULE *(methylphenidate hcl)*	PA	Prior Authorization required. Limited to 30 EA per 30 days.
ANALGESICS - ANTI-INFLAMMATORY : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
leflunomide 10 mg tablet (ARAVA)	QL	Limited to 30 EA per 30 days.
leflunomide 20 mg tablet (ARAVA)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARAVA 10 MG TABLET *(use leflunomide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ARAVA 20 MG TABLET *(use leflunomide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OTREXUP 10 MG/0.4 ML AUTO-INJ *(methotrexate/pf)*	PA	Prior Authorization required.
OTREXUP 12.5 MG/0.4 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
OTREXUP 15 MG/0.4 ML AUTO-INJ *(methotrexate/pf)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS - ANTI-INFLAMMATORY : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OTREXUP 17.5 MG/0.4 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
OTREXUP 20 MG/0.4 ML AUTO-INJ *(methotrexate/pf)*	PA	Prior Authorization required.
OTREXUP 22.5 MG/0.4 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
OTREXUP 25 MG/0.4 ML AUTO-INJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 10 MG/0.2 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 12.5 MG/0.25 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 15 MG/0.3 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 17.5 MG/0.35 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 20 MG/0.4 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 22.5 MG/0.45 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 25 MG/0.5 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 30 MG/0.6 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
RASUVO 7.5 MG/0.15 ML AUTOINJ *(methotrexate/pf)*	PA	Prior Authorization required.
REDITREX 10 MG/0.4 ML SYRINGE *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 12.5 MG/0.5 ML SYRING *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 15 MG/0.6 ML SYRINGE *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 17.5 MG/0.7 ML SYRING *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 20 MG/0.8 ML SYRINGE *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 22.5 MG/0.9 ML SYRING *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 25 MG/ML SYRINGE *(methotrexate/pf)*	PA	Prior Authorization Required.
REDITREX 7.5 MG/0.3 ML SYRINGE *(methotrexate/pf)*	PA	Prior Authorization Required.
RIDAURA 3 MG CAPSULE *(auranofin)*	PA	Prior Authorization required.

ANALGESICS - ANTI-INFLAMMATORY : NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
celecoxib 100 mg capsule (CELEBREX)		
celecoxib 200 mg capsule (CELEBREX)		
celecoxib 400 mg capsule (CELEBREX)		
celecoxib 50 mg capsule (CELEBREX)		
diclofenac pot 50 mg tablet (CATAFLAM)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS - ANTI-INFLAMMATORY : NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
diclofenac sod dr 25 mg tab (VOLTAREN)		
diclofenac sod dr 50 mg tab (VOLTAREN)		
diclofenac sod dr 75 mg tab (VOLTAREN)		
diclofenac sod ec 25 mg tab (VOLTAREN)		
diclofenac sod ec 50 mg tab (VOLTAREN)		
diclofenac sod ec 75 mg tab (VOLTAREN)		
diclofenac sod er 100 mg tab (VOLTAREN-XR)		
ec-naproxen dr 375 mg tablet (EC-NAPROSYN)		
ec-naproxen dr 500 mg tablet (EC-NAPROSYN)		
etodolac 200 mg capsule (LODINE)		
etodolac 300 mg capsule (LODINE)		
etodolac 400 mg tablet (LODINE)		
etodolac 500 mg tablet (LODINE)		
etodolac er 400 mg tablet (LODINE XL)		
etodolac er 500 mg tablet (LODINE XL)		
etodolac er 600 mg tablet (LODINE XL)		
flurbiprofen 100 mg tablet (ANSAID)		
IBU 400 MG TABLET *(ibuprofen)*	QL	Limited to 240 EA per 30 days.
IBU 600 MG TABLET *(ibuprofen)*	QL	Limited to 150 EA per 30 days.
IBU 800 MG TABLET *(ibuprofen)*	QL	Limited to 120 EA per 30 days.
ibuprofen 400 mg tablet (IBU)	QL	Limited to 240 EA per 30 days.
ibuprofen 600 mg tablet (IBU)	QL	Limited to 150 EA per 30 days.
ibuprofen 800 mg tablet (IBU)	QL	Limited to 120 EA per 30 days.
indomethacin 25 mg capsule (INDOCIN)		
indomethacin 50 mg capsule (INDOCIN)		
indomethacin er 75 mg capsule (INDOCIN SR)		
ketoprofen 25 mg capsule (ORUDIS)		
ketoprofen 50 mg capsule (ORUDIS)		
ketoprofen 75 mg capsule (ORUDIS)		
ketorolac 10 mg tablet (TORADOL)		
meloxicam 15 mg tablet (MOBIC)		
meloxicam 7.5 mg tablet (MOBIC)		
nabumetone 500 mg tablet (RELAFEN)		
nabumetone 750 mg tablet (RELAFEN)		
naproxen 125 mg/5 ml suspen (NAPROSYN)		
naproxen 250 mg tablet (NAPROSYN)		
naproxen 375 mg tablet (NAPROSYN)		
naproxen 500 mg tablet (NAPROSYN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS - ANTI-INFLAMMATORY : NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
naproxen dr 375 mg tablet (EC-NAPROSYN)		
naproxen dr 500 mg tablet (EC-NAPROXEN)		
naproxen sodium 275 mg tab (ANAPROX)		
naproxen sodium 550 mg tab (ANAPROX DS)		
naproxen sodium ds 550 mg tab (ANAPROX DS)		
sulindac 150 mg tablet (CLINORIL)		
sulindac 200 mg tablet (CLINORIL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARTHROTEC 50 MG-200 MCG TAB *(diclofenac sodium/misoprostol)*	PA	Prior Authorization required.
ARTHROTEC 75 MG-200 MCG TAB *(diclofenac sodium/misoprostol)*	PA	Prior Authorization required.
CELEBREX 100 MG CAPSULE *(use celecoxib)*	PA	Prior Authorization required.
CELEBREX 200 MG CAPSULE *(use celecoxib)*	PA	Prior Authorization required.
CELEBREX 400 MG CAPSULE *(use celecoxib)*	PA	Prior Authorization required.
CELEBREX 50 MG CAPSULE *(use celecoxib)*	PA	Prior Authorization required.
DAYPRO 600 MG CAPLET *(oxaprozin)*	PA	Prior Authorization required.
diclofenac-misoprost 50-0.2 tb (ARTHROTEC 50)	PA	Prior Authorization required.
diclofenac-misoprost 50-200 tb (ARTHROTEC 50)	PA	Prior Authorization required.
diclofenac-misoprost 75-0.2 tb (ARTHROTEC 75)	PA	Prior Authorization required.
diclofenac-misoprost 75-200 tb (ARTHROTEC 75)	PA	Prior Authorization required.
DUEXIS 800-26.6 MG TABLET *(ibuprofen/famotidine)*	PA	Prior Authorization required.
FELDENE 10 MG CAPSULE *(piroxicam)*	PA	Prior Authorization required.
FELDENE 20 MG CAPSULE *(piroxicam)*	PA	Prior Authorization required.
fenoprofen 400 mg capsule (FENORTHO)	PA	Prior Authorization required.
fenoprofen 600 mg tablet (NALFON)	PA	Prior Authorization required.
IBUPAK KIT *(ibuprofen/glycerin)*	PA	Prior Authorization required.
ibuprofen 100 mg/5 ml susp (CHILDREN'S ADVIL)	PA,QL	Prior Authorization required. Limited to 4,800 mL per 30 days.
INDOCIN 25 MG/5 ML SUSPENSION *(indomethacin)*	PA	Prior Authorization required.
INDOCIN 50 MG SUPPOSITORY *(indomethacin)*	PA	Prior Authorization required.
ketoprofen er 200 mg capsule (ORUVAIL)	PA	Prior Authorization required.
ketorolac 15.75 mg nasal spray (SPRIX)	PA	Prior Authorization required.
meclofenamate 100 mg capsule (MECLOMEN)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS - ANTI-INFLAMMATORY : NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDs)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
meclofenamate 50 mg capsule (MECLOMEN)	PA	Prior Authorization required.
mefenamic acid 250 mg capsule (PONSTEL)	PA	Prior Authorization required.
meloxicam 10 mg capsule (VIVLODEX)	PA	Prior Authorization Required.
meloxicam 5 mg capsule (VIVLODEX)	PA	Prior Authorization Required.
MOBIC 15 MG TABLET *(use meloxicam)*	PA	Prior Authorization required.
MOBIC 7.5 MG TABLET *(use meloxicam)*	PA	Prior Authorization required.
NALFON 400 MG CAPSULE *(fenoprofen calcium)*	PA	Prior Authorization required.
NALFON 600 MG TABLET *(fenoprofen calcium)*	PA	Prior Authorization required.
NAPRELAN CR 375 MG TABLET *(naproxen sodium)*	PA	Prior Authorization required.
NAPRELAN CR 500 MG TABLET *(naproxen sodium)*	PA	Prior Authorization required.
NAPRELAN CR 750 MG TABLET *(naproxen sodium)*	PA	Prior Authorization required.
naproxen sod cr 375 mg tablet (NAPRELAN)	PA	Prior Authorization required.
naproxen sod cr 500 mg tablet (NAPRELAN)	PA	Prior Authorization required.
naproxen sod cr 750 mg tablet (NAPRELAN)	PA	Prior Authorization required.
naproxen sod er 375 mg tablet (NAPRELAN)	PA	Prior Authorization required.
naproxen sod er 500 mg tablet (NAPRELAN)	PA	Prior Authorization required.
naproxen-esomepraz dr 375-20mg (VIMOVO)	PA	Prior Authorization required.
naproxen-esomepraz dr 500-20mg (VIMOVO)	PA	Prior Authorization required.
oxaprozin 600 mg caplet (DAYPRO)	PA	Prior Authorization required.
oxaprozin 600 mg tablet (DAYPRO)	PA	Prior Authorization required.
piroxicam 10 mg capsule (FELDENE)	PA	Prior Authorization required.
piroxicam 20 mg capsule (FELDENE)	PA	Prior Authorization required.
QMIIZ ODT 15 MG TABLET *(meloxicam)*	PA	Prior Authorization required.
QMIIZ ODT 7.5 MG TABLET *(meloxicam)*	PA	Prior Authorization required.
RELAFEN DS 1,000 MG TABLET *(nabumetone)*	PA	Prior Authorization required.
SPRIX 15.75 MG NASAL SPRAY *(ketorolac tromethamine)*	PA	Prior Authorization required.
TIVORBEX 20 MG CAPSULE *(indomethacin, submicronized)*	PA	Prior Authorization required.
TIVORBEX 40 MG CAPSULE *(indomethacin, submicronized)*	PA	Prior Authorization required.
tolmetin sodium 200 mg tab (TOLECTIN 200)	PA	Prior Authorization required.
tolmetin sodium 400 mg cap (TOLECTIN DS)	PA	Prior Authorization required.
tolmetin sodium 600 mg tab (TOLECTIN 600)	PA	Prior Authorization required.
VIMOVO DR 375-20 MG TABLET *(naproxen/esomeprazole magnesium)*	PA	Prior Authorization required.

Drug List

ANALGESICS - ANTI-INFLAMMATORY : NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDs)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VIMOVO DR 500-20 MG TABLET *(naproxen/esomeprazole magnesium)*	PA	Prior Authorization required.
VIVLODEX 10 MG CAPSULE *(meloxicam, submicronized)*	PA	Prior Authorization required.
VIVLODEX 5 MG CAPSULE *(meloxicam, submicronized)*	PA	Prior Authorization required.
ZIPSOR 25 MG CAPSULE *(diclofenac potassium)*	PA	Prior Authorization required.
ZORVOLEX 18 MG CAPSULE *(diclofenac submicronized)*	PA	Prior Authorization required.
ZORVOLEX 35 MG CAPSULE *(diclofenac submicronized)*	PA	Prior Authorization required.

ANALGESICS - NONNARCOTIC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BUPAP 50 MG-300 MG TABLET *(butalbital/acetaminophen)*		
butalb-acetamin-caff 50-300-40 (FIORICET)		
butalb-acetamin-caff 50-300-40 (ORBIVAN)		
butalb-acetamin-caff 50-325-40 (ESGIC)		
butalb-acetamin-caff 50-325-40 (ESGIC)	QL	Limited to 390 EA per 30 days.
butalbital-acetaminophn 50-300 (ORBIVAN CF)		
butalbital-acetaminophn 50-325 (MARTEN-TAB)	QL	Limited to 390 EA per 30 days.
butalbital-asa-caffeine cap (FIORINAL)	QL	Limited to 390 EA per 30 days.
diflunisal 500 mg tablet (DOLOBID)		
ESGIC CAPSULE *(butalbital/acetaminophen/caffeine)*		
salsalate 500 mg tablet (DISALCID)		
salsalate 750 mg tablet (DISALCID)		
ZEBUTAL 50-325-40 MG CAPSULE *(butalbital/acetaminophen/caffeine)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALLZITAL 25-325 MG TABLET *(butalbital/acetaminophen)*	PA	Prior Authorization required.
butalbital-acetaminophn 50-300	PA	Prior Authorization required.
ESGIC 50-325-40 MG TABLET *(use butalbital/acetaminophen/caffeine)*	PA,QL	Prior Authorization required. Limited to 390 EA per 30 days.
FIORICET 50-300-40 MG CAPSULE *(use butalbital/acetaminophen/caffeine)*	PA	Prior Authorization required.
FIORINAL 50-325-40 MG CAPSULE *(use butalbital/aspirin/caffeine)*	PA,QL	Prior Authorization required. Limited to 390 EA per 30 days.
VANATOL LQ ORAL SOLUTION *(butalbital/acetaminophen/caffeine)*	PA	Prior Authorization required.
VANATOL S ORAL SOLUTION *(butalbital/acetaminophen/caffeine)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS - NONNARCOTIC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VTOL LQ 50-325-40 MG/15 ML SOL *(butalbital/acetaminophen/caffeine)*	PA	Prior Authorization required.
ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Preferred		
codeine sulfate 15 mg tablet	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
codeine sulfate 30 mg tablet	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
codeine sulfate 60 mg tablet	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
hydromorphone 1 mg/ml solution (DILAUDID)		
hydromorphone 2 mg tablet (DILAUDID)	QL	Limited to 120 EA per 30 days.
hydromorphone 3 mg suppos (DILAUDID)		
hydromorphone 4 mg tablet (DILAUDID)	QL	Limited to 120 EA per 30 days.
hydromorphone 5 mg/5 ml soln (DILAUDID)		
hydromorphone 8 mg tablet (DILAUDID)		
morphine 10 mg/0.5 ml oral syr		
morphine sulf 10 mg suppos (RMS-SUPPOSITORY)		
morphine sulf 10 mg/5 ml soln (MSIR)	QL	Limited to 240 mL per 30 days.
morphine sulf 100 mg/5 ml conc (ROXANOL)	QL	Limited to 240 mL per 30 days.
morphine sulf 20 mg suppos (RMS-SUPPOSITORY)		
morphine sulf 20 mg/5 ml soln (MSIR)	QL	Limited to 240 mL per 30 days.
morphine sulf 30 mg suppos (RMS-SUPPOSITORY)		
morphine sulf 5 mg suppos (RMS-SUPPOSITORY)		
morphine sulfate ir 15 mg tab (MSIR)	QL	Limited to 120 EA per 30 days.
morphine sulfate ir 30 mg tab (MSIR)	QL	Limited to 120 EA per 30 days.
oxycodon 10 mg/0.5 ml oral syr		
oxycodone hcl 10 mg tablet (DAZIDOX)		
oxycodone hcl 100 mg/5 ml conc (ROXICODONE INTENSOL)		
oxycodone hcl 15 mg tablet (ROXICODONE)		
oxycodone hcl 20 mg tablet (DAZIDOX)		
oxycodone hcl 30 mg tablet (ROXICODONE)		
oxycodone hcl 5 mg capsule (OXYIR)	QL	Limited to 120 EA per 30 days.
oxycodone hcl 5 mg tablet (ROXICODONE)	QL	Limited to 120 EA per 30 days.
oxycodone hcl 5 mg/5 ml soln (ROXICODONE)		
tramadol hcl 50 mg tablet (ULTRAM)	QL,AL	Limited to 240 EA per 30 days. Limited to members age 18 and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
morphine sulf er 100 mg tablet (MS CONTIN)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
morphine sulf er 15 mg tablet (ORAMORPH SR)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
morphine sulf er 200 mg tablet (MS CONTIN)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
morphine sulf er 30 mg tablet (MS CONTIN)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
morphine sulf er 60 mg tablet (MS CONTIN)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ABSTRAL 100 MCG TAB SUBLINGUAL *(fentanyl citrate)*	PA	Prior Authorization required.
ABSTRAL 200 MCG TAB SUBLINGUAL *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 1,200 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 1,600 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 200 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 400 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 600 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ACTIQ 800 MCG LOZENGE *(fentanyl citrate)*	PA	Prior Authorization required.
ARYMO ER 30 MG TABLET *(morphine sulfate)*	PA	Prior Authorization required.
BELBUCA 150 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 300 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 450 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 600 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 75 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 750 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
BELBUCA 900 MCG FILM *(buprenorphine hcl)*	PA	Prior Authorization required.
buprenorphine 10 mcg/hr patch (BUTRANS)	PA	Prior Authorization required.
buprenorphine 15 mcg/hr patch (BUTRANS)	PA	Prior Authorization required.
buprenorphine 20 mcg/hr patch (BUTRANS)	PA	Prior Authorization required.
buprenorphine 5 mcg/hr patch (BUTRANS)	PA	Prior Authorization required.
buprenorphine 7.5 mcg/hr patch (BUTRANS)	PA	Prior Authorization required.
butorphanol 10 mg/ml spray (STADOL NS)	PA	Prior Authorization required.
BUTRANS 10 MCG/HR PATCH *(buprenorphine)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BUTRANS 15 MCG/HR PATCH *(buprenorphine)*	PA	Prior Authorization required.
BUTRANS 20 MCG/HR PATCH *(buprenorphine)*	PA	Prior Authorization required.
BUTRANS 5 MCG/HR PATCH *(buprenorphine)*	PA	Prior Authorization required.
BUTRANS 7.5 MCG/HR PATCH *(buprenorphine)*	PA	Prior Authorization required.
CONZIP 100 MG CAPSULE *(tramadol hcl)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
CONZIP 200 MG CAPSULE *(tramadol hcl)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
CONZIP 300 MG CAPSULE *(tramadol hcl)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
DILAUDID 2 MG TABLET *(use hydromorphone hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
DILAUDID 4 MG TABLET *(use hydromorphone hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
DILAUDID 5 MG/5 ML ORAL LIQUID *(use hydromorphone hcl)*	PA	Prior Authorization required.
DILAUDID 8 MG TABLET *(use hydromorphone hcl)*	PA	Prior Authorization required.
DISKETS 40 MG TABLET DISPR *(methadone hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
DURAGESIC 100 MCG/HR PATCH *(fentanyl)*	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
DURAGESIC 12 MCG/HR PATCH *(fentanyl)*	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
DURAGESIC 25 MCG/HR PATCH *(fentanyl)*	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
DURAGESIC 50 MCG/HR PATCH *(fentanyl)*	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
DURAGESIC 75 MCG/HR PATCH *(fentanyl)*	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 100 mcg/hr patch (DURAGESIC)	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 12 mcg/hr patch (DURAGESIC)	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 25 mcg/hr patch (DURAGESIC)	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 37.5 mcg/hr patch	PA	Prior Authorization required.
fentanyl 50 mcg/hr patch (DURAGESIC)	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 62.5 mcg/hr patch	PA	Prior Authorization required.
fentanyl 75 mcg/hr patch (DURAGESIC)	PA,QL	Prior Authorization required. Limited to 10 EA per 30 days.
fentanyl 87.5 mcg/hr patch	PA	Prior Authorization required.
fentanyl cit 100 mcg buccal tb (FENTORA)	PA	Prior Authorization required.
fentanyl cit 200 mcg buccal tb (FENTORA)	PA	Prior Authorization required.
fentanyl cit 400 mcg buccal tb (FENTORA)	PA	Prior Authorization required.
fentanyl cit 600 mcg buccal tb (FENTORA)	PA	Prior Authorization required.
fentanyl cit 800 mcg buccal tb (FENTORA)	PA	Prior Authorization required.
fentanyl cit otfc 1,200 mcg (ACTIQ)	PA	Prior Authorization required.
fentanyl cit otfc 1,600 mcg (ACTIQ)	PA	Prior Authorization required.
fentanyl citrate otfc 200 mcg (ACTIQ)	PA	Prior Authorization required.
fentanyl citrate otfc 400 mcg (ACTIQ)	PA	Prior Authorization required.

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
fentanyl citrate otfc 600 mcg (ACTIQ)	PA	Prior Authorization required.
fentanyl citrate otfc 800 mcg (ACTIQ)	PA	Prior Authorization required.
FENTORA 100 MCG BUCCAL TABLET *(fentanyl citrate)*	PA	Prior Authorization required.
FENTORA 200 MCG BUCCAL TABLET *(fentanyl citrate)*	PA	Prior Authorization required.
FENTORA 400 MCG BUCCAL TABLET *(fentanyl citrate)*	PA	Prior Authorization required.
FENTORA 600 MCG BUCCAL TABLET *(fentanyl citrate)*	PA	Prior Authorization required.
FENTORA 800 MCG BUCCAL TABLET *(fentanyl citrate)*	PA	Prior Authorization required.
hydrocodone er 10 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydrocodone er 15 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydrocodone er 20 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydrocodone er 30 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydrocodone er 40 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydrocodone er 50 mg capsule (ZOHYDRO ER)	PA	Prior Authorization required.
hydromorphone hcl er 12 mg tab (EXALGO)	PA	Prior Authorization required.
hydromorphone hcl er 16 mg tab (EXALGO)	PA	Prior Authorization required.
hydromorphone hcl er 32 mg tab (EXALGO)	PA	Prior Authorization required.
hydromorphone hcl er 8 mg tab (EXALGO)	PA	Prior Authorization required.
HYSINGLA ER 100 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 120 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 20 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 30 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 40 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 60 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
HYSINGLA ER 80 MG TABLET *(hydrocodone bitartrate)*	PA	Prior Authorization required.
KADIAN ER 10 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 100 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 20 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 200 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 30 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
KADIAN ER 40 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 50 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 60 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
KADIAN ER 80 MG CAPSULE *(morphine sulfate)*	PA	Prior Authorization required.
levorphanol 2 mg tablet (LEVO-DROMORAN)	PA	Prior Authorization required.
levorphanol 3 mg tablet	PA	Prior Authorization required.
meperidine 100 mg tablet (DEMEROL)	PA,QL	Prior Authorization required. Limited to 180 EA per 30 days.
meperidine 50 mg tablet (DEMEROL)	PA,QL	Prior Authorization required. Limited to 180 EA per 30 days.
meperidine 50 mg/5 ml solution (DEMEROL)	PA	Prior Authorization required.
methadone 10 mg/5 ml solution	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
methadone 10 mg/ml oral conc (METHADONE INTENSOL)	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
methadone 10 mg/ml oral conc (METHADOSE)	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
methadone 40 mg tablet dispr (DISKETS)	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
methadone 5 mg/5 ml solution	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
methadone hcl 10 mg tablet (DOLOPHINE HCL)	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
methadone hcl 5 mg tablet (DOLOPHINE HCL)	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
METHADONE INTENSOL 10 MG/ML *(methadone hcl)*	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
METHADOSE 10 MG/ML ORAL CONC *(methadone hcl)*	PA,QL	Prior Authorization required. Limited to 240 mL per 30 days.
METHADOSE 40 MG TABLET DISPR *(methadone hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
MORPHABOND ER 100 MG TABLET *(morphine sulfate)*	PA	Prior Authorization required.
MORPHABOND ER 15 MG TABLET *(morphine sulfate)*	PA	Prior Authorization required.
MORPHABOND ER 30 MG TABLET *(morphine sulfate)*	PA	Prior Authorization required.
MORPHABOND ER 60 MG TABLET *(morphine sulfate)*	PA	Prior Authorization required.
morphine sulfate er 10 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 100 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 120 mg cap (AVINZA)	PA	Prior Authorization required.
morphine sulfate er 20 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 30 mg cap (AVINZA)	PA	Prior Authorization required.
morphine sulfate er 30 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 40 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 45 mg cap (AVINZA)	PA	Prior Authorization required.
morphine sulfate er 50 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 60 mg cap (AVINZA)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
morphine sulfate er 60 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 75 mg cap (AVINZA)	PA	Prior Authorization required.
morphine sulfate er 80 mg cap (KADIAN)	PA	Prior Authorization required.
morphine sulfate er 90 mg cap (AVINZA)	PA	Prior Authorization required.
MS CONTIN ER 100 MG TABLET *(use morphine sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
MS CONTIN ER 15 MG TABLET *(use morphine sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
MS CONTIN ER 200 MG TABLET *(use morphine sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
MS CONTIN ER 30 MG TABLET *(use morphine sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
MS CONTIN ER 60 MG TABLET *(use morphine sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
NUCYNTA 100 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA 50 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA 75 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA ER 100 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA ER 150 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA ER 200 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA ER 250 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
NUCYNTA ER 50 MG TABLET *(tapentadol hcl)*	PA	Prior Authorization required.
OXAYDO 5 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXAYDO 7.5 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
oxycodone hcl er 10 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 15 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 20 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 30 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 40 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 60 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
oxycodone hcl er 80 mg tablet (OXYCONTIN)	PA	Prior Authorization required.
OXYCONTIN ER 10 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXYCONTIN ER 15 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXYCONTIN ER 20 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXYCONTIN ER 30 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OXYCONTIN ER 40 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXYCONTIN ER 60 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
OXYCONTIN ER 80 MG TABLET *(oxycodone hcl)*	PA	Prior Authorization required.
oxymorphone hcl 10 mg tablet (OPANA)	PA	Prior Authorization required.
oxymorphone hcl 5 mg tablet (OPANA)	PA	Prior Authorization required.
oxymorphone hcl er 10 mg tab (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 15 mg tab (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 20 mg tab (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 30 mg tab (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 40 mg tab (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 5 mg tablet (OPANA ER)	PA	Prior Authorization required.
oxymorphone hcl er 7.5 mg tab (OPANA ER)	PA	Prior Authorization required.
pentazocine-naloxone tablet (TALWIN NX)	PA	Prior Authorization required.
ROXICODONE 15 MG TABLET *(use oxycodone hcl)*	PA	Prior Authorization required.
ROXICODONE 30 MG TABLET *(use oxycodone hcl)*	PA	Prior Authorization required.
ROXICODONE 5 MG TABLET *(use oxycodone hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
tramadol er 100 mg tablet (RYZOLT)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol er 200 mg tablet (RYZOLT)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol er 300 mg tablet (RYZOLT)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl 100 mg tablet	PA,QL,AL	Prior Authorization required. Limited to 120 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 100 mg capsule (CONZIP)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 100 mg tablet (ULTRAM ER)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 200 mg capsule (CONZIP)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 200 mg tablet (ULTRAM ER)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 300 mg capsule (CONZIP)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
tramadol hcl er 300 mg tablet (ULTRAM ER)	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 18 and older.
ULTRAM 50 MG TABLET *(use tramadol hcl)*	PA,QL,AL	Prior Authorization required. Limited to 240 EA per 30 days; Limited to members age 18 and older.
XTAMPZA ER 13.5 MG CAPSULE *(oxycodone myristate)*	PA	Prior Authorization required.
XTAMPZA ER 18 MG CAPSULE *(oxycodone myristate)*	PA	Prior Authorization required.
XTAMPZA ER 27 MG CAPSULE *(oxycodone myristate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
XTAMPZA ER 36 MG CAPSULE *(oxycodone myristate)*	PA	Prior Authorization required.
XTAMPZA ER 9 MG CAPSULE *(oxycodone myristate)*	PA	Prior Authorization required.
ZOHYDRO ER 10 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ZOHYDRO ER 15 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ZOHYDRO ER 20 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ZOHYDRO ER 30 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ZOHYDRO ER 40 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ZOHYDRO ER 50 MG CAPSULE *(hydrocodone bitartrate)*	PA	Prior Authorization required.
ANALGESICS : OPIOID COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acetamin-codein 300-30 mg/12.5	AL	Limited to members age 18 and older.
acetaminop-codeine 120-12 mg/5	QL,AL	Limited to 5,010 mL per 30 days. Limited to members age 18 and older.
acetaminop-codeine 120-12 mg/5 (TYLENOL-CODEINE)	AL	Limited to members age 18 and older.
acetaminophen-cod #2 tablet (TYLENOL W/CODEINE NO.2)	QL,AL	Limited to 420 EA per 30 days. Limited to members age 18 and older.
acetaminophen-cod #3 tablet (TYLENOL-CODEINE NO.3)	QL,AL	Limited to 420 EA per 30 days. Limited to members age 18 and older.
acetaminophen-cod #4 tablet (TYLENOL-CODEINE NO.4)	QL,AL	Limited to 420 EA per 30 days. Limited to members age 18 and older.
asa-butalb-caff-cod #3 capsule (ASCOMP WITH CODEINE)	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
ASCOMP WITH CODEINE CAPSULE *(codeine phosphate/butalbital/aspirin/caffeine)*	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
butalbital comp-codeine #3 cap (ASCOMP WITH CODEINE)	QL,AL	Limited to 180 EA per 30 days; Limited to members age 18 and older.
ENDOCET 10-325 MG TABLET *(oxycodone hcl/acetaminophen)*	QL	Limited to 390 EA per 30 days.
ENDOCET 5-325 TABLET *(oxycodone hcl/acetaminophen)*	QL	Limited to 390 EA per 30 days.
ENDOCET 7.5-325 MG TABLET *(oxycodone hcl/acetaminophen)*	QL	Limited to 360 EA per 30 days.
hydrocodone-acetamin 10-300 mg (XODOL 10-300)		
hydrocodone-acetamin 10-325 mg (NORCO)	QL	Limited to 360 EA per 30 days.
hydrocodone-acetamin 2.5-108/5 (HYCET)		
hydrocodone-acetamin 5-217/10 (HYCET)		
hydrocodone-acetamin 5-300 mg (XODOL 5-300)		
hydrocodone-acetamin 5-325 mg (NORCO)	QL	Limited to 360 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
hydrocodone-acetamin 7.5-300 (XODOL 7.5-300)		
hydrocodone-acetamin 7.5-325 (NORCO)	QL	Limited to 360 EA per 30 days.
hydrocodone-acetamn 7.5-325/15	QL	Limited to 240 EA over 30 days.
hydrocodone-acetamn 7.5-325/15 (HYCET)	QL	Limited to 240 EA over 30 days.
hydrocodone-ibuprofen 10-200 (IBUDONE)		
hydrocodone-ibuprofen 5-200 mg (REPREXAIN)		
hydrocodone-ibuprofen 7.5-200 (VICOPROFEN)		
LORCET 5-325 MG TABLET *(hydrocodone bitartrate/acetaminophen)*	QL	Limited to 360 EA per 30 days.
LORCET HD 10-325 MG TABLET *(hydrocodone bitartrate/acetaminophen)*	QL	Limited to 360 EA per 30 days.
LORCET PLUS 7.5-325 MG TABLET *(hydrocodone bitartrate/acetaminophen)*	QL	Limited to 360 EA per 30 days.
oxycodon-acetaminophen 2.5-325 (PERCOCET)	QL	Limited to 360 EA per 30 days.
oxycodon-acetaminophen 7.5-325 (ENDOCET)	QL	Limited to 360 EA per 30 days.
oxycodone-acetaminophen 10-325 (ENDOCET)	QL	Limited to 390 EA per 30 days.
oxycodone-acetaminophen 5-325 (PERCOCET)	QL	Limited to 390 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
acetamin-caf-dihydrocodein 325 (DVORAH)	PA	Prior Authorization required.
acetamn-caf-dihydrcodein 320.5 (TREZIX)	PA	Prior Authorization required.
APADAZ 4.08-325 MG TABLET *(benzhydrocodone hcl/acetaminophen)*	PA	Prior Authorization required.
APADAZ 6.12-325 MG TABLET *(benzhydrocodone hcl/acetaminophen)*	PA	Prior Authorization required.
APADAZ 8.16-325 MG TABLET *(benzhydrocodone hcl/acetaminophen)*	PA	Prior Authorization required.
benzhydrocod-acetamin 4.08-325 (APADAZ)	PA	Prior Authorization required.
benzhydrocod-acetamin 6.12-325 (APADAZ)	PA	Prior Authorization required.
benzhydrocod-acetamin 8.16-325 (APADAZ)	PA	Prior Authorization required.
butalb-acetamin-caf-cod 50-300 (FIORICET WITH CODEINE)	PA,AL	Prior Authorization required. Limited to members age 18 and older.
butalb-acetamin-caf-cod 50-325 (FIORICET WITH CODEINE)	PA,QL,AL	Prior Authorization required. Limited to 180 EA per 30 days; Limited to members age 18 and older.
FIORINAL-COD 30-50-325-40 CAP *(use codeine phosphate/butalbital/aspirin/caffeine)*	PA,QL,AL	Prior Authorization required. Limited to 180 EA per 30 days; Limited to members age 18 and older.
LORTAB 10 MG-300 MG/15 ML ELXR *(hydrocodone bitartrate/acetaminophen)*	PA	Prior Authorization required.
NALOCET 2.5-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
NORCO 10-325 TABLET *(use hydrocodone bitartrate/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 360 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANALGESICS : OPIOID COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NORCO 5-325 TABLET *(use hydrocodone bitartrate/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 360 EA per 30 days.
NORCO 7.5-325 TABLET *(use hydrocodone bitartrate/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 360 EA per 30 days.
oxycodone-aspirin 4.8355-325 (ENDODAN)	PA	Prior Authorization required.
oxycodone-ibuprofen 5-400 tab (COMBUNOX)	PA	Prior Authorization required.
PANLOR 325-30-16 MG TABLET *(acetaminophen/caffeine/dihydrocodeine bitartrate)*	PA	Prior Authorization required.
PERCOCET 10-325 MG TABLET *(use oxycodone hcl/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 390 EA per 30 days.
PERCOCET 2.5-325 MG TABLET *(use oxycodone hcl/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 360 EA per 30 days.
PERCOCET 5-325 MG TABLET *(use oxycodone hcl/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 390 EA per 30 days.
PERCOCET 7.5-325 MG TABLET *(use oxycodone hcl/acetaminophen)*	PA,QL	Prior Authorization required. Limited to 360 EA per 30 days.
PRIMLEV 10-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
PRIMLEV 5-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
PRIMLEV 7.5-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
PROLATE 10-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
PROLATE 5-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
PROLATE 7.5-300 MG TABLET *(oxycodone hcl/acetaminophen)*	PA	Prior Authorization required.
tramadol-acetaminophn 37.5-325 (ULTRACET)	PA,QL,FL,AL	Prior Authorization required. Limited to 40 EA per fill; Limited to 1 fill per 30 days; Limited to members age 18 and older.
ULTRACET TABLET *(tramadol hcl/acetaminophen)*	PA,QL,FL,AL	Prior Authorization required. Limited to 40 EA per fill; Limited to 1 fill per 30 days; Limited to members age 18 and older.

ANAPHYLAXIS THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
epinephrine 0.15 mg auto-injct (AUVI-Q)	QL,FL	Limited to 2 EA per 30 days; Limited to 1 fill per 180 days.
epinephrine 0.15 mg auto-injct (EPI E-Z PEN JR.)	QL,FL	Limited to 2 EA per 30 days; Limited to 1 fill per 180 days.
epinephrine 0.3 mg auto-inject (AUVI-Q)	QL,FL	Limited to 2 EA per 30 days; Limited to 1 fill per 180 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EPIPEN 2-PAK 0.3 MG AUTO-INJCT *(use epinephrine)*	PA,QL,FL	Prior Authorization required. Limited to 2 EA per 30 days; Limited to 1 fill per 180 days.
EPIPEN JR 2-PAK 0.15 MG INJCTR *(use epinephrine)*	PA,QL,FL	Prior Authorization required. Limited to 2 EA per 30 days; Limited to 1 fill per 180 days.
SYMJEPI 0.15 MG/0.3 ML SYRINGE *(epinephrine)*	PA	Prior Authorization required.
SYMJEPI 0.3 MG/0.3 ML SYRINGE *(epinephrine)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Androgen-Anabolic		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ANADROL-50 TABLET *(oxymetholone)*	PA	Prior Authorization required.
ANDRODERM 2 MG/24HR PATCH *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
ANDRODERM 4 MG/24HR PATCH *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
ANDROGEL 1% (25 MG/2.5 G) PKT *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
ANDROGEL 1% (50 MG/5 G) PKT *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
ANDROGEL 1.62% GEL PUMP *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
ANDROGEL 1.62%(1.25G) GEL PCKT *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
ANDROGEL 1.62%(2.5G) GEL PCKT *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
AVEED 750 MG/3 ML VIAL *(testosterone undecanoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
DEPO-TESTOSTERONE 100 MG/ML VL *(testosterone cypionate)*		
DEPO-TESTOSTERONE 200 MG/ML *(testosterone cypionate)*		
DEPO-TESTOSTERONE 200 MG/ML VL *(testosterone cypionate)*		
FORTESTA 10 MG GEL PUMP *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
METHITEST 10 MG TABLET *(methyltestosterone)*	PA	Prior Authorization required. Requires the trial and failure of Testosterone Enanthate Injection or Depo-Testosterone (Testosterone Cypionate), and topical Testosterone Prodcuts (gel). May be subject to additional criteria.
methyltestosterone 10 mg cap (ANDROID)	PA	Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
STRIANT 30 MG MUCOADHESIVE *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
TESTIM 1% (50MG) GEL *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosteron cyp 1,000 mg/10 ml (DEPO-TESTOSTERONE)		
testosteron cyp 2,000 mg/10 ml (DEPO-TESTOSTERONE)		
testosteron enan 1,000 mg/5 ml (DELATESTRYL)		
testosterone 1% (25mg/2.5g) pk (ANDROGEL)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Androgen-Anabolic		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
testosterone 1% (50 mg/5 g) pk (VOGELXO)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 1.62% (2.5 g) pkt (ANDROGEL)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 1.62% gel pump (ANDROGEL)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 1.62%(1.25 g) pkt (ANDROGEL)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 10 mg gel pump (FORTESTA)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 12.5 mg/1.25 gram (VOGELXO)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 25 mg/2.5 gm pkt (ANDROGEL)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 30 mg/1.5 ml pump (AXIRON)	PA	Prior Authorization required. Requires the trial and failure of Testosterone Enanthate Injection or Depo-Testosterone (Testosterone Cypionate). May be subject to additional criteria.
testosterone 50 mg/5 gram gel (VOGELXO)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone 50 mg/5 gram pkt (VOGELXO)	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
testosterone cyp 100 mg/ml (DEPO-TESTOSTERONE)		
testosterone cyp 200 mg/ml (DEPO-TESTOSTERONE)		
testosterone enan 200 mg/ml (DELATESTRYL)		
VOGELXO 12.5 MG/1.25 GRAM PUMP *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
VOGELXO 50 MG/5 GRAM GEL *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
VOGELXO 50 MG/5 GRAM GEL PACKT *(testosterone)*	PA	Prior Authorization required. Requires documented trial and failure to Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate). May be subject to additional approval criteria.
XYOSTED 100 MG/0.5 ML AUTO-INJ *(testosterone enanthate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
XYOSTED 50 MG/0.5 ML AUTO-INJ *(testosterone enanthate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.
XYOSTED 75 MG/0.5 ML AUTO-INJ *(testosterone enanthate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization required. Requires documented trial and failure of Testosterone Enanthate Injection OR Depo-Testosterone (Testosterone Cypionate), AND topical Testosterone Products (gel). May be subject to additional approval criteria.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANORECTAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
hydrocortisone 1% cream (PROCTO-PAK)		
hydrocortisone 100 mg/60 ml (CORTENEMA)		
hydrocortisone 2.5% cream (PROCTO-KIT)		
PROCTO-MED HC 2.5% CREAM *(hydrocortisone)*		
PROCTOSOL-HC 2.5% CREAM *(hydrocortisone)*		
PROCTOZONE-HC 2.5% CREAM *(hydrocortisone)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ANA-LEX 2-2% KIT *(hydrocortisone acetate/lidocaine hcl/aloe vera)*	PA	Prior Authorization required.
ANUSOL-HC 2.5% CREAM *(use hydrocortisone)*	PA	Prior Authorization required.
CORTENEMA 100 MG/60 ML ENEMA *(use hydrocortisone)*	PA	Prior Authorization required.
CORTIFOAM 10% AEROSOL *(hydrocortisone acetate)*	PA	Prior Authorization required.
lidocaine-hc 2-2% cream kit	PA	Prior Authorization required.
lidocaine-hc 2.8-0.55% gel (RECTAGEL HC)	PA	Prior Authorization required.
lidocaine-hc 3-0.5% cream (ANAMANTLE HC)	PA	Prior Authorization required.
lidocaine-hc 3-0.5% cream (LIDAMANTLE HC)	PA	Prior Authorization required.
lidocaine-hc 3-0.5% cream kit (ANAMANTLE HC)	PA	Prior Authorization required.
lidocaine-hc 3-1% cream kit (ANAMANTLE HC FORTE)	PA	Prior Authorization required.
lidocaine-hc 3-2.5% gel kit (ANAMANTLE HC)	PA	Prior Authorization required.
LIDOCORT 3-0.5% CREAM *(lidocaine hcl/hydrocortisone acetate)*	PA	Prior Authorization required.
PROCTOFOAM-HC 1%-1% FOAM *(hydrocortisone acetate/pramoxine hcl)*	PA	Prior Authorization required.
RECTIV 0.4% OINTMENT *(nitroglycerin)*	PA	Prior Authorization required.
UCERIS 2 MG RECTAL FOAM *(budesonide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Anterior Pituitary Hormones and Hormone Antagonists		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
danazol 100 mg capsule (DANOCRINE)		
danazol 200 mg capsule (DANOCRINE)		
danazol 50 mg capsule (DANOCRINE)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIANXIETY AGENTS : BENZODIAZEPINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
alprazolam 0.25 mg tablet (XANAX)		
alprazolam 0.5 mg tablet (XANAX)		
alprazolam 1 mg tablet (XANAX)		
alprazolam 2 mg tablet (XANAX)	QL	Limited to 90 EA per 30 days.
ALPRAZOLAM INTENSOL 1 MG/ML *(alprazolam)*		
chlordiazepoxide 10 mg capsule (LIBRIUM)		
chlordiazepoxide 25 mg capsule (LIBRIUM)		
chlordiazepoxide 5 mg capsule (LIBRIUM)		
clorazepate 15 mg tablet (TRANXENE T-TAB)		
clorazepate 3.75 mg tablet (TRANXENE T-TAB)		
clorazepate 7.5 mg tablet (TRANXENE T-TAB)		
diazepam 10 mg tablet (VALIUM)		
diazepam 2 mg tablet (VALIUM)		
diazepam 5 mg tablet (VALIUM)		
diazepam 5 mg/5 ml oral soln		
diazepam 5 mg/5 ml solution		
diazepam 5 mg/ml oral conc		
diazepam 5 mg/ml oral conc (DIAZEPAM)		
lorazepam 0.5 mg tablet (ATIVAN)		
lorazepam 1 mg tablet (ATIVAN)		
lorazepam 2 mg tablet (ATIVAN)		
lorazepam 2 mg/ml oral concent (LORAZEPAM INTENSOL)		
LORAZEPAM INTENSOL 2 MG/ML *(lorazepam)*		
oxazepam 10 mg capsule (SERAX)		
oxazepam 15 mg capsule (SERAX)		
oxazepam 30 mg capsule (SERAX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
alprazolam er 0.5 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam er 1 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam er 2 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam er 3 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam odt 0.25 mg tab (NIRAVAM)	PA	Prior Authorization required.
alprazolam odt 0.5 mg tab (NIRAVAM)	PA	Prior Authorization required.
alprazolam odt 1 mg tab (NIRAVAM)	PA	Prior Authorization required.
alprazolam odt 2 mg tab (NIRAVAM)	PA	Prior Authorization required.
alprazolam xr 0.5 mg tablet (XANAX XR)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIANXIETY AGENTS : BENZODIAZEPINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
alprazolam xr 1 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam xr 2 mg tablet (XANAX XR)	PA	Prior Authorization required.
alprazolam xr 3 mg tablet (XANAX XR)	PA	Prior Authorization required.
ATIVAN 0.5 MG TABLET *(use lorazepam)*	PA	Prior Authorization required.
ATIVAN 1 MG TABLET *(use lorazepam)*	PA	Prior Authorization required.
ATIVAN 2 MG TABLET *(use lorazepam)*	PA	Prior Authorization required.
TRANXENE T-TAB 7.5 MG *(use clorazepate dipotassium)*	PA	Prior Authorization required.
XANAX 0.25 MG TABLET *(use alprazolam)*	PA	Prior Authorization required.
XANAX 0.5 MG TABLET *(use alprazolam)*	PA	Prior Authorization required.
XANAX 1 MG TABLET *(use alprazolam)*	PA	Prior Authorization required.
XANAX 2 MG TABLET *(use alprazolam)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
XANAX XR 0.5 MG TABLET *(alprazolam)*	PA	Prior Authorization required.
XANAX XR 1 MG TABLET *(alprazolam)*	PA	Prior Authorization required.
XANAX XR 2 MG TABLET *(alprazolam)*	PA	Prior Authorization required.
XANAX XR 3 MG TABLET *(alprazolam)*	PA	Prior Authorization required.

ANTIANXIETY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
buspirone hcl 10 mg tablet (BUSPAR)		
buspirone hcl 15 mg tablet (BUSPAR)		
buspirone hcl 30 mg tablet (BUSPAR)		
buspirone hcl 5 mg tablet (BUSPAR)		
buspirone hcl 7.5 mg tablet (VANSPAR)		
hydroxyzine 10 mg/5 ml soln (ATARAX)		
hydroxyzine 10 mg/5 ml syrup (ATARAX)		
hydroxyzine hcl 10 mg tablet (ATARAX)		
hydroxyzine hcl 25 mg tablet (ATARAX)		
hydroxyzine hcl 50 mg tablet (ATARAX)		
hydroxyzine pam 100 mg cap (VISTARIL)		
hydroxyzine pam 25 mg cap (VISTARIL)		
hydroxyzine pam 50 mg cap (VISTARIL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
meprobamate 200 mg tablet (MILTOWN)	PA	Prior Authorization required.
meprobamate 400 mg tablet (MILTOWN)	PA	Prior Authorization required.
VISTARIL 25 MG CAPSULE *(use hydroxyzine pamoate)*	PA	Prior Authorization required.
VISTARIL 50 MG CAPSULE *(use hydroxyzine pamoate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : ADRENERGIC COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BEVESPI AEROSPHERE INHALER *(glycopyrrolate/formoterol fumarate)*	QL	Limited to 1 inhaler per 30 days.
DULERA 100 MCG-5 MCG INHALER *(mometasone furoate/formoterol fumarate)*	QL	Limited to 13 g per 30 days.
DULERA 200 MCG-5 MCG INHALER *(mometasone furoate/formoterol fumarate)*	QL	Limited to 13 g per 30 days.
DULERA 50 MCG-5 MCG INHALER *(mometasone furoate/formoterol fumarate)*	QL	Limited to 13 g per 30 days.
fluticasone-salmeterol 100-50 (ADVAIR DISKUS)	QL	Quantity Limit of 2 each per 1 days
fluticasone-salmeterol 250-50 (ADVAIR DISKUS)	QL	Quantity Limit of 2 each per 1 days
iprat-albut 0.5-3(2.5) mg/3 ml (DUONEB)		
SYMBICORT 160-4.5 MCG INHALER *(budesonide/formoterol fumarate)*	QL	Limited to 10.2 g per 30 days.
SYMBICORT 80-4.5 MCG INHALER *(budesonide/formoterol fumarate)*	QL	Limited to 10.2 g per 30 days.
WIXELA 100-50 INHUB *(fluticasone propionate/salmeterol xinafoate)*	QL	Limited to 60 EA per 30 days.
WIXELA 250-50 INHUB *(fluticasone propionate/salmeterol xinafoate)*	QL	Limited to 60 EA per 30 days.
WIXELA 500-50 INHUB *(fluticasone propionate/salmeterol xinafoate)*	QL	Limited to 60 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADVAIR 100-50 DISKUS *(use fluticasone propionate/salmeterol xinafoate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADVAIR 250-50 DISKUS *(use fluticasone propionate/salmeterol xinafoate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADVAIR 500-50 DISKUS *(fluticasone propionate/salmeterol xinafoate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ADVAIR HFA 115-21 MCG INHALER *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
ADVAIR HFA 230-21 MCG INHALER *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
ADVAIR HFA 45-21 MCG INHALER *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO DIGIHALER 113-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO DIGIHALER 232-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO DIGIHALER 55-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO RESPICLICK 113-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO RESPICLICK 232-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
AIRDUO RESPICLICK 55-14 MCG *(fluticasone propionate/salmeterol xinafoate)*	PA	Prior Authorization required.
ANORO ELLIPTA 62.5-25 MCG INH *(umeclidinium bromide/vilanterol trifenatate)*	PA	Prior Authorization required.
BREO ELLIPTA 100-25 MCG INH *(fluticasone furoate/vilanterol trifenatate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : ADRENERGIC COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BREO ELLIPTA 200-25 MCG INH *(fluticasone furoate/vilanterol trifenatate)*	PA	Prior Authorization required.
BREZTRI AEROSPHERE INHALER *(budesonide/glycopyrrolate/formoterol fumarate)*	PA	Prior Authorization Required.
budesonide-formoterol 160-4.5 (SYMBICORT)	PA,QL	Prior Authorization required. Limited to 10.2 g per 30 days.
budesonide-formoterol 80-4.5 (SYMBICORT)	PA,QL	Prior Authorization required. Limited to 10.2 g per 30 days.
COMBIVENT RESPIMAT 20-100 MCG *(ipratropium bromide/albuterol sulfate)*	PA	Prior Authorization required.
DUAKLIR PRESSAIR 400-12MCG INH *(aclidinium bromide/formoterol fumarate)*	PA	Prior Authorization required.
fluticasone-salmeterol 100-50 (WIXELA INHUB)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
fluticasone-salmeterol 113-14 (AIRDUO RESPICLICK)	PA	Prior Authorization required.
fluticasone-salmeterol 232-14 (AIRDUO RESPICLICK)	PA	Prior Authorization required.
fluticasone-salmeterol 250-50 (WIXELA INHUB)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
fluticasone-salmeterol 500-50 (WIXELA INHUB)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
fluticasone-salmeterol 55-14 (AIRDUO RESPICLICK)	PA	Prior Authorization required.
STIOLTO RESPIMAT INHAL SPRAY *(tiotropium bromide/olodaterol hcl)*	PA	Prior Authorization required.
TRELEGY ELLIPTA 100-62.5-25 *(fluticasone furoate/umeclidinium bromide/vilanterol trifenat)*	PA	Prior Authorization required.
TRELEGY ELLIPTA 200-62.5-25 *(fluticasone furoate/umeclidinium bromide/vilanterol trifenat)*	PA	Prior Authorization required.
UTIBRON NEOHALER 27.5-15.6 MCG *(indacaterol maleate/glycopyrrolate)*	PA	Prior Authorization required.
ANTIASTHMATIC AND BRONCHODILATOR AGENTS : ANTICHOLINERGICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ATROVENT 17 MCG HFA INHALER *(ipratropium bromide)*	QL	Limited to 13.2 g per 30 days.
cromolyn 20 mg/2 ml neb soln (INTAL)		
ipratropium br 0.02% soln (ATROVENT)		
SPIRIVA 18 MCG CP-HANDIHALER *(tiotropium bromide)*		
SPIRIVA RESPIMAT 1.25 MCG INH *(tiotropium bromide)*	QL,AL	Limited to 4 g per 30 days; Limited to members between the ages of 6 and 17.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
INCRUSE ELLIPTA 62.5 MCG INH *(umeclidinium bromide)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : ANTICHOLINERGICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
LONHALA MAGNAIR 25 MCG REFILL *(glycopyrrolate/nebulizer accessories)*	PA	Prior Authorization required.
LONHALA MAGNAIR 25 MCG STARTER *(glycopyrrolate/nebulizer and accessories)*	PA	Prior Authorization required.
SEEBRI NEOHALER 15.6 MCG INHAL *(glycopyrrolate)*	PA	Prior Authorization required.
SPIRIVA RESPIMAT 2.5 MCG INH *(tiotropium bromide)*	PA	Prior Authorization required.
TUDORZA PRESSAIR 400 MCG INHAL *(aclidinium bromide)*	PA,QL	Prior Authorization required. Limited to 1 EA over 30 days.
YUPELRI 175 MCG/3 ML SOLUTION *(revefenacin)*	PA	Prior Authorization required.
ANTIASTHMATIC AND BRONCHODILATOR AGENTS : BETA ADRENERGICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
albuterol 2.5 mg/0.5 ml sol		
albuterol 5 mg/ml solution (VENTOLIN)		
albuterol hfa 90 mcg inhaler (PROAIR HFA)	QL,FL	Limited to 13.4 g per 30 days.
albuterol hfa 90 mcg inhaler (PROAIR HFA)	QL,FL	Limited to 17 g per 30 days.
albuterol hfa 90 mcg inhaler (PROAIR HFA)	QL,FL	Limited to 36 g per 30 days.
albuterol sul 0.63 mg/3 ml sol (ACCUNEB)		
albuterol sul 1.25 mg/3 ml sol (ACCUNEB)		
albuterol sul 2.5 mg/3 ml soln (PROVENTIL)	QL	Limited to 390 mL per 30 days.
albuterol sulf 2 mg/5 ml syrup (PROVENTIL)		
levalbuterol 0.31 mg/3 ml sol (XOPENEX)		
levalbuterol 0.63 mg/3 ml sol (XOPENEX)		
levalbuterol 1.25 mg/3 ml sol (XOPENEX)		
levalbuterol conc 1.25 mg/0.5 (XOPENEX CONCENTRATE)		
levalbuterol tar hfa 45mcg inh (XOPENEX HFA)		
PROAIR HFA 90 MCG INHALER *(albuterol sulfate)*	QL,FL	Limited to 17 g per 30 days.
PROVENTIL HFA 90 MCG INHALER *(albuterol sulfate)*	QL,FL	Limited to 13.4 g per 30 days.
SEREVENT DISKUS 50 MCG *(salmeterol xinafoate)*	QL	Limited to 1 inhaler per 30 days.
terbutaline sulfate 2.5 mg tab (BRETHINE)		
terbutaline sulfate 2.5 mg tab (BRICANYL)		
terbutaline sulfate 5 mg tab (BRETHINE)		
terbutaline sulfate 5 mg tab (BRICANYL)		
VENTOLIN HFA 90 MCG INHALER *(albuterol sulfate)*	QL,FL	Limited to 16 g per 30 days.
VENTOLIN HFA 90 MCG INHALER *(albuterol sulfate)*	QL,FL	Limited to 36 g per 30 days.
XOPENEX HFA 45 MCG INHALER *(levalbuterol tartrate)*		

Drug List

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : BETA ADRENERGICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
albuterol sulfate 2 mg tab (PROVENTIL)	PA	Prior Authorization required.
albuterol sulfate 4 mg tab (PROVENTIL)	PA	Prior Authorization required.
albuterol sulfate er 4 mg tab (VOSPIRE ER)	PA	Prior Authorization required.
albuterol sulfate er 8 mg tab (VOSPIRE ER)	PA	Prior Authorization required.
ARCAPTA NEOHALER 75 MCG CAP *(indacaterol maleate)*	PA	Prior Authorization required.
BROVANA 15 MCG/2 ML SOLUTION *(arformoterol tartrate)*	PA	Prior Authorization required.
metaproterenol 10 mg/5 ml syr (METAPREL)	PA	Prior Authorization required.
PERFOROMIST 20 MCG/2 ML SOLN *(formoterol fumarate)*	PA	Prior Authorization required.
PROAIR DIGIHALER 90 MCG INHALR *(albuterol sulfate)*	PA	Prior Authorization required.
PROAIR RESPICLICK 90 MCG INHLR *(albuterol sulfate)*	PA	Prior Authorization required.
STRIVERDI RESPIMAT INHAL SPRAY *(olodaterol hcl)*	PA	Prior Authorization required.
XOPENEX 0.31 MG/3 ML SOLUTION *(use levalbuterol hcl)*	PA	Prior Authorization required.
XOPENEX 0.63 MG/3 ML SOLUTION *(use levalbuterol hcl)*	PA	Prior Authorization required.
XOPENEX 1.25 MG/3 ML SOLUTION *(use levalbuterol hcl)*	PA	Prior Authorization required.
XOPENEX CONC 1.25 MG/0.5 ML *(use levalbuterol hcl)*	PA	Prior Authorization required.

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : LEUKOTRIENE MODULATORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
montelukast sod 10 mg tablet (SINGULAIR)	QL	Limited to 30 EA per 30 days.
montelukast sod 4 mg granules (SINGULAIR)	QL	Limited to 30 EA per 30 days.
montelukast sod 4 mg tab chew (SINGULAIR)	QL	Limited to 30 EA per 30 days.
montelukast sod 5 mg tab chew (SINGULAIR)	QL	Limited to 30 EA per 30 days.
zafirlukast 10 mg tablet (ACCOLATE)	QL	Limited to 60 EA per 30 days.
zafirlukast 20 mg tablet (ACCOLATE)	QL	Limited to 60 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACCOLATE 10 MG TABLET *(use zafirlukast)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ACCOLATE 20 MG TABLET *(use zafirlukast)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
SINGULAIR 10 MG TABLET *(use montelukast sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SINGULAIR 4 MG GRANULES *(use montelukast sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : LEUKOTRIENE MODULATORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SINGULAIR 4 MG TABLET CHEW *(use montelukast sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SINGULAIR 5 MG TABLET CHEW *(use montelukast sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
zileuton er 600 mg tablet (ZYFLO CR)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYFLO 600 MG FILMTAB *(zileuton)*	PA	Prior Authorization required.

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
THEO-24 ER 100 MG CAPSULE *(theophylline anhydrous)*		
THEO-24 ER 200 MG CAPSULE *(theophylline anhydrous)*		
THEO-24 ER 300 MG CAPSULE *(theophylline anhydrous)*		
THEO-24 ER 400 MG CAPSULE *(theophylline anhydrous)*		
theophylline 80 mg/15 ml soln		
theophylline 80 mg/15 ml soln (ELIXOPHYLLIN)		
theophylline 80 mg/15 ml soln (THEOLAIR)		
theophylline er 300 mg tab (QUIBRON-T/SR)		
theophylline er 400 mg tablet (UNI-DUR)		
theophylline er 450 mg tab (THEO-DUR)		
theophylline er 600 mg tablet (UNI-DUR)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DALIRESP 250 MCG TABLET *(roflumilast)*	PA	Prior Authorization required.
DALIRESP 500 MCG TABLET *(roflumilast)*	PA	Prior Authorization required.

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : MONOCLONAL ANTIBODIES		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
DUPIXENT 200 MG/1.14 ML SYRING *(dupilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUCALA 100 MG/ML POWDER VIAL *(mepolizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CINQAIR 100 MG/10 ML VIAL *(reslizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DUPIXENT 300 MG/2 ML PEN *(dupilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DUPIXENT 300 MG/2 ML SYRINGE *(dupilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FASENRA 30 MG/ML SYRINGE *(benralizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIASTHMATIC AND BRONCHODILATOR AGENTS : MONOCLONAL ANTIBODIES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FASENRA PEN 30 MG/ML *(benralizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUCALA 100 MG/ML AUTO-INJECTOR *(mepolizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUCALA 100 MG/ML SYRINGE *(mepolizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XOLAIR 150 MG/1.2 ML POWDER VL *(omalizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XOLAIR 150 MG/ML SYRINGE *(omalizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XOLAIR 75 MG/0.5 ML SYRINGE *(omalizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

ANTIASTHMATIC AND BRONCHODILATOR AGENTS : STEROID INHALANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ASMANEX TWISTHALER 110 MCG #30 *(mometasone furoate)*		
ASMANEX TWISTHALER 220 MCG #14 *(mometasone furoate)*		
ASMANEX TWISTHALER 220 MCG #30 *(mometasone furoate)*		
ASMANEX TWISTHALER 220 MCG #60 *(mometasone furoate)*		
ASMANEX TWISTHALR 220 MCG #120 *(mometasone furoate)*		
budesonide 0.25 mg/2 ml susp (PULMICORT)	QL,AL	Limited to 120 mL per 30 days; Limited to members age 7 and younger.
budesonide 0.5 mg/2 ml susp (PULMICORT)	QL,AL	Limited to 120 mL per 30 days; Limited to members age 7 and younger.
budesonide 1 mg/2 ml inh susp (PULMICORT)	QL,AL	Limited to 120 mL per 30 days; Limited to members age 7 and younger.
FLOVENT 100 MCG DISKUS *(fluticasone propionate)*		
FLOVENT 250 MCG DISKUS *(fluticasone propionate)*		
FLOVENT 50 MCG DISKUS *(fluticasone propionate)*		
FLOVENT HFA 110 MCG INHALER *(fluticasone propionate)*	QL	Limited to 12 g per 30 days.
FLOVENT HFA 220 MCG INHALER *(fluticasone propionate)*	QL	Limited to 12 g per 30 days.
FLOVENT HFA 44 MCG INHALER *(fluticasone propionate)*	QL	Limited to 10.6 g per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALVESCO 160 MCG INHALER *(ciclesonide)*	PA	Prior Authorization required.
ALVESCO 80 MCG INHALER *(ciclesonide)*	PA	Prior Authorization required.
ARMONAIR DIGIHALER 113 MCG *(fluticasone propionate)*	PA	Prior Authorization required.
ARMONAIR DIGIHALER 232 MCG *(fluticasone propionate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIASTHMATIC AND BRONCHODILATOR AGENTS : STEROID INHALANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARMONAIR DIGIHALER 55 MCG *(fluticasone propionate)*	PA	Prior Authorization required.
ARNUITY ELLIPTA 100 MCG INH *(fluticasone furoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ARNUITY ELLIPTA 200 MCG INH *(fluticasone furoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ARNUITY ELLIPTA 50 MCG INH *(fluticasone furoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ASMANEX HFA 100 MCG INHALER *(mometasone furoate)*	PA	Prior Authorization required.
ASMANEX HFA 200 MCG INHALER *(mometasone furoate)*	PA	Prior Authorization required.
ASMANEX HFA 50 MCG INHALER *(mometasone furoate)*	PA,QL	Prior Authorization required. Limited to 13 g per 30 days.
PULMICORT 0.25 MG/2 ML RESPUL *(use budesonide)*	PA,QL,AL	Prior Authorization required. Limited to 120 EA per 30 days; Limited to members age 7 and younger.
PULMICORT 0.5 MG/2 ML RESPULE *(use budesonide)*	PA,QL,AL	Prior Authorization required. Limited to 120 EA per 30 days; Limited to members age 7 and younger.
PULMICORT 1 MG/2 ML RESPULE *(use budesonide)*	PA,QL,AL	Prior Authorization required. Limited to 120 EA per 30 days; Limited to members age 7 and younger.
PULMICORT 180 MCG FLEXHALER *(budesonide)*	PA	Prior Authorization required.
PULMICORT 90 MCG FLEXHALER *(budesonide)*	PA	Prior Authorization required.
QVAR REDIHALER 40 MCG *(beclomethasone dipropionate)*	PA,QL	Prior Authorization required. Limited to 10.6 g per 30 days.
QVAR REDIHALER 80 MCG *(beclomethasone dipropionate)*	PA,QL	Prior Authorization required. Limited to 10.6 g per 30 days.

ANTIBIOITICS : FLUOROQUINOLONES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ciprofloxacin 250 mg/5 ml susp (CIPRO)	AL	Limited to members age 16 and older.
ciprofloxacin 500 mg/5 ml susp (CIPRO)	AL	Limited to members age 16 and older.
ciprofloxacin hcl 100 mg tab (CIPRO)	AL	Limited to members age 16 and older.
ciprofloxacin hcl 250 mg tab (CIPRO)	AL	Limited to members age 16 and older.
ciprofloxacin hcl 500 mg tab (CIPRO)	AL	Limited to members age 16 and older.
ciprofloxacin hcl 750 mg tab (CIPRO)	AL	Limited to members age 16 and older.
levofloxacin 25 mg/ml solution (LEVAQUIN)	AL	Limited to members age 16 and older.
levofloxacin 250 mg tablet (LEVAQUIN)	AL	Limited to members age 16 and older.
levofloxacin 250 mg/10 ml soln	AL	Limited to members age 16 and older.
levofloxacin 250 mg/10 ml soln (LEVAQUIN)	AL	Limited to members age 16 and older.
levofloxacin 500 mg tablet (LEVAQUIN)	AL	Limited to members age 16 and older.
levofloxacin 500 mg/20 ml soln (LEVAQUIN)	AL	Limited to members age 16 and older.
levofloxacin 750 mg tablet (LEVAQUIN)	AL	Limited to members age 16 and older.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AVELOX 400 MG TABLET *(moxifloxacin hcl)*	PA,AL	Prior Authorization required. Limited to members age 16 and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOITICS : FLUOROQUINOLONES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BAXDELA 450 MG TABLET *(delafloxacin meglumine)*	PA,QL,FL,AL	Prior Authorization required. Limited to 28 EA per fill; Limited to 1 fill per 30 days; Limited to members age 16 and older.
CIPRO 10% SUSPENSION *(use ciprofloxacin)*	PA,AL	Prior Authorization required. Limited to members age 16 and older.
CIPRO 250 MG TABLET *(use ciprofloxacin hcl)*	PA,AL	Prior Authorization required. Limited to members age 16 and older.
CIPRO 5% SUSPENSION *(use ciprofloxacin)*	PA,AL	Prior Authorization required. Limited to members age 16 and older.
CIPRO 500 MG TABLET *(use ciprofloxacin hcl)*	PA,AL	Prior Authorization required. Limited to members age 16 and older.
moxifloxacin hcl 400 mg tablet (AVELOX)	PA,AL	Prior Authorization required. Limited to members age 16 and older.
ofloxacin 300 mg tablet (FLOXIN)	PA,AL	Prior Authorization required. Limited to members age 16 and older.
ofloxacin 400 mg tablet (FLOXIN)	PA,AL	Prior Authorization required. Limited to members age 16 and older.
ANTIBIOTICS : AMINOGLYCOSIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
neomycin 500 mg tablet (MYCIFRADIN)		
paromomycin 250 mg capsule (HUMATIN)		
ANTIBIOTICS : AMINOGLYCOSIDES - INHALED		
Drug Name	**Drug Status**	**Criteria**
Preferred		
KITABIS PAK 300 MG/5 ML *(tobramycin/nebulizer)*	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARIKAYCE 590 MG/8.4 ML VIAL *(amikacin sulfate liposomal with nebulizer accessories)*	PA	Prior Authorization required.
BETHKIS 300 MG/4 ML AMPULE *(tobramycin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TOBI 300 MG/5 ML SOLUTION *(tobramycin in 0.225 % sodium chloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TOBI PODHALER 28 MG INHALE CAP *(tobramycin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tobramycin 300 mg/4 ml ampule (BETHKIS)	PA	Prior authorization required.
tobramycin 300 mg/5 ml ampule (TOBI)	PA	Prior Authorization required.
tobramycin pak 300 mg/5 ml (KITABIS PAK)	PA	Prior Authorization required.
ANTIBIOTICS : ANTI-INFECTIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
atovaquone 750 mg/5 ml susp (MEPRON)		
clindamycin (pedi) 75 mg/5 ml (CLEOCIN PEDIATRIC)	QL,FL	Limited to 300 mL per 10 days; Limited to 1 fill per 30 days.
clindamycin hcl 150 mg capsule (CLEOCIN HCL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIBIOTICS : ANTI-INFECTIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clindamycin hcl 300 mg capsule (CLEOCIN HCL)		
clindamycin hcl 75 mg capsule (CLEOCIN HCL)		
dapsone 100 mg tablet (AVLOSULFON)		
dapsone 25 mg tablet (AVLOSULFON)		
fosfomycin 3 gm sachet (MONUROL)		
methenamine hipp 1 gm tablet (HIPREX)		
methenamine mand 1 gm tablet (MANDELAMINE)		
methenamine mand 500 mg tablet (MANDELAMINE)		
metronidazole 250 mg tablet (FLAGYL)		
metronidazole 500 mg tablet (FLAGYL)		
MONUROL 3 GM SACHET *(fosfomycin tromethamine)*		
NEBUPENT 300 MG INHAL POWDER *(pentamidine isethionate)*		
nitrofurantoin 25 mg/5 ml susp (FURADANTIN)		
nitrofurantoin mcr 100 mg cap (MACRODANTIN)		
nitrofurantoin mcr 25 mg cap (MACRODANTIN)		
nitrofurantoin mcr 50 mg cap (MACRODANTIN)		
nitrofurantoin mono-mcr 100 mg (MACROBID)		
pentamidine 300 mg inhal powdr (NEBUPENT)		
sulfadiazine 500 mg tablet (SULFADIAZINE)		
sulfamethoxazole-tmp ds tablet (BACTRIM DS)		
sulfamethoxazole-tmp ss tablet (BACTRIM)		
sulfamethoxazole-tmp susp (SULFATRIM)		
SULFATRIM PEDIATRIC SUSPENSION *(sulfamethoxazole/trimethoprim)*		
trimethoprim 100 mg tablet (PROLOPRIM)		
vancomycin 250 mg/5 ml soln (FIRVANQ)		
vancomycin hcl 125 mg capsule (VANCOCIN HCL)		
vancomycin hcl 250 mg capsule (VANCOCIN HCL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BACTRIM 400-80 MG TABLET *(use sulfamethoxazole/trimethoprim)*	PA	Prior Authorization required.
BACTRIM DS TABLET *(use sulfamethoxazole/trimethoprim)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIBIOTICS : ANTI-INFECTIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CAYSTON 75 MG INHAL SOLUTION *(aztreonam lysine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CLEOCIN HCL 150 MG CAPSULE *(use clindamycin hcl)*	PA	Prior Authorization required.
CLEOCIN HCL 300 MG CAPSULE *(use clindamycin hcl)*	PA	Prior Authorization required.
CLEOCIN HCL 75 MG CAPSULE *(use clindamycin hcl)*	PA	Prior Authorization required.
CLEOCIN PEDIATRIC 75 MG/5 ML *(use clindamycin palmitate hcl)*	PA,QL,FL	Prior Authorization required. Limited to 300 mL per 10 days; Limited to 1 fill per 30 days.
FIRVANQ 25 MG/ML SOLUTION *(vancomycin hcl)*	PA	Prior Authorization required.
FIRVANQ 50 MG/ML SOLUTION *(use vancomycin hcl)*	PA	Prior Authorization required.
FLAGYL 250 MG TABLET *(use metronidazole)*	PA	Prior Authorization required.
FLAGYL 375 CAPSULE *(metronidazole)*	PA	Prior Authorization required.
FLAGYL 500 MG TABLET *(use metronidazole)*	PA	Prior Authorization required.
FURADANTIN 25 MG/5 ML SUSP *(use nitrofurantoin)*	PA	Prior Authorization Required.
HIPREX 1 GM TABLET *(use methenamine hippurate)*	PA	Prior Authorization required.
HYOPHEN TABLET *(methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin)*	PA	Prior Authorization required.
LAMPIT 120 MG TABLET *(nifurtimox)*	PA	Prior authorization required.
LAMPIT 30 MG TABLET *(nifurtimox)*	PA	Prior authorization required.
linezolid 100 mg/5 ml susp (ZYVOX)	PA	Prior Authorization required.
linezolid 600 mg tablet (ZYVOX)	PA	Prior Authorization required.
MACROBID 100 MG CAPSULE *(use nitrofurantoin monohydrate/macrocrystals)*	PA	Prior Authorization required.
MACRODANTIN 100 MG CAPSULE *(use nitrofurantoin macrocrystal)*	PA	Prior Authorization required.
MACRODANTIN 25 MG CAPSULE *(use nitrofurantoin macrocrystal)*	PA	Prior Authorization required.
MACRODANTIN 50 MG CAPSULE *(use nitrofurantoin macrocrystal)*	PA	Prior Authorization required.
me-naphos-mb-hyo 1 tablet (UROGESIC-BLUE)	PA	Prior Authorization required.
MEPRON 750 MG/5 ML SUSPENSION *(use atovaquone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
metronidazole 375 mg capsule (FLAGYL)	PA	Prior Authorization required.
nitazoxanide 500 mg tablet (ALINIA)	PA	Prior Authorization Required.
PHOSPHASAL TABLET *(methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)*	PA	Prior Authorization required.
SIVEXTRO 200 MG TABLET *(tedizolid phosphate)*	PA	Prior Authorization required.
SOLOSEC 2 GM GRANULE PACKET *(secnidazole)*	PA	Prior Authorization required.
tinidazole 250 mg tablet (TINDAMAX)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIBIOTICS : ANTI-INFECTIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
tinidazole 500 mg tablet (TINDAMAX)	PA	Prior Authorization required.
URIMAR-T TABLET *(methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)*	PA	Prior Authorization required.
URIN D.S. TABLET *(methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)*	PA	Prior Authorization required.
URO-458 TABLET *(methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)*	PA	Prior Authorization required.
URO-MP CAPSULE *(methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)*	PA	Prior Authorization required.
UROGESIC-BLUE TABLET *(methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)*	PA	Prior Authorization required.
USTELL CAPSULE *(methenamine/methylene blue/salicylate/sodium phos/hyoscyamin)*	PA	Prior Authorization required.
VANCOCIN HCL 125 MG CAPSULE *(use vancomycin hcl)*	PA	Prior Authorization required.
VANCOCIN HCL 250 MG CAPSULE *(use vancomycin hcl)*	PA	Prior Authorization required.
XENLETA 600 MG TABLET *(lefamulin acetate)*	PA,QL,FL	Prior Authorization required. Limited to 20 EA per fill; Limited to 1 fill per 30 days.
XIFAXAN 200 MG TABLET *(rifaximin)*	PA	Prior Authorization required.
XIFAXAN 550 MG TABLET *(rifaximin)*	PA	Prior Authorization required.
ZYVOX 100 MG/5 ML SUSPENSION *(linezolid)*	PA	Prior Authorization required.
ZYVOX 600 MG TABLET *(linezolid)*	PA	Prior Authorization required.

ANTIBIOTICS : ANTIMYCOBACTERIAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cycloserine 250 mg capsule (SEROMYCIN)		
ethambutol hcl 100 mg tablet (MYAMBUTOL)		
ethambutol hcl 400 mg tablet (MYAMBUTOL)		
isoniazid 100 mg tablet (NYDRAZID)		
isoniazid 300 mg tablet (NIAZID)		
isoniazid 50 mg/5 ml solution (LANIAZID)		
pyrazinamide 500 mg tablet		
rifabutin 150 mg capsule (MYCOBUTIN)		
rifampin 150 mg capsule (RIFADIN)		
rifampin 300 mg capsule (RIFADIN)		
TRECATOR 250 MG TABLET *(ethionamide)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIBIOTICS : ANTIMYCOBACTERIAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
MYAMBUTOL 400 MG TABLET *(use ethambutol hcl)*	PA	Prior Authorization required.
MYCOBUTIN 150 MG CAPSULE *(use rifabutin)*	PA	Prior Authorization required.
PASER GRANULES 4 GM PACKET *(aminosalicylic acid)*	PA	Prior Authorization required.
pretomanid 200 mg tablet	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
PRIFTIN 150 MG TABLET *(rifapentine)*	PA	Prior Authorization required.
SIRTURO 100 MG TABLET *(bedaquiline fumarate)*	PA	Prior Authorization required.
SIRTURO 20 MG TABLET *(bedaquiline fumarate)*	PA	Prior Authorization required.

ANTIBIOTICS : CEPHALOSPORINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cefaclor 125 mg/5 ml susp (CECLOR)		
cefaclor 250 mg capsule (CECLOR)		
cefaclor 250 mg/5 ml susp (CECLOR)		
cefaclor 375 mg/5 ml suspen (CECLOR)		
cefaclor 500 mg capsule (CECLOR)		
cefadroxil 1 gm tablet (ULTRACEF DOSA-TROL)		
cefadroxil 250 mg/5 ml susp (ULTRACEF)		
cefadroxil 500 mg capsule (ULTRACEF)		
cefadroxil 500 mg/5 ml susp (DURICEF)		
cefdinir 125 mg/5 ml susp (OMNICEF)		
cefdinir 250 mg/5 ml susp (OMNICEF)		
cefdinir 300 mg capsule (OMNICEF)		
cefixime 400 mg capsule (SUPRAX)	QL	Limited to 30 EA per 30 days.
cefprozil 125 mg/5 ml susp (CEFZIL)		
cefprozil 250 mg/5 ml susp (CEFZIL)		
cefuroxime axetil 250 mg tab (CEFTIN)		
cefuroxime axetil 500 mg tab (CEFTIN)		
cephalexin 125 mg/5 ml susp (KEFLEX)		
cephalexin 250 mg capsule (KEFLEX)		
cephalexin 250 mg tablet (KEFLET)		
cephalexin 250 mg/5 ml susp (KEFLEX)		
cephalexin 500 mg capsule (KEFLEX)		
cephalexin 500 mg tablet (KEFLET)		
cephalexin 750 mg capsule (KEFLEX)		
SUPRAX 400 MG CAPSULE *(cefixime)*	QL	Limited to 30 EA per 30 days.

Drug List

ANTIBIOTICS : CEPHALOSPORINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
cefaclor er 500 mg tablet (CECLOR CD)	PA	Prior Authorization required.
cefixime 100 mg/5 ml susp (SUPRAX)	PA	Prior Authorization required.
cefixime 200 mg/5 ml susp (SUPRAX)	PA	Prior Authorization required.
cefpodoxime 100 mg tablet (VANTIN)	PA	Prior Authorization required.
cefpodoxime 100 mg/5 ml susp (VANTIN)	PA	Prior Authorization required.
cefpodoxime 200 mg tablet (VANTIN)	PA	Prior Authorization required.
cefpodoxime 50 mg/5 ml susp (VANTIN)	PA	Prior Authorization required.
cefprozil 250 mg tablet (CEFZIL)	PA	Prior Authorization required.
cefprozil 500 mg tablet (CEFZIL)	PA	Prior Authorization required.
KEFLEX 250 MG CAPSULE *(use cephalexin)*	PA	Prior Authorization required.
KEFLEX 500 MG CAPSULE *(use cephalexin)*	PA	Prior Authorization required.
KEFLEX 750 MG CAPSULE *(use cephalexin)*	PA	Prior Authorization required.
SUPRAX 100 MG TABLET CHEWABLE *(cefixime)*	PA	Prior Authorization required.
SUPRAX 100 MG/5 ML SUSPENSION *(cefixime)*	PA	Prior Authorization required.
SUPRAX 200 MG TABLET CHEWABLE *(cefixime)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SUPRAX 200 MG/5 ML SUSPENSION *(cefixime)*	PA	Prior Authorization required.
SUPRAX 500 MG/5 ML SUSPENSION *(cefixime)*	PA	Prior Authorization required.

ANTIBIOTICS : MACROLIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
azithromycin 1 gm pwd packet (ZITHROMAX)		
azithromycin 100 mg/5 ml susp (ZITHROMAX)		
azithromycin 200 mg/5 ml susp (ZITHROMAX)		
azithromycin 250 mg tablet (ZITHROMAX)	QL	Limited to 60 tablets per 180 days.
azithromycin 500 mg tablet (ZITHROMAX)	QL	Limited to 60 tablets per 180 days.
azithromycin 600 mg tablet (ZITHROMAX)		
clarithromycin 125 mg/5 ml sus (BIAXIN)		
clarithromycin 250 mg tablet (BIAXIN)		
clarithromycin 250 mg/5 ml sus (BIAXIN)		
clarithromycin 500 mg tablet (BIAXIN)		
clarithromycin er 500 mg tab (BIAXIN XL)		
E.E.S. 200 MG/5 ML SUSPENSION *(erythromycin ethylsuccinate)*		
E.E.S. 400 FILMTAB *(erythromycin ethylsuccinate)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOTICS : MACROLIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ERY-TAB DR 250 MG TABLET *(erythromycin base)*		
ERY-TAB DR 333 MG TABLET *(erythromycin base)*		
ERY-TAB DR 500 MG TABLET *(erythromycin base)*		
ERYPED 200 MG/5 ML SUSPENSION *(erythromycin ethylsuccinate)*		
ERYPED 400 MG/5 ML SUSPENSION *(erythromycin ethylsuccinate)*		
ERYTHROCIN 250 MG FILMTAB *(erythromycin stearate)*		
erythromycin 200 mg/5 ml susp (E.E.S. 200)		
erythromycin 200 mg/5 ml susp (ERYPED 200)		
erythromycin 250 mg filmtab		
erythromycin 400 mg/5 ml susp (ERYPED 400)		
erythromycin 500 mg filmtab		
erythromycin dr 250 mg cap (ERYC)		
erythromycin dr 250 mg tablet (ILOTYCIN)		
erythromycin dr 333 mg tablet (ERY-TAB)		
erythromycin dr 500 mg tablet (ERY-TAB)		
erythromycin es 400 mg tab (E.E.S. 400)		
PCE 333 MG TABLET *(erythromycin base)*		
PCE 500 MG TABLET *(erythromycin base)*		
ZITHROMAX 1 GM POWDER PACKET *(azithromycin)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DIFICID 200 MG TABLET *(fidaxomicin)*	PA	Prior Authorization required.
DIFICID 40 MG/ML SUSPENSION *(fidaxomicin)*	PA	Prior Authorization Required.
ZITHROMAX 100 MG/5 ML SUSP *(use azithromycin)*	PA	Prior Authorization required.
ZITHROMAX 200 MG/5 ML SUSP *(use azithromycin)*	PA	Prior Authorization required.
ZITHROMAX 250 MG TABLET *(use azithromycin)*	PA,QL	Prior Authorization required. Limited to 60 tablets per 180 days.
ZITHROMAX 250 MG Z-PAK TABLET *(use azithromycin)*	PA,QL	Prior Authorization required. Limited to 60 tablets per 180 days.
ZITHROMAX 500 MG TABLET *(use azithromycin)*	PA,QL	Prior Authorization required. Limited to 60 tablets per 180 days.
ZITHROMAX TRI-PAK 500 MG TAB *(use azithromycin)*	PA,QL	Prior Authorization required. Limited to 3 EA per fill.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOTICS : PENICILLINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amox-clav 200-28.5 mg tab chew (AUGMENTIN)		
amox-clav 200-28.5 mg/5 ml sus (AUGMENTIN)		
amox-clav 250-125 mg tablet (AUGMENTIN)		
amox-clav 250-62.5 mg/5 ml sus (AUGMENTIN)		
amox-clav 400-57 mg tab chew (AUGMENTIN)		
amox-clav 400-57 mg/5 ml susp (AUGMENTIN)		
amox-clav 500-125 mg tablet (AUGMENTIN)		
amox-clav 600-42.9 mg/5 ml sus (AUGMENTIN ES-600)		
amox-clav 875-125 mg tablet (AUGMENTIN)		
amoxicillin 125 mg tab chew (AMOXIL)		
amoxicillin 125 mg/5 ml susp (LAROTID)		
amoxicillin 200 mg/5 ml susp (AMOXIL)		
amoxicillin 250 mg capsule (AMOXIL)		
amoxicillin 250 mg capsule (LAROTID)		
amoxicillin 250 mg tab chew (AMOXIL)		
amoxicillin 250 mg/5 ml susp (LAROTID)		
amoxicillin 400 mg/5 ml susp (AMOXIL)		
amoxicillin 500 mg capsule (LAROTID)		
amoxicillin 500 mg capsule (TRIMOX)		
amoxicillin 500 mg tablet (AMOXIL)		
amoxicillin 875 mg tablet (AMOXIL)		
ampicillin 500 mg capsule (PRINCIPEN 500)		
AUGMENTIN 125-31.25 MG/5 ML *(amoxicillin/potassium clavulanate)*		
AUGMENTIN 250-62.5 MG/5 ML *(amoxicillin/potassium clavulanate)*		
dicloxacillin 250 mg capsule (PATHOCIL)		
dicloxacillin 500 mg capsule (PATHOCIL)		
penicillin vk 125 mg/5 ml soln (PEN-VEE K)		
penicillin vk 250 mg tablet (PEN-VEE K)		
penicillin vk 250 mg/5 ml soln (PEN-VEE K)		
penicillin vk 500 mg tablet (V-CILLIN K)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amox-clav er 1,000-62.5 mg tab (AUGMENTIN XR)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOTICS : TETRACYCLINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
demeclocycline 150 mg tablet (DECLOMYCIN)	QL	Limited to 120 EA per 30 days.
demeclocycline 300 mg tablet (DECLOMYCIN)	QL	Limited to 60 EA per 30 days.
doxycycline 25 mg/5 ml susp (VIBRAMYCIN)		
doxycycline hyclate 100 mg cap (MORGIDOX)		
doxycycline hyclate 100 mg tab (VIBRA-TABS)		
doxycycline hyclate 150 mg tab (ACTICLATE)		
doxycycline hyclate 20 mg tab (PERIOSTAT)		
doxycycline hyclate 50 mg cap (MORGIDOX)		
doxycycline hyclate 50 mg cap (VIBRAMYCIN)		
doxycycline hyclate 75 mg tab (ACTICLATE)		
doxycycline mono 100 mg cap (MONDOXYNE NL)		
doxycycline mono 100 mg cap (MONODOX)		
doxycycline mono 100 mg tablet (ADOXA)		
doxycycline mono 150 mg cap (ADOXA)		
doxycycline mono 150 mg tablet (ADOXA PAK)		
doxycycline mono 50 mg cap (MONODOX)		
doxycycline mono 50 mg tablet (ADOXA)		
doxycycline mono 75 mg capsule (MONODOX)		
doxycycline mono 75 mg tablet (ADOXA)		
minocycline 100 mg capsule (MINOCIN)		
minocycline 50 mg capsule (MINOCIN)		
minocycline 75 mg capsule (MINOCIN)		
minocycline hcl 100 mg tablet (DYNACIN)		
minocycline hcl 50 mg tablet (DYNACIN)		
minocycline hcl 75 mg tablet (DYNACIN)		
MORGIDOX 100 MG CAPSULE *(doxycycline hyclate)*		
MORGIDOX 50 MG CAPSULE *(doxycycline hyclate)*		
tetracycline 250 mg capsule (ACHROMYCIN V)		
tetracycline 250 mg capsule (SUMYCIN 250)		
tetracycline 500 mg capsule (SUMYCIN 500)		
VIBRAMYCIN 50 MG/5 ML SYRUP *(doxycycline calcium)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOTICS : TETRACYCLINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DORYX DR 200 MG TABLET *(doxycycline hyclate)*	PA	Prior Authorization required.
DORYX DR 50 MG TABLET *(doxycycline hyclate)*	PA	Prior Authorization required.
DORYX DR 80 MG TABLET *(doxycycline hyclate)*	PA	Prior Authorization required.
DORYX MPC DR 120 MG TABLET *(doxycycline hyclate)*	PA	Prior Authorization required.
doxycycline hyc dr 100 mg tab (DORYX)	PA	Prior Authorization required.
doxycycline hyc dr 150 mg tab (DORYX)	PA	Prior Authorization required.
doxycycline hyc dr 200 mg tab (DORYX)	PA	Prior Authorization required.
doxycycline hyc dr 50 mg tab (DORYX)	PA	Prior Authorization required.
doxycycline hyc dr 75 mg tab (DORYX)	PA	Prior Authorization required.
doxycycline hyc dr 80 mg tab (DORYX)	PA	Prior Authorization required.
MINOCIN 75 MG PELLETIZED CAP *(use minocycline hcl)*	PA	Prior Authorization required.
minocycline er 105 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 115 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 135 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 45 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 55 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 65 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 80 mg tablet (SOLODYN)	PA	Prior Authorization required.
minocycline er 90 mg tablet (SOLODYN)	PA	Prior Authorization required.
MINOLIRA ER 105 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
MINOLIRA ER 135 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
MORGIDOX 1X100 MG KIT *(doxycycline hyclate/skin cleanser combination no.19)*	PA	Prior Authorization required.
MORGIDOX 1X50 MG KIT *(doxycycline hyclate/skin cleanser combination no.19)*	PA	Prior Authorization required.
MORGIDOX 2X100 MG KIT *(doxycycline hyclate/skin cleanser combination no.19)*	PA	Prior Authorization required.
NUZYRA 150 MG TABLET *(omadacycline tosylate)*	PA,QL	Prior Authorization required. Limited to 6 EA over 30 days.
SOLODYN ER 105 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
SOLODYN ER 115 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
SOLODYN ER 55 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
SOLODYN ER 65 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
SOLODYN ER 80 MG TABLET *(minocycline hcl)*	PA	Prior Authorization required.
VIBRAMYCIN 100 MG CAPSULE *(use doxycycline hyclate)*	PA	Prior Authorization required.
VIBRAMYCIN 25 MG/5 ML SUSP *(use doxycycline monohydrate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIBIOTICS : TETRACYCLINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
XIMINO ER 135 MG CAPSULE *(minocycline hcl)*	PA	Prior Authorization required.
XIMINO ER 45 MG CAPSULE *(minocycline hcl)*	PA	Prior Authorization required.
XIMINO ER 90 MG CAPSULE *(minocycline hcl)*	PA	Prior Authorization required.

ANTICOAGULANTS : COUMARIN		
Drug Name	**Drug Status**	**Criteria**
Preferred		
JANTOVEN 1 MG TABLET *(warfarin sodium)*		
JANTOVEN 10 MG TABLET *(warfarin sodium)*		
JANTOVEN 2 MG TABLET *(warfarin sodium)*		
JANTOVEN 2.5 MG TABLET *(warfarin sodium)*		
JANTOVEN 3 MG TABLET *(warfarin sodium)*		
JANTOVEN 4 MG TABLET *(warfarin sodium)*		
JANTOVEN 5 MG TABLET *(warfarin sodium)*		
JANTOVEN 6 MG TABLET *(warfarin sodium)*		
JANTOVEN 7.5 MG TABLET *(warfarin sodium)*		
warfarin sodium 1 mg tablet (JANTOVEN)		
warfarin sodium 10 mg tablet (COUMADIN)		
warfarin sodium 2 mg tablet (JANTOVEN)		
warfarin sodium 2.5 mg tablet (COUMADIN)		
warfarin sodium 3 mg tablet (COUMADIN)		
warfarin sodium 4 mg tablet (JANTOVEN)		
warfarin sodium 5 mg tablet (JANTOVEN)		
warfarin sodium 6 mg tablet (JANTOVEN)		
warfarin sodium 7.5 mg tablet (COUMADIN)		

ANTICOAGULANTS : DIRECT FACTOR XA INHIBITORS & MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ELIQUIS 2.5 MG TABLET *(apixaban)*	PA	Prior Authorization required.
ELIQUIS 5 MG TABLET *(apixaban)*	PA	Prior Authorization required.
ELIQUIS DVT-PE TREAT START 5MG *(apixaban)*	PA	Prior Authorization required.
XARELTO 10 MG TABLET *(rivaroxaban)*	PA	Prior Authorization required.
XARELTO 15 MG TABLET *(rivaroxaban)*	PA	Prior Authorization required.
XARELTO 2.5 MG TABLET *(rivaroxaban)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICOAGULANTS : DIRECT FACTOR XA INHIBITORS & MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
XARELTO 20 MG TABLET *(rivaroxaban)*	PA	Prior Authorization required.
XARELTO DVT-PE TREAT START 30D *(rivaroxaban)*	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BEVYXXA 40 MG CAPSULE *(betrixaban maleate)*	PA	Prior Authorization required.
PRADAXA 110 MG CAPSULE *(dabigatran etexilate mesylate)*	PA	Prior Authorization required.
PRADAXA 150 MG CAPSULE *(dabigatran etexilate mesylate)*	PA	Prior Authorization required.
PRADAXA 75 MG CAPSULE *(dabigatran etexilate mesylate)*	PA	Prior Authorization required.
SAVAYSA 15 MG TABLET *(edoxaban tosylate)*	PA	Prior Authorization required.
SAVAYSA 30 MG TABLET *(edoxaban tosylate)*	PA	Prior Authorization required.
SAVAYSA 60 MG TABLET *(edoxaban tosylate)*	PA	Prior Authorization required.
ANTICOAGULANTS : HEPARIN AND HEPARINOID-LIKE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
enoxaparin 100 mg/ml syringe (LOVENOX)	QL	Limited to 84 mLs (84 syringes) per 365 days.
enoxaparin 120 mg/0.8 ml syr (LOVENOX)	QL	Limited to 67.2 mL (84 syringes) per 365 days.
enoxaparin 150 mg/ml syringe (LOVENOX)	QL	Limited to 84 mLs (84 syringes) per 365 days.
enoxaparin 30 mg/0.3 ml syr (LOVENOX)	QL	Limited to 25.2 mL (84 syringes) per 365 days.
enoxaparin 300 mg/3 ml vial (LOVENOX)	QL	Limited to 252 mL (84 vials) per 365 days.
enoxaparin 40 mg/0.4 ml syr (LOVENOX)	QL	Limited to 33.6 mL (84 syringes) per 365 days.
enoxaparin 40 mg/0.4 ml syr (LOVENOX)	QL	Quanity Limits Restricted to 33.600 ml over 365 days
enoxaparin 60 mg/0.6 ml syr (LOVENOX)	QL	Limited to 50.4 mL (84 syringes) per 365 days.
enoxaparin 80 mg/0.8 ml syr (LOVENOX)	QL	Limited to 67.2 mL (84 syringes) per 365 days.
fondaparinux 10 mg/0.8 ml syr (ARIXTRA)	QL	Limited to 33.6 mL (42 syringes) per 365 days.
fondaparinux 2.5 mg/0.5 ml syr (ARIXTRA)	QL	Limited to 21 mL (42 syringes) per 365 days.
fondaparinux 5 mg/0.4 ml syr (ARIXTRA)	QL	Limited to 16.8 mL (42 syringes) per 365 days.
fondaparinux 7.5 mg/0.6 ml syr (ARIXTRA)	QL	Limited to 25.2 mL (42 syringes) per 365 days.
FRAGMIN 10,000 UNIT/ML SYRINGE *(dalteparin sodium,porcine)*		
FRAGMIN 12,500 UNIT/0.5 ML SYR *(dalteparin sodium,porcine)*		
FRAGMIN 15,000 UNIT/0.6 ML SYR *(dalteparin sodium,porcine)*		
FRAGMIN 18,000 UNIT/0.72 ML *(dalteparin sodium,porcine)*		
FRAGMIN 2,500 UNIT/0.2 ML SYR *(dalteparin sodium,porcine)*		
FRAGMIN 5,000 UNIT/0.2 ML SYR *(dalteparin sodium,porcine)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICOAGULANTS : HEPARIN AND HEPARINOID-LIKE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
FRAGMIN 7,500 UNIT/0.3 ML SYR *(dalteparin sodium,porcine)*		
FRAGMIN 95,000 UNIT/3.8 ML VL *(dalteparin sodium,porcine)*		
heparin 10,000 unit/10 ml vial (LIQUAEMIN SODIUM)		
heparin 2,000 unit/2 ml vial		
heparin 30,000 unit/30 ml vial (LIQUAEMIN SODIUM)		
heparin 40,000 unit/4 ml vial (HEP-LOCK)		
heparin 5,000 unit/ml carpujct		
heparin 50,000 unit/10 ml vial (LIQUAEMIN SODIUM)		
heparin 50,000 unit/5 ml vial (HEP-LOCK)		
heparin sod 1,000 unit/ml vial (LIQUAEMIN SODIUM)		
heparin sod 10,000 unit/ml vl (HEP-LOCK)		
heparin sod 20,000 unit/ml vl (LIQUAEMIN SODIUM)		
heparin sod 5,000 unit/0.5 ml		
heparin sod 5,000 unit/0.5 ml (HEPARIN SODIUM)		
heparin sod 5,000 unit/ml syrg		
heparin sod 5,000 unit/ml syrg		
heparin sod 5,000 unit/ml vial (LIQUAEMIN SODIUM)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARIXTRA 10 MG/0.8 ML SYRINGE *(use fondaparinux sodium)*	PA,QL	Prior Authorization required. Limited to 33.6 mL (42 syringes) per 365 days.
ARIXTRA 2.5 MG/0.5 ML SYRINGE *(use fondaparinux sodium)*	PA,QL	Prior Authorization required. Limited to 21 mL (42 syringes) per 365 days.
ARIXTRA 5 MG/0.4 ML SYRINGE *(use fondaparinux sodium)*	PA,QL	Prior Authorization required. Limited to 16.8 mL (42 syringes) per 365 days.
ARIXTRA 7.5 MG/0.6 ML SYRINGE *(use fondaparinux sodium)*	PA,QL	Prior Authorization required. Limited to 25.2 mL (42 syringes) per 365 days.
LOVENOX 100 MG/ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 84 mLs (84 syringes) per 365 days.
LOVENOX 120 MG/0.8 ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 67.2 mL (84 syringes) per 365 days.
LOVENOX 150 MG/ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 84 mLs (84 syringes) per 365 days.
LOVENOX 30 MG/0.3 ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 25.2 mL (84 syringes) per 365 days.
LOVENOX 300 MG/3 ML VIAL *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 252 mL (84 vials) per 365 days.
LOVENOX 40 MG/0.4 ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 33.6 mL (84 syringes) per 365 days.
LOVENOX 60 MG/0.6 ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 50.4 mL (84 syringes) per 365 days.

Drug List

ANTICOAGULANTS : HEPARIN AND HEPARINOID-LIKE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
LOVENOX 80 MG/0.8 ML SYRINGE *(use enoxaparin sodium)*	PA,QL	Prior Authorization required. Limited to 67.2 mL (84 syringes) per 365 days.
ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
carbamazepine 100 mg tab chew (TEGRETOL)		
carbamazepine 100 mg/5 ml susp (TEGRETOL)		
carbamazepine 200 mg tablet (EPITOL)	QL	Limited to 240 EA per 30 days.
carbamazepine 200 mg/10ml susp (CARBAMAZEPINE)		
carbamazepine er 100 mg tablet (TEGRETOL XR)		
carbamazepine er 200 mg tablet (TEGRETOL XR)		
carbamazepine er 400 mg tablet (TEGRETOL XR)		
clonazepam 0.5 mg tablet (KLONOPIN)		
clonazepam 1 mg tablet (KLONOPIN)		
clonazepam 2 mg tablet (KLONOPIN)		
DIASTAT 2.5 MG PEDI SYSTEM *(diazepam)*	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
DIASTAT ACUDIAL 12.5-15-20 MG *(diazepam)*	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
DIASTAT ACUDIAL 5-7.5-10 MG KT *(diazepam)*	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
diazepam 10 mg rectal gel syst (DIASTAT ACUDIAL)	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
diazepam 2.5 mg rectal gel sys (DIASTAT)	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
diazepam 20 mg rectal gel syst (DIASTAT ACUDIAL)	QL,FL	Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
divalproex dr 125 mg cap sprnk (DEPAKOTE SPRINKLE)		
divalproex dr 125 mg cp(sprnk) (DEPAKOTE SPRINKLE)		
divalproex sod dr 125 mg tab (DEPAKOTE)		
divalproex sod dr 250 mg tab (DEPAKOTE)		
divalproex sod dr 500 mg tab (DEPAKOTE)		
divalproex sod er 250 mg tab (DEPAKOTE ER)		
divalproex sod er 500 mg tab (DEPAKOTE ER)		
EPITOL 200 MG TABLET *(carbamazepine)*	QL	Limited to 240 EA per 30 days.
ethosuximide 250 mg capsule (ZARONTIN)		
ethosuximide 250 mg/5 ml soln (ZARONTIN)		
gabapentin 100 mg capsule (NEURONTIN)	QL	Limited to 270 EA per 30 days.
gabapentin 250 mg/5 ml soln	QL	Limited to 2,250 mL per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
gabapentin 250 mg/5 ml soln (NEURONTIN)	QL	Limited to 2,250 mL per 30 days.
gabapentin 300 mg capsule (NEURONTIN)	QL	Limited to 360 EA per 30 days.
gabapentin 300 mg/6 ml soln	QL	Limited to 2,160 mL per 30 days.
gabapentin 400 mg capsule (NEURONTIN)	QL	Limited to 270 EA per 30 days.
gabapentin 600 mg tablet (NEURONTIN)	QL	Limited to 180 EA per 30 days.
gabapentin 800 mg tablet (NEURONTIN)	QL	Limited to 120 EA per 30 days.
lamotrigine 100 mg tablet (LAMICTAL)		
lamotrigine 150 mg tablet (LAMICTAL)		
lamotrigine 200 mg tablet (LAMICTAL)		
lamotrigine 25 mg disper tab (LAMICTAL)		
lamotrigine 25 mg tablet (LAMICTAL)		
lamotrigine 5 mg disper tablet (LAMICTAL)		
levetiracetam 1,000 mg tablet (KEPPRA)		
levetiracetam 100 mg/ml soln (KEPPRA)		
levetiracetam 250 mg tablet (KEPPRA)		
levetiracetam 500 mg tablet (KEPPRA)		
levetiracetam 500 mg/5 ml soln		
levetiracetam 750 mg tablet (KEPPRA)		
levetiracetam er 500 mg tablet (KEPPRA XR)		
levetiracetam er 750 mg tablet (KEPPRA XR)		
oxcarbazepine 150 mg tablet (TRILEPTAL)	QL	Limited to 270 EA per 30 days.
oxcarbazepine 300 mg tablet (TRILEPTAL)	QL	Limited to 270 EA per 30 days.
oxcarbazepine 300 mg/5 ml susp (TRILEPTAL)	QL	Limited to 1,000 mL per 30 days.
oxcarbazepine 600 mg tablet (TRILEPTAL)	QL	Limited to 120 EA per 30 days.
phenytoin 100 mg/4 ml susp		
phenytoin 125 mg/5 ml susp (DILANTIN-125)		
phenytoin 50 mg infatab (DILANTIN)		
phenytoin 50 mg tablet chew (DILANTIN)		
phenytoin sod ext 100 mg cap (DILANTIN)		
phenytoin sod ext 200 mg cap (PHENYTEK)		
phenytoin sod ext 300 mg cap (PHENYTEK)		
pregabalin 100 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 150 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 20 mg/ml solution (LYRICA)	QL	Limited to 900 mL per 30 days.
pregabalin 200 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 225 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 25 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 300 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
pregabalin 50 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
pregabalin 75 mg capsule (LYRICA)	QL	Limited to 60 EA per 30 days.
primidone 250 mg tablet (MYSOLINE)		
primidone 50 mg tablet (MYSOLINE)		
ROWEEPRA 500 MG TABLET *(levetiracetam)*		
SUBVENITE 100 MG TABLET *(lamotrigine)*		
SUBVENITE 150 MG TABLET *(lamotrigine)*		
SUBVENITE 200 MG TABLET *(lamotrigine)*		
SUBVENITE 25 MG TABLET *(lamotrigine)*		
topiramate 100 mg tablet (TOPAMAX)		
topiramate 15 mg sprinkle cap (TOPAMAX)		
topiramate 200 mg tablet (TOPAMAX)		
topiramate 25 mg sprinkle cap (TOPAMAX)		
topiramate 25 mg tablet (TOPAMAX)		
topiramate 50 mg tablet (TOPAMAX)		
valproic acid 250 mg capsule (DEPAKENE)		
valproic acid 250 mg/5 ml soln		
valproic acid 250 mg/5 ml soln (DEPAKENE)		
valproic acid 500 mg/10 ml sol		
zonisamide 100 mg capsule (ZONEGRAN)		
zonisamide 25 mg capsule (ZONEGRAN)		
zonisamide 50 mg capsule (ZONEGRAN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
APTIOM 200 MG TABLET *(eslicarbazepine acetate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
APTIOM 400 MG TABLET *(eslicarbazepine acetate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
APTIOM 600 MG TABLET *(eslicarbazepine acetate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
APTIOM 800 MG TABLET *(eslicarbazepine acetate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
BANZEL 200 MG TABLET *(rufinamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
BANZEL 40 MG/ML SUSPENSION *(rufinamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 2,400 mL per 30 days.
BANZEL 400 MG TABLET *(rufinamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 240 EA per 30 days.

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BRIVIACT 10 MG TABLET *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
BRIVIACT 10 MG/ML ORAL SOLN *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 600 mL per 30 days.
BRIVIACT 100 MG TABLET *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
BRIVIACT 25 MG TABLET *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
BRIVIACT 50 MG TABLET *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
BRIVIACT 75 MG TABLET *(brivaracetam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
carbamazepine er 100 mg cap (CARBATROL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
carbamazepine er 200 mg cap (CARBATROL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
carbamazepine er 300 mg cap (CARBATROL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
CARBATROL ER 100 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
CARBATROL ER 200 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
CARBATROL ER 300 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
CELONTIN 300 MG KAPSEAL *(methsuximide)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clobazam 10 mg tablet (ONFI)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
clobazam 2.5 mg/ml suspension (ONFI)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 240 mL per 30 days.
clobazam 20 mg tablet (ONFI)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
clonazepam 0.125 mg dis tab (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 0.125 mg odt (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 0.25 mg odt (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
clonazepam 0.5 mg dis tablet (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 0.5 mg odt (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 1 mg dis tablet (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 1 mg odt (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
clonazepam 2 mg odt (KLONOPIN)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE DR 125 MG SPRINKLE CP *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE DR 125 MG TABLET *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE DR 250 MG TABLET *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE DR 500 MG TABLET *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE ER 250 MG TABLET *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DEPAKOTE ER 500 MG TABLET *(use divalproex sodium)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DIACOMIT 250 MG CAPSULE *(stiripentol)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DIACOMIT 250 MG POWDER PACKET *(stiripentol)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DIACOMIT 500 MG CAPSULE *(stiripentol)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DIACOMIT 500 MG POWDER PACKET *(stiripentol)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DILANTIN 100 MG CAPSULE *(use phenytoin sodium extended)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DILANTIN 125 MG/5 ML SUSP *(use phenytoin)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DILANTIN 30 MG CAPSULE *(phenytoin sodium extended)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
DILANTIN 50 MG INFATAB *(use phenytoin)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EPIDIOLEX 100 MG/ML SOLUTION *(cannabidiol (cbd))*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 600 mL per 30 days.
felbamate 400 mg tablet (FELBATOL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
felbamate 600 mg tablet (FELBATOL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
felbamate 600 mg/5 ml susp (FELBATOL)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FELBATOL 400 MG TABLET *(felbamate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FELBATOL 600 MG TABLET *(felbamate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FELBATOL 600 MG/5 ML SUSP *(felbamate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FINTEPLA 2.2 MG/ML SOLUTION *(fenfluramine hcl)*	PA	Prior Authorization required.
FYCOMPA 0.5 MG/ML ORAL SUSP *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 10 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 12 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 2 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 4 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 6 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
FYCOMPA 8 MG TABLET *(perampanel)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
GABITRIL 12 MG TABLET *(tiagabine hcl)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
GABITRIL 16 MG TABLET *(tiagabine hcl)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
GABITRIL 2 MG TABLET *(tiagabine hcl)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
GABITRIL 4 MG TABLET *(tiagabine hcl)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
KEPPRA 1,000 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA 100 MG/ML ORAL SOLN *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA 250 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA 500 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA 750 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA XR 500 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KEPPRA XR 750 MG TABLET *(use levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KLONOPIN 0.5 MG TABLET *(use clonazepam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KLONOPIN 1 MG TABLET *(use clonazepam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
KLONOPIN 2 MG TABLET *(use clonazepam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 100 MG TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 150 MG TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 200 MG TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 25 MG DISPER TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 25 MG TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL 5 MG DISPER TABLET *(use lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL ODT 100 MG TABLET *(lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL ODT 200 MG TABLET *(lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL ODT 25 MG TABLET *(lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
LAMICTAL ODT 50 MG TABLET *(lamotrigine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
LAMICTAL ODT START KIT (BLUE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 28 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL ODT START KIT (GREEN) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 56 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL ODT START KT (ORANGE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL TAB START KIT (BLUE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL TAB START KIT (GREEN) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 56 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL TB START KIT (ORANGE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 49 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL XR 100 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR 200 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR 25 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR 250 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR 300 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR 50 MG TABLET *(lamotrigine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LAMICTAL XR START KIT (BLUE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 28 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL XR START KIT (GREEN) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
LAMICTAL XR START KIT (ORANGE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
lamotrigine er 100 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine er 200 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine er 25 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine er 250 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine er 300 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine er 50 mg tablet (LAMICTAL XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
lamotrigine odt 100 mg tablet (LAMICTAL ODT)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
lamotrigine odt 200 mg tablet (LAMICTAL ODT)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
lamotrigine odt 25 mg tablet (LAMICTAL ODT)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
lamotrigine odt 50 mg tablet (LAMICTAL ODT)	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
lamotrigine odt kit (blue) (LAMICTAL ODT (BLUE))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 28 EA per 30 days; Limited to 1 fill per 365 days.
lamotrigine odt kit (green) (LAMICTAL ODT (GREEN))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 56 EA per 30 days; Limited to 1 fill per 365 days.
lamotrigine odt kit (orange) (LAMICTAL ODT (ORANGE))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
lamotrigine tab start kit-blue (LAMICTAL (BLUE))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
lamotrigine tab start kt-green (LAMICTAL (GREEN))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 56 EA per 30 days; Limited to 1 fill per 365 days.
lamotrigine tab start kt-orang (LAMICTAL (ORANGE))	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 49 EA per 30 days; Limited to 1 fill per 365 days.
LYRICA 100 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
LYRICA 150 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 20 MG/ML ORAL SOLUTION *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 900 mL per 30 days.
LYRICA 200 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 225 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 25 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 300 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 50 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
LYRICA 75 MG CAPSULE *(use pregabalin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
MYSOLINE 250 MG TABLET *(use primidone)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
MYSOLINE 50 MG TABLET *(use primidone)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
NAYZILAM 5 MG NASAL SPRAY *(midazolam)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 2 EA per 30 days; Limited to 4 fills per 365 days.
NEURONTIN 100 MG CAPSULE *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 90 EA per 30 days.
NEURONTIN 250 MG/5 ML SOLN *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 1,050 mL per 30 days.
NEURONTIN 250 MG/5 ML SOLUTION *(use gabapentin)*	PA,QL	Prior Authorization required. Limited to 2,250 mL per 30 days.
NEURONTIN 300 MG CAPSULE *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 90 EA per 30 days.
NEURONTIN 400 MG CAPSULE *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 90 EA per 30 days.
NEURONTIN 600 MG TABLET *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 90 EA per 30 days.
NEURONTIN 800 MG TABLET *(use gabapentin)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
ONFI 10 MG TABLET *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ONFI 2.5 MG/ML SUSPENSION *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 240 mL per 30 days.
ONFI 20 MG TABLET *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
OXTELLAR XR 150 MG TABLET *(oxcarbazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
OXTELLAR XR 300 MG TABLET *(oxcarbazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
OXTELLAR XR 600 MG TABLET *(oxcarbazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
PEGANONE 250 MG TABLET *(ethotoin)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
PHENYTEK 200 MG CAPSULE *(use phenytoin sodium extended)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
PHENYTEK 300 MG CAPSULE *(use phenytoin sodium extended)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
QUDEXY XR 100 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
QUDEXY XR 150 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
QUDEXY XR 200 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
QUDEXY XR 25 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
QUDEXY XR 50 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
rufinamide 40 mg/ml suspension (BANZEL)	PA	Prior Authorization required.
SABRIL 500 MG POWDER PACKET *(vigabatrin)*	PA,QL,SP	Restricted to specialty pharmacies. Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 200 EA per month.
SABRIL 500 MG TABLET *(vigabatrin)*	PA,QL,SP	Restricted to specialty pharmacies. Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 180 EA per 30 days.
SPRITAM 1,000 MG TABLET *(levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
SPRITAM 250 MG TABLET *(levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SPRITAM 500 MG TABLET *(levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
SPRITAM 750 MG TABLET *(levetiracetam)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
SUBVENITE TAB START KIT (BLUE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 35 EA per 30 days; Limited to 1 fill per 365 days.
SUBVENITE TAB START KIT(GREEN) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 56 EA per 30 days; Limited to 1 fill per 365 days.
SUBVENITE TAB START KT(ORANGE) *(lamotrigine)*	PA,QL,FL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 49 EA per 30 days; Limited to 1 fill per 365 days.
SYMPAZAN 10 MG FILM *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
SYMPAZAN 20 MG FILM *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
SYMPAZAN 5 MG FILM *(clobazam)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
TEGRETOL 100 MG/5 ML SUSP *(use carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TEGRETOL 200 MG TABLET *(use carbamazepine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 240 EA per 30 days.
TEGRETOL XR 100 MG TABLET *(use carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TEGRETOL XR 200 MG TABLET *(use carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TEGRETOL XR 400 MG TABLET *(use carbamazepine)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
tiagabine hcl 12 mg tablet (GABITRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
tiagabine hcl 16 mg tablet (GABITRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
tiagabine hcl 2 mg tablet (GABITRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
tiagabine hcl 4 mg tablet (GABITRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
TOPAMAX 100 MG TABLET *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TOPAMAX 15 MG SPRINKLE CAP *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TOPAMAX 200 MG TABLET *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TOPAMAX 25 MG SPRINKLE CAP *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TOPAMAX 25 MG TABLET *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
TOPAMAX 50 MG TABLET *(use topiramate)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
topiramate er 100 mg capsule (QUDEXY XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
topiramate er 150 mg capsule (QUDEXY XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
topiramate er 200 mg capsule (QUDEXY XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
topiramate er 25 mg capsule (QUDEXY XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
topiramate er 50 mg capsule (QUDEXY XR)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
TRILEPTAL 150 MG TABLET *(use oxcarbazepine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 270 EA per 30 days.
TRILEPTAL 300 MG TABLET *(use oxcarbazepine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 270 EA per 30 days.
TRILEPTAL 300 MG/5 ML SUSP *(use oxcarbazepine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 1,000 mL per 30 days.
TRILEPTAL 600 MG TABLET *(use oxcarbazepine)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 120 EA per 30 days.
TROKENDI XR 100 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
TROKENDI XR 200 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
TROKENDI XR 25 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
TROKENDI XR 50 MG CAPSULE *(topiramate)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 30 EA per 30 days.
VALTOCO 10 MG NASAL SPRAY *(diazepam)*	PA	Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTICONVULSANTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VALTOCO 15 MG NASAL SPRAY *(diazepam)*	PA	Prior Authorization Required.
VALTOCO 20 MG NASAL SPRAY *(diazepam)*	PA	Prior Authorization Required.
VALTOCO 5 MG NASAL SPRAY *(diazepam)*	PA	Prior Authorization Required.
vigabatrin 500 mg powder packt (SABRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 200 EA per month.
vigabatrin 500 mg tablet (SABRIL)	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 180 EA per 30 days.
VIGADRONE 500 MG POWDER PACKET *(vigabatrin)*	PA,QL,SP	Restricted to specialty pharmacies. Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 200 EA per month.
VIMPAT 10 MG/ML SOLUTION *(lacosamide)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
VIMPAT 100 MG TABLET *(lacosamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
VIMPAT 150 MG TABLET *(lacosamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
VIMPAT 200 MG TABLET *(lacosamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
VIMPAT 50 MG TABLET *(lacosamide)*	PA,QL	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records. Limited to 60 EA per 30 days.
XCOPRI 100 MG TABLET *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 12.5-25 MG TITRATION PK *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 150 MG TABLET *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 150-200 MG TITRATION PK *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 200 MG TABLET *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 250 MG DAILY DOSE PACK *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 350 MG DAILY DOSE PACK *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 50 MG TABLET *(cenobamate)*	PA	Prior Authorization Required.
XCOPRI 50-100 MG TITRATION PAK *(cenobamate)*	PA	Prior Authorization Required.
ZARONTIN 250 MG CAPSULE *(use ethosuximide)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
ZARONTIN 250 MG/5 ML SOLUTION *(use ethosuximide)*	PA	Prior Authorization is not required on anticonvulsant medications for those participants with a diagnosis of epilepsy or seizure disorder. Diagnosis code must be submitted at point of sale or within records.
ZARONTIN 250 MG/5 ML SOLUTION *(use ethosuximide)*	PA	Prior Authorization required.

Drug List

ANTIDEPRESSANTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amitriptyline hcl 10 mg tab (ELAVIL)		
amitriptyline hcl 100 mg tab (ELAVIL)		
amitriptyline hcl 150 mg tab (ELAVIL)		
amitriptyline hcl 25 mg tab (ELAVIL)		
amitriptyline hcl 50 mg tab (ELAVIL)		
amitriptyline hcl 75 mg tab (ELAVIL)		
bupropion hcl 100 mg tablet (WELLBUTRIN)		
bupropion hcl 75 mg tablet (WELLBUTRIN)		
bupropion hcl sr 100 mg tablet (WELLBUTRIN SR)	QL	Limited to 60 EA per 30 days.
bupropion hcl sr 150 mg tablet (WELLBUTRIN SR)	QL	Limited to 60 EA per 30 days.
bupropion hcl sr 200 mg tablet (WELLBUTRIN SR)	QL	Limited to 60 EA per 30 days.
bupropion hcl xl 150 mg tablet (WELLBUTRIN XL)	QL	Limited to 30 EA per 30 days.
bupropion hcl xl 300 mg tablet (WELLBUTRIN XL)	QL	Limited to 30 EA per 30 days.
bupropion hcl xl 450 mg tablet (FORFIVO XL)		
clomipramine 25 mg capsule (ANAFRANIL)		
clomipramine 50 mg capsule (ANAFRANIL)		
clomipramine 75 mg capsule (ANAFRANIL)		
desipramine 10 mg tablet (NORPRAMIN)		
desipramine 100 mg tablet (NORPRAMIN)		
desipramine 150 mg tablet (NORPRAMIN)		
desipramine 25 mg tablet (NORPRAMIN)		
desipramine 50 mg tablet (NORPRAMIN)		
desipramine 75 mg tablet (NORPRAMIN)		
doxepin 10 mg capsule (SINEQUAN)		
doxepin 10 mg/ml oral conc (SINEQUAN)		
doxepin 100 mg capsule (SINEQUAN)		
doxepin 150 mg capsule (SINEQUAN)		
doxepin 25 mg capsule (SINEQUAN)		
doxepin 50 mg capsule (SINEQUAN)		
doxepin 75 mg capsule (SINEQUAN)		
imipramine hcl 10 mg tablet (TOFRANIL)		
imipramine hcl 25 mg tablet (TOFRANIL)		
imipramine hcl 50 mg tablet (TOFRANIL)		
maprotiline 25 mg tablet (LUDIOMIL)		
maprotiline 50 mg tablet (LUDIOMIL)		
maprotiline 75 mg tablet (LUDIOMIL)		
mirtazapine 15 mg odt (REMERON)	QL	Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
mirtazapine 15 mg tablet (REMERON)	QL	Limited to 30 EA per 30 days.
mirtazapine 30 mg odt (REMERON)	QL	Limited to 30 EA per 30 days.
mirtazapine 30 mg tablet (REMERON)	QL	Limited to 30 EA per 30 days.
mirtazapine 45 mg odt (REMERON)	QL	Limited to 30 EA per 30 days.
mirtazapine 45 mg tablet (REMERON)	QL	Limited to 30 EA per 30 days.
mirtazapine 7.5 mg tablet	QL	Limited to 30 EA per 30 days.
nortriptyline 10 mg/5 ml soln (PAMELOR)		
nortriptyline hcl 10 mg cap (PAMELOR)		
nortriptyline hcl 25 mg cap (AVENTYL HCL)		
nortriptyline hcl 25 mg cap (PAMELOR)		
nortriptyline hcl 50 mg cap (PAMELOR)		
nortriptyline hcl 75 mg cap (PAMELOR)		
phenelzine sulfate 15 mg tab (NARDIL)		
protriptyline hcl 10 mg tablet (VIVACTIL)		
protriptyline hcl 5 mg tablet (VIVACTIL)		
tranylcypromine sulf 10 mg tab (PARNATE)		
trazodone 100 mg tablet (DESYREL)		
trazodone 150 mg tablet (DESYREL)		
trazodone 300 mg tablet (DESYREL)		
trazodone 50 mg tablet (DESYREL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amoxapine 100 mg tablet (ASENDIN)	PA	Prior Authorization required.
amoxapine 150 mg tablet (ASENDIN)	PA	Prior Authorization required.
amoxapine 25 mg tablet (ASENDIN)	PA	Prior Authorization required.
amoxapine 50 mg tablet (ASENDIN)	PA	Prior Authorization required.
ANAFRANIL 25 MG CAPSULE *(use clomipramine hcl)*	PA	Prior Authorization required.
ANAFRANIL 50 MG CAPSULE *(use clomipramine hcl)*	PA	Prior Authorization required.
ANAFRANIL 75 MG CAPSULE *(use clomipramine hcl)*	PA	Prior Authorization required.
APLENZIN ER 174 MG TABLET *(bupropion hbr)*	PA	Prior Authorization required.
APLENZIN ER 348 MG TABLET *(bupropion hbr)*	PA	Prior Authorization required.
APLENZIN ER 522 MG TABLET *(bupropion hbr)*	PA	Prior Authorization required.
EMSAM 12 MG/24 HOURS PATCH *(selegiline)*	PA	Prior Authorization required.
EMSAM 6 MG/24 HOURS PATCH *(selegiline)*	PA	Prior Authorization required.
EMSAM 9 MG/24 HOURS PATCH *(selegiline)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FORFIVO XL 450 MG TABLET *(use bupropion hcl)*	PA	Prior Authorization required.
imipramine pamoate 100 mg cap (TOFRANIL-PM)	PA	Prior Authorization required.
imipramine pamoate 125 mg cap (TOFRANIL-PM)	PA	Prior Authorization required.
imipramine pamoate 150 mg cap (TOFRANIL-PM)	PA	Prior Authorization required.
imipramine pamoate 75 mg cap (TOFRANIL-PM)	PA	Prior Authorization required.
MARPLAN 10 MG TABLET *(isocarboxazid)*	PA	Prior Authorization required.
NARDIL 15 MG TABLET *(use phenelzine sulfate)*	PA	Prior Authorization required.
nefazodone hcl 100 mg tablet (SERZONE)	PA	Prior Authorization required.
nefazodone hcl 150 mg tablet (SERZONE)	PA	Prior Authorization required.
nefazodone hcl 200 mg tablet (SERZONE)	PA	Prior Authorization required.
nefazodone hcl 250 mg tablet (SERZONE)	PA	Prior Authorization required.
nefazodone hcl 50 mg tablet (SERZONE)	PA	Prior Authorization required.
NORPRAMIN 10 MG TABLET *(use desipramine hcl)*	PA	Prior Authorization required.
NORPRAMIN 25 MG TABLET *(use desipramine hcl)*	PA	Prior Authorization required.
PAMELOR 10 MG CAPSULE *(use nortriptyline hcl)*	PA	Prior Authorization required.
PAMELOR 25 MG CAPSULE *(use nortriptyline hcl)*	PA	Prior Authorization required.
PAMELOR 50 MG CAPSULE *(use nortriptyline hcl)*	PA	Prior Authorization required.
PAMELOR 75 MG CAPSULE *(use nortriptyline hcl)*	PA	Prior Authorization required.
REMERON 15 MG SOLTAB *(use mirtazapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
REMERON 15 MG TABLET *(use mirtazapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
REMERON 30 MG SOLTAB *(use mirtazapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
REMERON 30 MG TABLET *(use mirtazapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
REMERON 45 MG SOLTAB *(use mirtazapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SPRAVATO 56 MG DOSE PACK *(esketamine hcl)*	PA	Prior Authorization required.
SPRAVATO 84 MG DOSE PACK *(esketamine hcl)*	PA	Prior Authorization required.
SURMONTIL 100 MG CAPSULE *(trimipramine maleate)*	PA	Prior Authorization required.
SURMONTIL 25 MG CAPSULE *(trimipramine maleate)*	PA	Prior Authorization required.
SURMONTIL 50 MG CAPSULE *(trimipramine maleate)*	PA	Prior Authorization required.
TOFRANIL 10 MG TABLET *(use imipramine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TOFRANIL 25 MG TABLET *(use imipramine hcl)*	PA	Prior Authorization required.
TOFRANIL 50 MG TABLET *(use imipramine hcl)*	PA	Prior Authorization required.
trimipramine maleate 100 mg cp (SURMONTIL)	PA	Prior Authorization required.
trimipramine maleate 25 mg cap (SURMONTIL)	PA	Prior Authorization required.
trimipramine maleate 50 mg cap (SURMONTIL)	PA	Prior Authorization required.
TRINTELLIX 10 MG TABLET *(vortioxetine hydrobromide)*	PA	Prior Authorization required.
TRINTELLIX 20 MG TABLET *(vortioxetine hydrobromide)*	PA	Prior Authorization required.
TRINTELLIX 5 MG TABLET *(vortioxetine hydrobromide)*	PA	Prior Authorization required.
VIIBRYD 10 MG TABLET *(vilazodone hcl)*	PA	Prior Authorization required.
VIIBRYD 10-20 MG STARTER PACK *(vilazodone hcl)*	PA	Prior Authorization required.
VIIBRYD 20 MG TABLET *(vilazodone hcl)*	PA	Prior Authorization required.
VIIBRYD 40 MG TABLET *(vilazodone hcl)*	PA	Prior Authorization required.
WELLBUTRIN SR 100 MG TABLET *(use bupropion hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
WELLBUTRIN SR 150 MG TABLET *(use bupropion hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
WELLBUTRIN SR 200 MG TABLET *(use bupropion hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
WELLBUTRIN XL 150 MG TABLET *(use bupropion hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
WELLBUTRIN XL 300 MG TABLET *(use bupropion hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

ANTIDEPRESSANTS : SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
citalopram hbr 10 mg tablet (CELEXA)		
citalopram hbr 10 mg/5 ml soln (CELEXA)		
citalopram hbr 20 mg tablet (CELEXA)		
citalopram hbr 20 mg/10 ml sol (CELEXA)		
citalopram hbr 40 mg tablet (CELEXA)		
escitalopram 10 mg tablet (LEXAPRO)	QL	Limited to 45 EA per 30 days.
escitalopram 20 mg tablet (LEXAPRO)	QL	Limited to 30 EA per 30 days.
escitalopram 5 mg tablet (LEXAPRO)	QL	Limited to 45 EA per 30 days.
escitalopram oxalate 10mg/10ml (LEXAPRO)		
escitalopram oxalate 5 mg/5 ml (LEXAPRO)		
fluoxetine 20 mg/5 ml solution (PROZAC)		
fluoxetine hcl 10 mg capsule (PROZAC)		
fluoxetine hcl 10 mg capsule (PROZAC)	QL	Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
fluoxetine hcl 10 mg tablet (SARAFEM)		
fluoxetine hcl 20 mg capsule (PROZAC)	QL	Limited to 60 EA per 30 days.
fluoxetine hcl 20 mg capsule (SARAFEM)	QL	Limited to 30 EA per 30 days.
fluoxetine hcl 20 mg tablet (SARAFEM)		
fluoxetine hcl 40 mg capsule (PROZAC)	QL	Limited to 60 EA per 30 days.
fluoxetine hcl 60 mg tablet		
fluvoxamine maleate 100 mg tab (LUVOX)		
fluvoxamine maleate 25 mg tab (LUVOX)		
fluvoxamine maleate 50 mg tab (LUVOX)		
paroxetine hcl 10 mg tablet (PAXIL)		
paroxetine hcl 20 mg tablet (PAXIL)		
paroxetine hcl 30 mg tablet (PAXIL)		
paroxetine hcl 40 mg tablet (PAXIL)		
sertraline 20 mg/ml oral conc (ZOLOFT)		
sertraline hcl 100 mg tablet (ZOLOFT)		
sertraline hcl 25 mg tablet (ZOLOFT)		
sertraline hcl 50 mg tablet (ZOLOFT)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CELEXA 10 MG TABLET *(use citalopram hydrobromide)*	PA	Prior Authorization required.
CELEXA 20 MG TABLET *(use citalopram hydrobromide)*	PA	Prior Authorization required.
CELEXA 40 MG TABLET *(use citalopram hydrobromide)*	PA	Prior Authorization required.
fluoxetine dr 90 mg capsule (PROZAC WEEKLY)	PA	Prior Authorization required.
fluvoxamine er 100 mg capsule (LUVOX CR)	PA	Prior Authorization required.
fluvoxamine er 150 mg capsule (LUVOX CR)	PA	Prior Authorization required.
LEXAPRO 10 MG TABLET *(use escitalopram oxalate)*	PA,QL	Prior Authorization required. Limited to 45 EA per 30 days.
LEXAPRO 20 MG TABLET *(use escitalopram oxalate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
LEXAPRO 5 MG TABLET *(use escitalopram oxalate)*	PA,QL	Prior Authorization required. Limited to 45 EA per 30 days.
paroxetine cr 12.5 mg tablet (PAXIL CR)	PA	Prior Authorization required.
paroxetine cr 25 mg tablet (PAXIL CR)	PA	Prior Authorization required.
paroxetine cr 37.5 mg tablet (PAXIL CR)	PA	Prior Authorization required.
paroxetine er 12.5 mg tablet (PAXIL CR)	PA	Prior Authorization required.
paroxetine er 25 mg tablet (PAXIL CR)	PA	Prior Authorization required.
paroxetine er 37.5 mg tablet (PAXIL CR)	PA	Prior Authorization required.
PAXIL 10 MG TABLET *(use paroxetine hcl)*	PA	Prior Authorization required.
PAXIL 10 MG/5 ML SUSPENSION *(paroxetine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PAXIL 20 MG TABLET *(use paroxetine hcl)*	PA	Prior Authorization required.
PAXIL 30 MG TABLET *(use paroxetine hcl)*	PA	Prior Authorization required.
PAXIL 40 MG TABLET *(use paroxetine hcl)*	PA	Prior Authorization required.
PAXIL CR 12.5 MG TABLET *(paroxetine hcl)*	PA	Prior Authorization required.
PAXIL CR 25 MG TABLET *(paroxetine hcl)*	PA	Prior Authorization required.
PAXIL CR 37.5 MG TABLET *(paroxetine hcl)*	PA	Prior Authorization required.
PEXEVA 10 MG TABLET *(paroxetine mesylate)*	PA	Prior Authorization required.
PEXEVA 20 MG TABLET *(paroxetine mesylate)*	PA	Prior Authorization required.
PEXEVA 30 MG TABLET *(paroxetine mesylate)*	PA	Prior Authorization required.
PEXEVA 40 MG TABLET *(paroxetine mesylate)*	PA	Prior Authorization required.
PROZAC 10 MG PULVULE *(use fluoxetine hcl)*	PA	Prior Authorization required.
PROZAC 20 MG PULVULE *(use fluoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
PROZAC 40 MG PULVULE *(use fluoxetine hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOLOFT 100 MG TABLET *(use sertraline hcl)*	PA	Prior Authorization required.
ZOLOFT 20 MG/ML ORAL CONC *(use sertraline hcl)*	PA	Prior Authorization required.
ZOLOFT 25 MG TABLET *(use sertraline hcl)*	PA	Prior Authorization required.
ZOLOFT 50 MG TABLET *(use sertraline hcl)*	PA	Prior Authorization required.

ANTIDEPRESSANTS : SELECTIVE SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITOR (SNRIs)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
duloxetine hcl dr 20 mg cap (CYMBALTA)	QL	Limited to 60 EA per 30 days.
duloxetine hcl dr 30 mg cap (CYMBALTA)	QL	Limited to 60 EA per 30 days.
duloxetine hcl dr 40 mg cap (IRENKA)	QL	Limited to 60 EA per 30 days.
duloxetine hcl dr 60 mg cap (CYMBALTA)	QL	Limited to 60 EA per 30 days.
venlafaxine hcl 100 mg tablet (EFFEXOR)	QL	Limited to 90 EA per 30 days.
venlafaxine hcl 25 mg tablet (EFFEXOR)	QL	Limited to 90 EA per 30 days.
venlafaxine hcl 37.5 mg tablet (EFFEXOR)	QL	Limited to 90 EA per 30 days.
venlafaxine hcl 50 mg tablet (EFFEXOR)	QL	Limited to 90 EA per 30 days.
venlafaxine hcl 75 mg tablet (EFFEXOR)	QL	Limited to 90 EA per 30 days.
venlafaxine hcl er 150 mg cap (EFFEXOR XR)		
venlafaxine hcl er 37.5 mg cap (EFFEXOR XR)		
venlafaxine hcl er 75 mg cap (EFFEXOR XR)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDEPRESSANTS : SELECTIVE SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITOR (SNRIs)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CYMBALTA 20 MG CAPSULE *(use duloxetine hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
CYMBALTA 30 MG CAPSULE *(use duloxetine hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
CYMBALTA 60 MG CAPSULE *(use duloxetine hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
desvenlafaxine er 100 mg tab	PA	Prior Authorization required.
desvenlafaxine er 50 mg tab	PA	Prior Authorization required.
desvenlafaxine succnt er 100mg (PRISTIQ)	PA	Prior Authorization required.
desvenlafaxine succnt er 25 mg (PRISTIQ)	PA	Prior Authorization required.
desvenlafaxine succnt er 50 mg (PRISTIQ)	PA	Prior Authorization required.
DRIZALMA SPRINKLE DR 20 MG CAP *(duloxetine hcl)*	PA	Prior Authorization required.
DRIZALMA SPRINKLE DR 30 MG CAP *(duloxetine hcl)*	PA	Prior Authorization required.
DRIZALMA SPRINKLE DR 40 MG CAP *(duloxetine hcl)*	PA	Prior Authorization required.
DRIZALMA SPRINKLE DR 60 MG CAP *(duloxetine hcl)*	PA	Prior Authorization required.
EFFEXOR XR 150 MG CAPSULE *(use venlafaxine hcl)*	PA	Prior Authorization required.
EFFEXOR XR 37.5 MG CAPSULE *(use venlafaxine hcl)*	PA	Prior Authorization required.
EFFEXOR XR 75 MG CAPSULE *(use venlafaxine hcl)*	PA	Prior Authorization required.
FETZIMA 20-40 MG TITRATION PAK *(levomilnacipran hcl)*	PA	Prior Authorization required.
FETZIMA ER 120 MG CAPSULE *(levomilnacipran hcl)*	PA	Prior Authorization required.
FETZIMA ER 20 MG CAPSULE *(levomilnacipran hcl)*	PA	Prior Authorization required.
FETZIMA ER 40 MG CAPSULE *(levomilnacipran hcl)*	PA	Prior Authorization required.
FETZIMA ER 80 MG CAPSULE *(levomilnacipran hcl)*	PA	Prior Authorization required.
PRISTIQ ER 100 MG TABLET *(desvenlafaxine succinate)*	PA	Prior Authorization required.
PRISTIQ ER 25 MG TABLET *(desvenlafaxine succinate)*	PA	Prior Authorization required.
PRISTIQ ER 50 MG TABLET *(desvenlafaxine succinate)*	PA	Prior Authorization required.
venlafaxine hcl er 150 mg tab	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
venlafaxine hcl er 225 mg tab	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
venlafaxine hcl er 37.5 mg tab	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
venlafaxine hcl er 75 mg tab	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ANTIDIABETICS : COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
glipizide-metformin 2.5-250 mg (METAGLIP)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
glipizide-metformin 2.5-500 mg (METAGLIP)		
glipizide-metformin 5-500 mg (METAGLIP)		
glyburid-metformin 1.25-250 mg (GLUCOVANCE)		
glyburide-metformin 2.5-500 mg (GLUCOVANCE)		
glyburide-metformin 5-500 mg (GLUCOVANCE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTOPLUS MET 15 MG-500 MG TAB *(pioglitazone hcl/metformin hcl)*	PA	Prior Authorization required.
ACTOPLUS MET 15 MG-850 MG TAB *(pioglitazone hcl/metformin hcl)*	PA	Prior Authorization required.
alogliptin-metformin 12.5-1000 (KAZANO)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
alogliptin-metformin 12.5-500 (KAZANO)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
alogliptin-pioglit 12.5-15 mg (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin-pioglit 12.5-30 mg (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin-pioglit 12.5-45 mg (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin-pioglit 25-15 mg tb (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin-pioglit 25-30 mg tb (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin-pioglit 25-45 mg tb (OSENI)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DUETACT 30-2 MG TABLET *(pioglitazone hcl/glimepiride)*	PA	Prior Authorization required.
DUETACT 30-4 MG TABLET *(pioglitazone hcl/glimepiride)*	PA	Prior Authorization required.
GLYXAMBI 10 MG-5 MG TABLET *(empagliflozin/linagliptin)*	PA	Prior Authorization required.
GLYXAMBI 25 MG-5 MG TABLET *(empagliflozin/linagliptin)*	PA	Prior Authorization required.
INVOKAMET 150-1,000 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET 150-500 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET 50-1,000 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET 50-500 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET XR 150-1,000 MG TAB *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET XR 150-500 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET XR 50-1,000 MG TAB *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
INVOKAMET XR 50-500 MG TABLET *(canagliflozin/metformin hcl)*	PA	Prior Authorization required.
JANUMET 50-1,000 MG TABLET *(sitagliptin phosphate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JANUMET 50-500 MG TABLET *(sitagliptin phosphate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
JANUMET XR 100-1,000 MG TABLET *(sitagliptin phosphate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JANUMET XR 50-1,000 MG TABLET *(sitagliptin phosphate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JANUMET XR 50-500 MG TABLET *(sitagliptin phosphate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
JENTADUETO 2.5 MG-1000 MG TAB *(linagliptin/metformin hcl)*	PA	Prior Authorization required.
JENTADUETO 2.5 MG-500 MG TAB *(linagliptin/metformin hcl)*	PA	Prior Authorization required.
JENTADUETO 2.5 MG-850 MG TAB *(linagliptin/metformin hcl)*	PA	Prior Authorization required.
JENTADUETO XR 2.5 MG-1,000 MG *(linagliptin/metformin hcl)*	PA	Prior Authorization required.
JENTADUETO XR 5 MG-1,000 MG TB *(linagliptin/metformin hcl)*	PA	Prior Authorization required.
KAZANO 12.5-1,000 MG TABLET *(alogliptin benzoate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
KAZANO 12.5-500 MG TABLET *(alogliptin benzoate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
KOMBIGLYZE XR 2.5-1,000 MG TAB *(saxagliptin hcl/metformin hcl)*	PA	Prior Authorization required.
KOMBIGLYZE XR 5-1,000 MG TAB *(saxagliptin hcl/metformin hcl)*	PA	Prior Authorization required.
KOMBIGLYZE XR 5-500 MG TABLET *(saxagliptin hcl/metformin hcl)*	PA	Prior Authorization required.
OSENI 12.5-15 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OSENI 12.5-30 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OSENI 12.5-45 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OSENI 25-15 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OSENI 25-30 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
OSENI 25-45 MG TABLET *(alogliptin benzoate/pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
pioglitazone-glimepiride 30-2 (DUETACT)	PA	Prior Authorization required.
pioglitazone-glimepiride 30-4 (DUETACT)	PA	Prior Authorization required.
pioglitazone-metformin 15-500 (ACTOPLUS MET)	PA	Prior Authorization required.
pioglitazone-metformin 15-850 (ACTOPLUS MET)	PA	Prior Authorization required.
QTERN 10 MG-5 MG TABLET *(dapagliflozin propanediol/saxagliptin hcl)*	PA	Prior Authorization required.
QTERN 5 MG-5 MG TABLET *(dapagliflozin propanediol/saxagliptin hcl)*	PA	Prior Authorization required.
repaglinide-metformin 1-500 mg (PRANDIMET)	PA	Prior Authorization required.
repaglinide-metformin 2-500 mg (PRANDIMET)	PA	Prior Authorization required.
SEGLUROMET 2.5-1,000 MG TABLET *(ertugliflozin pidolate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SEGLUROMET 2.5-500 MG TABLET *(ertugliflozin pidolate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
SEGLUROMET 7.5-1,000 MG TABLET *(ertugliflozin pidolate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
SEGLUROMET 7.5-500 MG TABLET *(ertugliflozin pidolate/metformin hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
SOLIQUA 100 UNIT-33 MCG/ML PEN *(insulin glargine,human recombinant analog/lixisenatide)*	PA	Prior Authorization required.
STEGLUJAN 15-100 MG TABLET *(ertugliflozin pidolate/sitagliptin phosphate)*	PA	Prior Authorization required.
STEGLUJAN 5-100 MG TABLET *(ertugliflozin pidolate/sitagliptin phosphate)*	PA	Prior Authorization required.
SYNJARDY 12.5-1,000 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY 12.5-500 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY 5-1,000 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY 5-500 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY XR 10-1,000 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY XR 12.5-1,000 MG TAB *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY XR 25-1,000 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
SYNJARDY XR 5-1,000 MG TABLET *(empagliflozin/metformin hcl)*	PA	Prior Authorization required.
TRIJARDY XR 10-5-1,000 MG TAB *(empagliflozin/linagliptin/metformin hcl)*	PA	Prior Authorization required.
TRIJARDY XR 12.5-2.5-1,000 MG *(empagliflozin/linagliptin/metformin hcl)*	PA	Prior Authorization required.
TRIJARDY XR 25-5-1,000 MG TAB *(empagliflozin/linagliptin/metformin hcl)*	PA	Prior Authorization required.
TRIJARDY XR 5-2.5-1,000 MG TAB *(empagliflozin/linagliptin/metformin hcl)*	PA	Prior Authorization required.
XIGDUO XR 10 MG-1,000 MG TAB *(dapagliflozin propanediol/metformin hcl)*	PA	Prior Authorization required.
XIGDUO XR 10 MG-500 MG TABLET *(dapagliflozin propanediol/metformin hcl)*	PA	Prior Authorization required.
XIGDUO XR 2.5 MG-1,000 MG TAB *(dapagliflozin propanediol/metformin hcl)*	PA	Prior Authorization required.
XIGDUO XR 5 MG-1,000 MG TABLET *(dapagliflozin propanediol/metformin hcl)*	PA	Prior Authorization required.
XIGDUO XR 5 MG-500 MG TABLET *(dapagliflozin propanediol/metformin hcl)*	PA	Prior Authorization required.
XULTOPHY 100 UNIT-3.6MG/ML PEN *(insulin degludec/liraglutide)*	PA	Prior Authorization required.

Drug List

ANTIDIABETICS : DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
JANUVIA 100 MG TABLET *(sitagliptin phosphate)*	QL	Limited to 30 EA per 30 days.
JANUVIA 25 MG TABLET *(sitagliptin phosphate)*	QL	Limited to 30 EA per 30 days.
JANUVIA 50 MG TABLET *(sitagliptin phosphate)*	QL	Limited to 30 EA per 30 days.
TRADJENTA 5 MG TABLET *(linagliptin)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
alogliptin 12.5 mg tablet (NESINA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin 25 mg tablet (NESINA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
alogliptin 6.25 mg tablet (NESINA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NESINA 12.5 MG TABLET *(alogliptin benzoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NESINA 25 MG TABLET *(alogliptin benzoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NESINA 6.25 MG TABLET *(alogliptin benzoate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ONGLYZA 2.5 MG TABLET *(saxagliptin hcl)*	PA	Prior Authorization required.
ONGLYZA 5 MG TABLET *(saxagliptin hcl)*	PA	Prior Authorization required.
ANTIDIABETICS : INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BYETTA 10 MCG DOSE PEN INJ *(exenatide)*		
BYETTA 5 MCG DOSE PEN INJ *(exenatide)*		
VICTOZA 2-PAK 18 MG/3 ML PEN *(liraglutide)*		
VICTOZA 3-PAK 18 MG/3 ML PEN *(liraglutide)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADLYXIN 10-20 MCG STARTER PACK *(lixisenatide)*	PA	Prior Authorization required.
ADLYXIN 20 MCG MAINTENANCE PK *(lixisenatide)*	PA	Prior Authorization required.
BYDUREON 2 MG PEN INJECT *(exenatide microspheres)*	PA	Prior Authorization required.
BYDUREON 2 MG VIAL *(exenatide microspheres)*	PA	Prior Authorization required.
BYDUREON BCISE 2 MG AUTOINJECT *(exenatide microspheres)*	PA	Prior Authorization required.
OZEMPIC 0.25-0.5 MG DOSE PEN *(semaglutide)*	PA	Prior Authorization required.
OZEMPIC 1 MG DOSE PEN (1.5 ML) *(semaglutide)*	PA	Prior Authorization required.
RYBELSUS 14 MG TABLET *(semaglutide)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
RYBELSUS 3 MG TABLET *(semaglutide)*	PA	Prior Authorization required.
RYBELSUS 7 MG TABLET *(semaglutide)*	PA	Prior Authorization required.
TRULICITY 0.75 MG/0.5 ML PEN *(dulaglutide)*	PA	Prior Authorization required.
TRULICITY 1.5 MG/0.5 ML PEN *(dulaglutide)*	PA	Prior Authorization required.
TRULICITY 3 MG/0.5 ML PEN *(dulaglutide)*	PA	Prior Authorization required.
TRULICITY 4.5 MG/0.5 ML PEN *(dulaglutide)*	PA	Prior Authorization required.

ANTIDIABETICS : INSULIN		
Drug Name	**Drug Status**	**Criteria**
Preferred		
HUMALOG 100 UNIT/ML CARTRIDGE *(insulin lispro)*		
HUMALOG 100 UNIT/ML KWIKPEN *(insulin lispro)*	QL	Limited to 60 mL per 30 days.
HUMALOG 100 UNIT/ML VIAL *(insulin lispro)*	QL	Limited to 60 mL per 30 days.
HUMALOG 200 UNIT/ML KWIKPEN *(insulin lispro)*		
HUMALOG JR 100 UNIT/ML KWIKPEN *(insulin lispro)*		
HUMALOG MIX 50-50 KWIKPEN *(insulin lispro protamine and insulin lispro)*		
HUMALOG MIX 50-50 VIAL *(insulin lispro protamine and insulin lispro)*	QL	Limited to 30 mL per 30 days.
HUMALOG MIX 75-25 KWIKPEN *(insulin lispro protamine and insulin lispro)*		
HUMALOG MIX 75-25 VIAL *(insulin lispro protamine and insulin lispro)*	QL	Limited to 30 mL per 30 days.
HUMULIN R 500 UNIT/ML KWIKPEN *(insulin regular, human)*		
HUMULIN R 500 UNIT/ML VIAL *(insulin regular, human)*		
insulin lispro 100 unit/ml pen (ADMELOG SOLOSTAR)	QL	Limited to 60 mL per 30 days.
insulin lispro 100 unit/ml vl (ADMELOG)	QL	Limited to 60 mL per 30 days.
insulin lispro jr 100 unit/ml (HUMALOG JUNIOR KWIKPEN)		
insulin lispro mix 75-25 kwkpn (HUMALOG MIX 75-25 KWIKPEN)		
LANTUS 100 UNIT/ML VIAL *(insulin glargine,human recombinant analog)*		
LANTUS SOLOSTAR 100 UNIT/ML *(insulin glargine,human recombinant analog)*	QL	Limited to 60 mL per 30 days.
LEVEMIR 100 UNIT/ML VIAL *(insulin detemir)*		
LEVEMIR FLEXTOUCH 100 UNIT/ML *(insulin detemir)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : INSULIN		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADMELOG 100 UNIT/ML VIAL *(use insulin lispro)*	PA,QL	Prior Authorization required. Limited to 60 mL per 30 days.
ADMELOG SOLOSTAR 100 UNIT/ML *(use insulin lispro)*	PA,QL	Prior Authorization required. Limited to 60 mL per 30 days.
AFREZZA 12 UNIT CARTRIDGE *(insulin regular, human)*	PA	Prior Authorization required.
AFREZZA 4 UNIT CARTRIDGE *(insulin regular, human)*	PA	Prior Authorization required.
AFREZZA 4 UNIT/8 UNIT/12 UNIT *(insulin regular, human)*	PA	Prior Authorization required.
AFREZZA 8 UNIT CARTRIDGE *(insulin regular, human)*	PA	Prior Authorization required.
AFREZZA 90-4 UNIT / 90-8 UNIT *(insulin regular, human)*	PA	Prior Authorization required.
AFREZZA 90-8 UNIT / 90-12 UNIT *(insulin regular, human)*	PA	Prior Authorization required.
APIDRA 100 UNIT/ML VIAL *(insulin glulisine)*	PA	Prior Authorization required.
APIDRA SOLOSTAR 100 UNIT/ML *(insulin glulisine)*	PA	Prior Authorization required.
BASAGLAR 100 UNIT/ML KWIKPEN *(insulin glargine,human recombinant analog)*	PA,QL	Prior Authorization required. Limited to 60 mL per 30 days.
FIASP 100 UNIT/ML FLEXTOUCH *(insulin aspart (niacinamide))*	PA	Prior Authorization required.
FIASP 100 UNIT/ML VIAL *(insulin aspart (niacinamide))*	PA	Prior Authorization required.
FIASP PENFILL 100 UNIT/ML CART *(insulin aspart (niacinamide))*	PA	Prior Authorization required.
insulin aspart 100 unit/ml crt (NOVOLOG)	PA	Prior Authorization required.
insulin aspart 100 unit/ml pen (NOVOLOG FLEXPEN)	PA	Prior Authorization required.
insulin aspart 100 unit/ml vl (NOVOLOG)	PA	Prior Authorization required.
insulin aspart prot (mix70-30) (NOVOLOG MIX 70-30)	PA	Prior Authorization required.
insulin aspart prot (mix70-30) (NOVOLOG MIX 70-30 FLEXPEN)	PA	Prior Authorization required.
LYUMJEV 100 UNIT/ML KWIKPEN *(insulin lispro-aabc)*	PA	Prior Authorization required.
LYUMJEV 100 UNIT/ML VIAL *(insulin lispro-aabc)*	PA	Prior Authorization required.
LYUMJEV 200 UNIT/ML KWIKPEN *(insulin lispro-aabc)*	PA	Prior Authorization required.
NOVOLOG 100 UNIT/ML CARTRIDGE *(insulin aspart)*	PA	Prior Authorization required.
NOVOLOG 100 UNIT/ML FLEXPEN *(insulin aspart)*	PA	Prior Authorization required.
NOVOLOG 100 UNIT/ML VIAL *(insulin aspart)*	PA	Prior Authorization required.
NOVOLOG MIX 70-30 FLEXPEN *(insulin aspart protamine human/insulin aspart)*	PA	Prior Authorization required.
NOVOLOG MIX 70-30 VIAL *(insulin aspart protamine human/insulin aspart)*	PA	Prior Authorization required.
SEMGLEE 100 UNIT/ML PEN *(insulin glargine,human recombinant analog)*	PA	Prior Authorization required.

Drug List

ANTIDIABETICS : INSULIN		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SEMGLEE 100 UNIT/ML VIAL *(insulin glargine,human recombinant analog)*	PA	Prior Authorization required.
TOUJEO MAX SOLOSTR 300 UNIT/ML *(insulin glargine,human recombinant analog)*	PA	Prior Authorization required.
TOUJEO SOLOSTAR 300 UNIT/ML *(insulin glargine,human recombinant analog)*	PA	Prior Authorization required.
TRESIBA 100 UNIT/ML VIAL *(insulin degludec)*	PA	Prior Authorization required.
TRESIBA FLEXTOUCH 100 UNIT/ML *(insulin degludec)*	PA	Prior Authorization required.
TRESIBA FLEXTOUCH 200 UNIT/ML *(insulin degludec)*	PA	Prior Authorization required.

ANTIDIABETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acarbose 100 mg tablet (PRECOSE)	QL	Limited to 90 EA per 30 days.
acarbose 25 mg tablet (PRECOSE)	QL	Limited to 90 EA per 30 days.
acarbose 50 mg tablet (PRECOSE)	QL	Limited to 90 EA per 30 days.
AVANDIA 2 MG TABLET *(rosiglitazone maleate)*		
AVANDIA 4 MG TABLET *(rosiglitazone maleate)*		
diazoxide 50 mg/ml oral susp (PROGLYCEM)		
glimepiride 1 mg tablet (AMARYL)		
glimepiride 2 mg tablet (AMARYL)		
glimepiride 4 mg tablet (AMARYL)		
glipizide 10 mg tablet (GLUCOTROL)		
glipizide 5 mg tablet (GLUCOTROL)		
glipizide er 10 mg tablet (GLUCOTROL XL)		
glipizide er 2.5 mg tablet (GLUCOTROL XL)		
glipizide er 5 mg tablet (GLUCOTROL XL)		
glipizide xl 10 mg tablet (GLUCOTROL XL)		
glipizide xl 2.5 mg tablet (GLUCOTROL XL)		
glipizide xl 5 mg tablet (GLUCOTROL XL)		
GLUCAGEN 1 MG HYPOKIT *(glucagon,human recombinant)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 180 days.
GLUCAGON 1 MG EMERGENCY KIT *(glucagon hcl)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 180 days.
GLUCAGON 1 MG EMERGENCY KIT *(glucagon,human recombinant)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 180 days.
glyburide 1.25 mg tablet (DIABETA)		
glyburide 2.5 mg tablet (DIABETA)		
glyburide 5 mg tablet (DIABETA)		
glyburide micro 1.5 mg tab (GLYNASE)		
glyburide micro 3 mg tablet (GLYNASE)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
glyburide micro 6 mg tablet (GLYNASE)		
metformin er 1,000 mg gastr-tb (GLUMETZA)		
metformin er 1,000 mg osm-tab (FORTAMET)		
metformin er 500 mg gastrc-tb (GLUMETZA)		
metformin er 500 mg osmotic tb (FORTAMET)		
metformin hcl 1,000 mg tablet (GLUCOPHAGE)		
metformin hcl 500 mg tablet (GLUCOPHAGE)		
metformin hcl 850 mg tablet (GLUCOPHAGE)		
metformin hcl er 500 mg tablet (GLUCOPHAGE XR)		
metformin hcl er 750 mg tablet (GLUCOPHAGE XR)		
miglitol 100 mg tablet (GLYSET)		
miglitol 25 mg tablet (GLYSET)		
miglitol 50 mg tablet (GLYSET)		
nateglinide 120 mg tablet (STARLIX)		
nateglinide 60 mg tablet (STARLIX)		
pioglitazone hcl 15 mg tablet (ACTOS)	QL	Limited to 30 EA per 30 days.
pioglitazone hcl 30 mg tablet (ACTOS)	QL	Limited to 30 EA per 30 days.
pioglitazone hcl 45 mg tablet (ACTOS)	QL	Limited to 30 EA per 30 days.
PROGLYCEM 50 MG/ML ORAL SUSP *(diazoxide)*		
tolbutamide 500 mg tablet (ORINASE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTOS 15 MG TABLET *(use pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ACTOS 30 MG TABLET *(use pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ACTOS 45 MG TABLET *(use pioglitazone hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
AMARYL 1 MG TABLET *(use glimepiride)*	PA	Prior Authorization required.
AMARYL 2 MG TABLET *(use glimepiride)*	PA	Prior Authorization required.
AMARYL 4 MG TABLET *(use glimepiride)*	PA	Prior Authorization required.
BAQSIMI 3 MG SPRAY ONE PACK *(glucagon)*	PA	Prior Authorization required.
BAQSIMI 3 MG SPRAY TWO PACK *(glucagon)*	PA	Prior Authorization required.
CYCLOSET 0.8 MG TABLET *(bromocriptine mesylate)*	PA	Prior Authorization required.
FORTAMET ER 1,000 MG TABLET *(use metformin hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FORTAMET ER 500 MG TABLET *(use metformin hcl)*	PA	Prior Authorization required.
GLUCOPHAGE XR 500 MG TAB *(use metformin hcl)*	PA	Prior Authorization required.
GLUCOPHAGE XR 750 MG TAB *(use metformin hcl)*	PA	Prior Authorization required.
GLUCOTROL 10 MG TABLET *(use glipizide)*	PA	Prior Authorization required.
GLUCOTROL 5 MG TABLET *(use glipizide)*	PA	Prior Authorization required.
GLUCOTROL XL 10 MG TABLET *(use glipizide)*	PA	Prior Authorization required.
GLUCOTROL XL 2.5 MG TABLET *(use glipizide)*	PA	Prior Authorization required.
GLUCOTROL XL 5 MG TABLET *(use glipizide)*	PA	Prior Authorization required.
GLUMETZA ER 1,000 MG TABLET *(use metformin hcl)*	PA	Prior Authorization required.
GLUMETZA ER 500 MG TABLET *(use metformin hcl)*	PA	Prior Authorization required.
GLYNASE 1.5 MG PRESTAB *(use glyburide,micronized)*	PA	Prior Authorization required.
GLYNASE 3 MG PRESTAB *(use glyburide,micronized)*	PA	Prior Authorization required.
GLYNASE 6 MG PRESTAB *(use glyburide,micronized)*	PA	Prior Authorization required.
GLYSET 100 MG TABLET *(use miglitol)*	PA	Prior Authorization required.
GLYSET 25 MG TABLET *(use miglitol)*	PA	Prior Authorization required.
GLYSET 50 MG TABLET *(use miglitol)*	PA	Prior Authorization required.
GVOKE HYPOPEN 1-PK 1 MG/0.2 ML *(glucagon)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
GVOKE HYPOPEN 1PK 0.5MG/0.1 ML *(glucagon)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
GVOKE HYPOPEN 2-PK 1 MG/0.2 ML *(glucagon)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
GVOKE HYPOPEN 2PK 0.5MG/0.1 ML *(glucagon)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
GVOKE PFS 1-PK 1 MG/0.2 ML SYR *(glucagon)*	PA,QL,FL	Prior Authorization required. Limited to 0.2 mL per fill; Limited to 1 fill per 180 days.
GVOKE PFS 1PK 0.5MG/0.1 ML SYR *(glucagon)*	PA,QL,FL	Prior Authorization required. Limited to 0.1 mL per fill; Limited to 1 fill per 180 days.
GVOKE PFS 2-PK 1 MG/0.2 ML SYR *(glucagon)*	PA,QL,FL	Prior Authorization required. Limited to 0.2 mL per fill; Limited to 1 fill per 180 days.
GVOKE PFS 2PK 0.5MG/0.1 ML SYR *(glucagon)*	PA,QL,FL	Prior Authorization required. Limited to 0.1 mL per fill; Limited to 1 fill per 180 days.
KORLYM 300 MG TABLET *(mifepristone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
metformin hcl 500 mg/5 ml soln (RIOMET)	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PRANDIN 1 MG TABLET *(repaglinide)*	PA	Prior Authorization required.
PRANDIN 2 MG TABLET *(repaglinide)*	PA	Prior Authorization required.
PRECOSE 100 MG TABLET *(use acarbose)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PRECOSE 25 MG TABLET *(use acarbose)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PRECOSE 50 MG TABLET *(use acarbose)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.

Drug List

ANTIDIABETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
repaglinide 0.5 mg tablet (PRANDIN)	PA	Prior Authorization required.
repaglinide 1 mg tablet (PRANDIN)	PA	Prior Authorization required.
repaglinide 2 mg tablet (PRANDIN)	PA	Prior Authorization required.
RIOMET 500 MG/5 ML SOLUTION *(metformin hcl)*	PA	Prior Authorization required.
RIOMET ER 500 MG/5 ML SUSP *(metformin hcl)*	PA	Prior Authorization required.
STARLIX 120 MG TABLET *(use nateglinide)*	PA	Prior Authorization required.
STARLIX 60 MG TABLET *(use nateglinide)*	PA	Prior Authorization required.
SYMLINPEN 120 PEN INJECTOR *(pramlintide acetate)*	PA	Prior Authorization required.
SYMLINPEN 60 PEN INJECTOR *(pramlintide acetate)*	PA	Prior Authorization required.

ANTIDIABETICS : SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
INVOKANA 100 MG TABLET *(canagliflozin)*		
INVOKANA 300 MG TABLET *(canagliflozin)*		
JARDIANCE 10 MG TABLET *(empagliflozin)*		
JARDIANCE 25 MG TABLET *(empagliflozin)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FARXIGA 10 MG TABLET *(dapagliflozin propanediol)*	PA	Prior Authorization required.
FARXIGA 5 MG TABLET *(dapagliflozin propanediol)*	PA	Prior Authorization required.
STEGLATRO 15 MG TABLET *(ertugliflozin pidolate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
STEGLATRO 5 MG TABLET *(ertugliflozin pidolate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

Antidiarrheals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
diphenoxylat-atrop 2.5-0.025/5 (LOMOTIL)	QL	Limited to 118 mL per 30 days.
diphenoxylate-atrop 2.5-0.025 (LOMOTIL)		
loperamide 2 mg capsule (IMODIUM A-D)		
paregoric liquid		

ANTIDOTES AND SPECIFIC ANTAGONISTS : ANTIDOTES - CHELATING AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CHEMET 100 MG CAPSULE *(succimer)*	SP	Restricted to specialty pharmacies.
CLOVIQUE 250 MG CAPSULE *(trientine hcl)*	SP	Restricted to specialty pharmacies.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDOTES AND SPECIFIC ANTAGONISTS : ANTIDOTES - CHELATING AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
DEPEN 250 MG TITRATAB *(penicillamine)*		
penicillamine 250 mg capsule (CUPRIMINE)	QL	Limited to 120 EA per 30 days.
penicillamine 250 mg tablet (DEPEN)	QL	Limited to 120 EA per 30 days.
trientine hcl 250 mg capsule (CLOVIQUE)		
trientine hcl 250 mg capsule (SYPRINE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CUPRIMINE 250 MG CAPSULE *(use penicillamine)*	PA	Prior Authorization required.
deferasirox 125 mg tb for susp (EXJADE)	PA	Prior Authorization required.
deferasirox 180 mg granule (JADENU SPRINKLE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
deferasirox 180 mg tablet (JADENU)	PA	Prior Authorization required.
deferasirox 250 mg tb for susp (EXJADE)	PA	Prior Authorization required.
deferasirox 360 mg granule (JADENU SPRINKLE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
deferasirox 360 mg tablet (JADENU)	PA	Prior Authorization required.
deferasirox 500 mg tb for susp (EXJADE)	PA	Prior Authorization required.
deferasirox 90 mg granule (JADENU SPRINKLE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
deferasirox 90 mg tablet (JADENU)	PA	Prior Authorization required.
deferiprone 500 mg tablet (FERRIPROX)	PA	Prior authorization required.
EXJADE 125 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EXJADE 250 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EXJADE 500 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FERRIPROX 1,000 MG TAB(2X/DAY) *(deferiprone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FERRIPROX 1,000 MG TABLET *(deferiprone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FERRIPROX 100 MG/ML SOLUTION *(deferiprone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FERRIPROX 500 MG TABLET *(deferiprone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU 180 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU 360 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU 90 MG TABLET *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU SPRINKLE 180 MG GRANULE *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU SPRINKLE 360 MG GRANULE *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JADENU SPRINKLE 90 MG GRANULE *(deferasirox)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SYPRINE 250 MG CAPSULE *(use trientine hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIEMETICS : 5-HT3 RECEPTOR ANTAGONISTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ondansetron 4 mg/5 ml solution (ZOFRAN)		
ondansetron hcl 4 mg tablet (ZOFRAN)	QL	Limited to 30 EA per 30 days.
ondansetron hcl 8 mg tablet (ZOFRAN)	QL	Limited to 30 EA per 30 days.
ondansetron odt 4 mg tablet (ZOFRAN ODT)	QL	Limited to 30 EA per 30 days.
ondansetron odt 8 mg tablet (ZOFRAN ODT)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ANZEMET 100 MG TABLET *(dolasetron mesylate)*	PA	Prior Authorization required.
ANZEMET 50 MG TABLET *(dolasetron mesylate)*	PA	Prior Authorization required.
granisetron hcl 1 mg tablet (KYTRIL)	PA	Prior Authorization required.
SANCUSO 3.1 MG/24 HR PATCH *(granisetron)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZOFRAN 4 MG TABLET *(use ondansetron hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOFRAN 8 MG TABLET *(use ondansetron hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZUPLENZ 4 MG SOLUBLE FILM *(ondansetron)*	PA	Prior Authorization required.
ZUPLENZ 8 MG SOLUBLE FILM *(ondansetron)*	PA	Prior Authorization required.

ANTIEMETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
meclizine 12.5 mg tablet (ANTIVERT)		
meclizine 25 mg tablet (ANTIVERT)		
meclizine 25 mg tablet (DRAMAMINE LESS DROWSY)		
scopolamine 1 mg/3 day patch (TRANSDERM-SCOP)		
TRANSDERM-SCOP 1.5 MG (1MG/3D) *(scopolamine)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AKYNZEO 300-0.5 MG CAPSULE *(netupitant/palonosetron hcl)*	PA	Prior Authorization required.
BONJESTA ER 20-20 MG TABLET *(doxylamine succinate/pyridoxine hcl (vitamin b6))*	PA	Prior Authorization required.
DICLEGIS DR 10-10 MG TABLET *(doxylamine succinate/pyridoxine hcl (vitamin b6))*	PA	Prior Authorization required.
doxylamine-pyridoxine 10-10 mg (DICLEGIS)	PA	Prior Authorization required.
dronabinol 10 mg capsule (MARINOL)	PA	Prior Authorization required.
dronabinol 2.5 mg capsule (MARINOL)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIEMETICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
dronabinol 5 mg capsule (MARINOL)	PA	Prior Authorization required.
MARINOL 10 MG CAPSULE *(dronabinol)*	PA	Prior Authorization required.
MARINOL 2.5 MG CAPSULE *(dronabinol)*	PA	Prior Authorization required.
MARINOL 5 MG CAPSULE *(dronabinol)*	PA	Prior Authorization required.
TIGAN 300 MG CAPSULE *(trimethobenzamide hcl)*	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.
trimethobenzamide 300 mg cap (TIGAN)	PA,QL	Prior Authorization required. Limited to 120 EA per 30 days.

ANTIEMETICS : SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
aprepitant 125 mg capsule (EMEND)		
aprepitant 125-80-80 mg pack (EMEND)		
aprepitant 40 mg capsule (EMEND)		
aprepitant 80 mg capsule (EMEND)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EMEND 125 MG POWDER PACKET *(aprepitant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EMEND 80 MG CAPSULE *(use aprepitant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EMEND TRIPACK *(use aprepitant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VARUBI 90 MG TABLET *(rolapitant hcl)*	PA	Prior Authorization required.

ANTIFUNGALS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
fluconazole 10 mg/ml susp (DIFLUCAN)		
fluconazole 100 mg tablet (DIFLUCAN)	QL	Limited to 30 EA per 30 days.
fluconazole 150 mg tablet (DIFLUCAN)	QL	Limited to 30 EA per 30 days.
fluconazole 200 mg tablet (DIFLUCAN)	QL	Limited to 30 EA per 30 days.
fluconazole 40 mg/ml susp (DIFLUCAN)		
fluconazole 50 mg tablet (DIFLUCAN)	QL	Limited to 30 EA per 30 days.
griseofulvin 125 mg/5 ml susp (GRIFULVIN V)		
griseofulvin micro 500 mg tab (FULVICIN U/F)		
griseofulvin micro 500 mg tab (GRIFULVIN V)		
griseofulvin ultra 125 mg tab (GRIS-PEG)		
griseofulvin ultra 250 mg tab (GRIS-PEG)		
ketoconazole 200 mg tablet (NIZORAL)		
nystatin 500,000 unit oral tab (MYCOSTATIN)		
terbinafine hcl 250 mg tablet (LAMISIL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIFUNGALS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ANCOBON 250 MG CAPSULE *(flucytosine)*	PA	Prior Authorization required.
ANCOBON 500 MG CAPSULE *(flucytosine)*	PA	Prior Authorization required.
CRESEMBA 186 MG CAPSULE *(isavuconazonium sulfate)*	PA	Prior Authorization required.
DIFLUCAN 10 MG/ML SUSPENSION *(use fluconazole)*	PA	Prior Authorization required.
DIFLUCAN 100 MG TABLET *(use fluconazole)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIFLUCAN 150 MG TABLET *(use fluconazole)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIFLUCAN 200 MG TABLET *(use fluconazole)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIFLUCAN 40 MG/ML SUSPENSION *(use fluconazole)*	PA	Prior Authorization required.
DIFLUCAN 50 MG TABLET *(use fluconazole)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
flucytosine 250 mg capsule (ANCOBON)	PA	Prior Authorization required.
flucytosine 500 mg capsule (ANCOBON)	PA	Prior Authorization required.
itraconazole 10 mg/ml solution (SPORANOX)	PA	Prior Authorization required.
itraconazole 100 mg capsule (SPORANOX)	PA	Prior Authorization required.
NOXAFIL 40 MG/ML SUSPENSION *(posaconazole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOXAFIL DR 100 MG TABLET *(posaconazole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
posaconazole dr 100 mg tablet (NOXAFIL)	PA	Prior Authorization required.
SPORANOX 10 MG/ML SOLUTION *(itraconazole)*	PA	Prior Authorization required.
SPORANOX 100 MG CAPSULE *(itraconazole)*	PA	Prior Authorization required.
TOLSURA 65 MG CAPSULE *(itraconazole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VFEND 200 MG TABLET *(voriconazole)*	PA	Prior Authorization required.
VFEND 40 MG/ML SUSPENSION *(voriconazole)*	PA	Prior Authorization required.
VFEND 50 MG TABLET *(voriconazole)*	PA	Prior Authorization required.
voriconazole 200 mg tablet (VFEND)	PA	Prior Authorization required.
voriconazole 40 mg/ml susp (VFEND)	PA	Prior Authorization required.
voriconazole 50 mg tablet (VFEND)	PA	Prior Authorization required.

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
clemastine fum 2.68 mg tab (TAVIST)		
cyproheptadine 2 mg/5 ml soln (PERIACTIN)		
cyproheptadine 2 mg/5 ml syrup (PERIACTIN)		
cyproheptadine 4 mg tablet (PERIACTIN)		
diphenhydramine 12.5 mg/5 ml (DIPHEN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
diphenhydramine 25 mg/10 ml (DIPHEN)		
diphenhydramine 50 mg/ml vial (BENADRYL)		
promethazine 12.5 mg tablet (PHENERGAN)		
promethazine 25 mg tablet (PHENERGAN)		
promethazine 50 mg tablet (PHENERGAN)		
promethazine 6.25 mg/5 ml soln (PHENERGAN)		
promethazine 6.25 mg/5 ml syrp (PHENERGAN)		

ANTIHYPERLIPIDEMICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
atorvastatin 10 mg tablet (LIPITOR)	QL	Limited to 30 EA per 30 days.
atorvastatin 20 mg tablet (LIPITOR)	QL	Limited to 30 EA per 30 days.
atorvastatin 40 mg tablet (LIPITOR)	QL	Limited to 30 EA per 30 days.
atorvastatin 80 mg tablet (LIPITOR)	QL	Limited to 30 EA per 30 days.
cholestyramine light packet (PREVALITE)		
cholestyramine light powder (PREVALITE)		
cholestyramine packet (QUESTRAN)		
cholestyramine powder (QUESTRAN)		
ezetimibe 10 mg tablet (ZETIA)		
fenofibrate 120 mg tablet (FENOGLIDE)		
fenofibrate 130 mg capsule (ANTARA)		
fenofibrate 134 mg capsule (TRICOR)		
fenofibrate 145 mg tablet (TRICOR)		
fenofibrate 150 mg capsule (LIPOFEN)		
fenofibrate 160 mg tablet (LOFIBRA)		
fenofibrate 200 mg capsule (LOFIBRA)		
fenofibrate 40 mg tablet (FENOGLIDE)		
fenofibrate 43 mg capsule (ANTARA)		
fenofibrate 48 mg tablet (TRICOR)		
fenofibrate 50 mg capsule (LIPOFEN)		
fenofibrate 54 mg tablet (LOFIBRA)		
fenofibrate 67 mg capsule (LOFIBRA)		
fenofibric acid dr 135 mg cap (TRILIPIX)		
fenofibric acid dr 45 mg cap (TRILIPIX)		
gemfibrozil 600 mg tablet (LOPID)		
lovastatin 10 mg tablet (MEVACOR)	QL	Limited to 30 EA per 30 days.
lovastatin 20 mg tablet (MEVACOR)	QL	Limited to 30 EA per 30 days.
lovastatin 40 mg tablet (MEVACOR)	QL	Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIHYPERLIPIDEMICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
pravastatin sodium 10 mg tab (PRAVACHOL)	QL	Limited to 30 EA per 30 days.
pravastatin sodium 20 mg tab (PRAVACHOL)	QL	Limited to 30 EA per 30 days.
pravastatin sodium 40 mg tab (PRAVACHOL)	QL	Limited to 30 EA per 30 days.
pravastatin sodium 80 mg tab (PRAVACHOL)	QL	Limited to 30 EA per 30 days.
PREVALITE PACKET *(cholestyramine/aspartame)*		
PREVALITE POWDER *(cholestyramine/aspartame)*		
rosuvastatin calcium 10 mg tab (CRESTOR)	QL	Limited to 30 EA per 30 days.
rosuvastatin calcium 20 mg tab (CRESTOR)	QL	Limited to 30 EA per 30 days.
rosuvastatin calcium 40 mg tab (CRESTOR)	QL	Limited to 30 EA per 30 days.
rosuvastatin calcium 5 mg tab (CRESTOR)	QL	Limited to 30 EA per 30 days.
simvastatin 10 mg tablet (ZOCOR)	QL	Limited to 30 EA per 30 days.
simvastatin 20 mg tablet (ZOCOR)	QL	Limited to 30 EA per 30 days.
simvastatin 40 mg tablet (ZOCOR)	QL	Limited to 30 EA per 30 days.
simvastatin 5 mg tablet (ZOCOR)	QL	Limited to 30 EA per 30 days.
simvastatin 80 mg tablet (ZOCOR)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALTOPREV 20 MG TABLET *(lovastatin)*	PA	Prior Authorization required.
ALTOPREV 40 MG TABLET *(lovastatin)*	PA	Prior Authorization required.
ALTOPREV 60 MG TABLET *(lovastatin)*	PA	Prior Authorization required.
ANTARA 30 MG CAPSULE *(fenofibrate,micronized)*	PA	Prior Authorization required.
ANTARA 90 MG CAPSULE *(fenofibrate,micronized)*	PA	Prior Authorization required.
colesevelam 625 mg tablet (WELCHOL)	PA	Prior Authorization required.
colesevelam hcl 3.75 g packet (WELCHOL)	PA	Prior Authorization required.
COLESTID 1 GM TABLET *(colestipol hcl)*	PA	Prior Authorization required.
COLESTID FLAVORED GRANULES *(colestipol hcl)*	PA	Prior Authorization required.
COLESTID GRANULES *(colestipol hcl)*	PA	Prior Authorization required.
COLESTID GRANULES PACKET *(colestipol hcl)*	PA	Prior Authorization required.
colestipol hcl 1 gm tablet (COLESTID)	PA	Prior Authorization required.
colestipol hcl granules (COLESTID)	PA	Prior Authorization required.
colestipol hcl granules packet (COLESTID)	PA	Prior Authorization required.
colestipol micronized 1 gm tab (COLESTID)	PA	Prior Authorization required.
CRESTOR 10 MG TABLET *(use rosuvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CRESTOR 20 MG TABLET *(use rosuvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIHYPERLIPIDEMICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CRESTOR 40 MG TABLET *(use rosuvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CRESTOR 5 MG TABLET *(use rosuvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
EZALLOR SPRINKLE 10 MG CAPSULE *(rosuvastatin calcium)*	PA	Prior Authorization required.
EZALLOR SPRINKLE 20 MG CAPSULE *(rosuvastatin calcium)*	PA	Prior Authorization required.
EZALLOR SPRINKLE 40 MG CAPSULE *(rosuvastatin calcium)*	PA	Prior Authorization required.
EZALLOR SPRINKLE 5 MG CAPSULE *(rosuvastatin calcium)*	PA	Prior Authorization required.
ezetimibe-simvastatin 10-10 mg (VYTORIN)	PA	Prior Authorization required.
ezetimibe-simvastatin 10-20 mg (VYTORIN)	PA	Prior Authorization required.
ezetimibe-simvastatin 10-40 mg (VYTORIN)	PA	Prior Authorization required.
ezetimibe-simvastatin 10-80 mg (VYTORIN)	PA	Prior Authorization required.
fenofibric acid 105 mg tablet (FIBRICOR)	PA	Prior Authorization required.
fenofibric acid 35 mg tablet (FIBRICOR)	PA	Prior Authorization required.
FENOGLIDE 120 MG TABLET *(use fenofibrate)*	PA	Prior Authorization required.
FENOGLIDE 40 MG TABLET *(use fenofibrate)*	PA	Prior Authorization required.
FIBRICOR 105 MG TABLET *(fenofibric acid)*	PA	Prior Authorization required.
FIBRICOR 35 MG TABLET *(fenofibric acid)*	PA	Prior Authorization required.
fluvastatin er 80 mg tablet (LESCOL XL)	PA	Prior Authorization required.
fluvastatin sodium 20 mg cap (LESCOL)	PA	Prior Authorization required.
fluvastatin sodium 40 mg cap (LESCOL)	PA	Prior Authorization required.
icosapent ethyl 1 gram capsule (VASCEPA)	PA	Prior Authorization required.
JUXTAPID 10 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JUXTAPID 20 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JUXTAPID 30 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JUXTAPID 40 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JUXTAPID 5 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JUXTAPID 60 MG CAPSULE *(lomitapide mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LESCOL XL 80 MG TABLET *(fluvastatin sodium)*	PA	Prior Authorization required.
LIPITOR 10 MG TABLET *(use atorvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
LIPITOR 20 MG TABLET *(use atorvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
LIPITOR 40 MG TABLET *(use atorvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
LIPITOR 80 MG TABLET *(use atorvastatin calcium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

Drug List

ANTIHYPERLIPIDEMICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
LIPOFEN 150 MG CAPSULE *(use fenofibrate)*	PA	Prior Authorization required.
LIPOFEN 50 MG CAPSULE *(use fenofibrate)*	PA	Prior Authorization required.
LIVALO 1 MG TABLET *(pitavastatin calcium)*	PA	Prior Authorization required.
LIVALO 2 MG TABLET *(pitavastatin calcium)*	PA	Prior Authorization required.
LIVALO 4 MG TABLET *(pitavastatin calcium)*	PA	Prior Authorization required.
LOPID 600 MG TABLET *(use gemfibrozil)*	PA	Prior Authorization required.
LOVAZA 1 GM CAPSULE *(omega-3 acid ethyl esters)*	PA	Prior Authorization required.
NEXLETOL 180 MG TABLET *(bempedoic acid)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
NEXLIZET 180-10 MG TABLET *(bempedoic acid/ezetimibe)*	PA	Prior Authorization required.
niacin er 1,000 mg tablet (NIASPAN)	PA	Prior Authorization required.
niacin er 500 mg tablet (NIASPAN)	PA	Prior Authorization required.
niacin er 750 mg tablet (NIASPAN)	PA	Prior Authorization required.
NIASPAN ER 1,000 MG TABLET *(niacin)*	PA	Prior Authorization required.
NIASPAN ER 500 MG TABLET *(niacin)*	PA	Prior Authorization required.
NIASPAN ER 750 MG TABLET *(niacin)*	PA	Prior Authorization required.
omega-3 ethyl esters 1 gm cap (LOVAZA)	PA	Prior Authorization required.
PRALUENT 150 MG/ML PEN *(alirocumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PRALUENT 75 MG/ML PEN *(alirocumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PRAVACHOL 20 MG TABLET *(use pravastatin sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
PRAVACHOL 40 MG TABLET *(use pravastatin sodium)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
QUESTRAN LIGHT POWDER *(use cholestyramine/aspartame)*	PA	Prior Authorization required.
QUESTRAN PACKET *(use cholestyramine (with sugar))*	PA	Prior Authorization required.
QUESTRAN POWDER *(use cholestyramine (with sugar))*	PA	Prior Authorization required.
REPATHA 140 MG/ML SURECLICK *(evolocumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REPATHA 140 MG/ML SYRINGE *(evolocumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REPATHA 420 MG/3.5ML PUSHTRONX *(evolocumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TRICOR 145 MG TABLET *(use fenofibrate nanocrystallized)*	PA	Prior Authorization required.
TRICOR 48 MG TABLET *(use fenofibrate nanocrystallized)*	PA	Prior Authorization required.
TRILIPIX DR 135 MG CAPSULE *(use fenofibric acid (choline))*	PA	Prior Authorization required.
TRILIPIX DR 45 MG CAPSULE *(use fenofibric acid (choline))*	PA	Prior Authorization required.
VASCEPA 0.5 GM CAPSULE *(icosapent ethyl)*	PA	Prior Authorization required.

Drug List

ANTIHYPERLIPIDEMICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VASCEPA 1 GM CAPSULE *(icosapent ethyl)*	PA	Prior Authorization required.
VYTORIN 10-10 MG TABLET *(ezetimibe/simvastatin)*	PA	Prior Authorization required.
VYTORIN 10-20 MG TABLET *(ezetimibe/simvastatin)*	PA	Prior Authorization required.
VYTORIN 10-40 MG TABLET *(ezetimibe/simvastatin)*	PA	Prior Authorization required.
VYTORIN 10-80 MG TABLET *(ezetimibe/simvastatin)*	PA	Prior Authorization required.
WELCHOL 3.75G PACKET *(colesevelam hcl)*	PA	Prior Authorization required.
WELCHOL 625 MG TABLET *(colesevelam hcl)*	PA	Prior Authorization required.
ZETIA 10 MG TABLET *(use ezetimibe)*	PA	Prior Authorization required.
ZOCOR 10 MG TABLET *(use simvastatin)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOCOR 20 MG TABLET *(use simvastatin)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOCOR 40 MG TABLET *(use simvastatin)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOCOR 80 MG TABLET *(use simvastatin)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZYPITAMAG 1 MG TABLET *(pitavastatin magnesium)*	PA	Prior Authorization required.
ZYPITAMAG 2 MG TABLET *(pitavastatin magnesium)*	PA	Prior Authorization required.
ZYPITAMAG 4 MG TABLET *(pitavastatin magnesium)*	PA	Prior Authorization required.
Antihypertensive Therapy Agents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
isoxsuprine 10 mg tablet (VASODILAN)	QL	Limited to 120 EA per 30 days.
isoxsuprine 20 mg tablet (VASODILAN)	QL	Limited to 120 EA per 30 days.
ANTIMYASTHENIC AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
pyridostigmine 60 mg/5 ml soln (MESTINON)		
pyridostigmine br 30 mg tablet		
pyridostigmine br 60 mg tablet (MESTINON)		
pyridostigmine er 180 mg tab (MESTINON)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FIRDAPSE 10 MG TABLET *(amifampridine phosphate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
guanidine hcl 125 mg tablet	PA	Prior Authorization required.
MESTINON 180 MG TIMESPAN *(use pyridostigmine bromide)*	PA	Prior Authorization required.
MESTINON 60 MG TABLET *(use pyridostigmine bromide)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTIMYASTHENIC AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
MESTINON 60 MG/5 ML SOLUTION *(use pyridostigmine bromide)*	PA	Prior Authorization required.
RUZURGI 10 MG TABLET *(amifampridine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Antineoplastic - Antimetabolites		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
methotrexate 1 gram/40 ml vial (METHOTREXATE)		
methotrexate 250 mg/10 ml vial (METHOTREXATE)		
methotrexate 250 mg/10 ml vial (METHOTREXATE SODIUM)		
methotrexate 50 mg/2 ml vial (METHOTREXATE)		
methotrexate 50 mg/2 ml vial (METHOTREXATE SODIUM)		
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ALKYLATING AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cyclophosphamide 25 mg capsule		
cyclophosphamide 50 mg capsule		
GLEOSTINE 10 MG CAPSULE *(lomustine)*	SP	Restricted to specialty pharmacies.
GLEOSTINE 100 MG CAPSULE *(lomustine)*	SP	Restricted to specialty pharmacies.
GLEOSTINE 40 MG CAPSULE *(lomustine)*	SP	Restricted to specialty pharmacies.
GLEOSTINE 5 MG CAPSULE *(lomustine)*	SP	Restricted to specialty pharmacies.
LEUKERAN 2 MG TABLET *(chlorambucil)*	SP	Restricted to specialty pharmacies.
melphalan 2 mg tablet (ALKERAN)		
MYLERAN 2 MG TABLET *(busulfan)*	SP	Restricted to specialty pharmacies.
temozolomide 100 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
temozolomide 140 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
temozolomide 180 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
temozolomide 20 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
temozolomide 250 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
temozolomide 5 mg capsule (TEMODAR)	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALKERAN 2 MG TABLET *(use melphalan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TEMODAR 100 MG CAPSULE *(use temozolomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TEMODAR 140 MG CAPSULE *(use temozolomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TEMODAR 180 MG CAPSULE *(use temozolomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ALKYLATING AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TEMODAR 20 MG CAPSULE *(use temozolomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TEMODAR 250 MG CAPSULE *(use temozolomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTIMETABOLITES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
mercaptopurine 50 mg tablet (PURINETHOL)		
methotrexate 2.5 mg tablet		
TABLOID 40 MG TABLET *(thioguanine)*	SP	Restricted to specialty pharmacies.
TREXALL 10 MG TABLET *(methotrexate sodium)*		
TREXALL 15 MG TABLET *(methotrexate sodium)*		
TREXALL 5 MG TABLET *(methotrexate sodium)*		
TREXALL 7.5 MG TABLET *(methotrexate sodium)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
capecitabine 150 mg tablet (XELODA)	PA	Prior Authorization required.
capecitabine 500 mg tablet (XELODA)	PA	Prior Authorization required.
ONUREG 200 MG TABLET *(azacitidine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ONUREG 300 MG TABLET *(azacitidine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PURIXAN 20 MG/ML ORAL SUSP *(mercaptopurine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XATMEP 2.5 MG/ML ORAL SOLUTION *(methotrexate)*	PA	Prior Authorization required.
XELODA 150 MG TABLET *(capecitabine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XELODA 500 MG TABLET *(capecitabine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC - HORMONAL AND RELATED		
Drug Name	**Drug Status**	**Criteria**
Preferred		
abiraterone 500 mg tablet (ZYTIGA)		
abiraterone acetate 250 mg tab (ZYTIGA)		
anastrozole 1 mg tablet (ARIMIDEX)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 40 and older.
bicalutamide 50 mg tablet (CASODEX)		
EMCYT 140 MG CAPSULE *(estramustine phosphate sodium)*	SP	Restricted to specialty pharmacies.
exemestane 25 mg tablet (AROMASIN)	AL	Limited to members age 40 and older.
flutamide 125 mg capsule (EULEXIN)		
letrozole 2.5 mg tablet (FEMARA)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 40 and older.
LYSODREN 500 MG TABLET *(mitotane)*	SP	Restricted to specialty pharmacies.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC - HORMONAL AND RELATED		
Drug Name	**Drug Status**	**Criteria**
Preferred		
megestrol 20 mg tablet (MEGACE)		
megestrol 40 mg tablet (MEGACE)		
megestrol 800 mg/20 ml susp		
megestrol acet 40 mg/ml susp (MEGACE)		
megestrol acet 400 mg/10 ml		
nilutamide 150 mg tablet (NILANDRON)	SP	Restricted to specialty pharmacies.
SOLTAMOX 20 MG/10 ML SOLN *(tamoxifen citrate)*		
tamoxifen 10 mg tablet (NOLVADEX)	QL	Limited to 60 EA per 30 days.
tamoxifen 20 mg tablet (NOLVADEX)	QL	Limited to 60 EA per 30 days.
toremifene citrate 60 mg tab (FARESTON)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARIMIDEX 1 MG TABLET *(use anastrozole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 40 and older.
AROMASIN 25 MG TABLET *(use exemestane)*	PA,SP,AL	Restricted to specialty pharmacies. Prior Authorization required. Limited to members age 40 and older.
CASODEX 50 MG TABLET *(use bicalutamide)*	PA	Prior Authorization required.
ERLEADA 60 MG TABLET *(apalutamide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FARESTON 60 MG TABLET *(use toremifene citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FEMARA 2.5 MG TABLET *(use letrozole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members age 40 and older.
NUBEQA 300 MG TABLET *(darolutamide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XTANDI 40 MG CAPSULE *(enzalutamide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
YONSA 125 MG TABLET *(abiraterone acetate, submicronized)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYTIGA 250 MG TABLET *(use abiraterone acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYTIGA 500 MG TABLET *(use abiraterone acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CAPRELSA 100 MG TABLET *(vandetanib)*	SP	Restricted to specialty pharmacies.
CAPRELSA 300 MG TABLET *(vandetanib)*	SP	Restricted to specialty pharmacies.
erlotinib hcl 100 mg tablet (TARCEVA)		
erlotinib hcl 150 mg tablet (TARCEVA)		
erlotinib hcl 25 mg tablet (TARCEVA)		
IRESSA 250 MG TABLET *(gefitinib)*	SP	Restricted to specialty pharmacies.
JAKAFI 10 MG TABLET *(ruxolitinib phosphate)*	SP	Restricted to specialty pharmacies.
JAKAFI 15 MG TABLET *(ruxolitinib phosphate)*	SP	Restricted to specialty pharmacies.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
JAKAFI 20 MG TABLET *(ruxolitinib phosphate)*	SP	Restricted to specialty pharmacies.
JAKAFI 25 MG TABLET *(ruxolitinib phosphate)*	SP	Restricted to specialty pharmacies.
JAKAFI 5 MG TABLET *(ruxolitinib phosphate)*	SP	Restricted to specialty pharmacies.
NEXAVAR 200 MG TABLET *(sorafenib tosylate)*	SP	Restricted to specialty pharmacies.
SUTENT 12.5 MG CAPSULE *(sunitinib malate)*	SP	Restricted to specialty pharmacies.
SUTENT 25 MG CAPSULE *(sunitinib malate)*	SP	Restricted to specialty pharmacies.
SUTENT 37.5 MG CAPSULE *(sunitinib malate)*	SP	Restricted to specialty pharmacies.
SUTENT 50 MG CAPSULE *(sunitinib malate)*	SP	Restricted to specialty pharmacies.
VOTRIENT 200 MG TABLET *(pazopanib hcl)*	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AFINITOR 10 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR 2.5 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR 5 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR 7.5 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR DISPERZ 2 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR DISPERZ 3 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFINITOR DISPERZ 5 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALECENSA 150 MG CAPSULE *(alectinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALUNBRIG 180 MG TABLET *(brigatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALUNBRIG 30 MG TABLET *(brigatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALUNBRIG 90 MG TABLET *(brigatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALUNBRIG 90 MG-180 MG TAB PACK *(brigatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AYVAKIT 100 MG TABLET *(avapritinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AYVAKIT 200 MG TABLET *(avapritinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AYVAKIT 300 MG TABLET *(avapritinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BALVERSA 3 MG TABLET *(erdafitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BALVERSA 4 MG TABLET *(erdafitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BALVERSA 5 MG TABLET *(erdafitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BOSULIF 100 MG TABLET *(bosutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BOSULIF 400 MG TABLET *(bosutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BOSULIF 500 MG TABLET *(bosutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BRAFTOVI 75 MG CAPSULE *(encorafenib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BRUKINSA 80 MG CAPSULE *(zanubrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CABOMETYX 20 MG TABLET *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CABOMETYX 40 MG TABLET *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CABOMETYX 60 MG TABLET *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CALQUENCE 100 MG CAPSULE *(acalabrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COMETRIQ 100 MG DAILY-DOSE PK *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COMETRIQ 140 MG DAILY-DOSE PK *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COMETRIQ 60 MG DAILY-DOSE PACK *(cabozantinib s-malate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COPIKTRA 15 MG CAPSULE *(duvelisib)*	PA	Prior Authorization required.
COPIKTRA 25 MG CAPSULE *(duvelisib)*	PA	Prior Authorization required.
COTELLIC 20 MG TABLET *(cobimetinib fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
everolimus 2.5 mg tablet (AFINITOR)	PA	Prior Authorization required.
everolimus 5 mg tablet (AFINITOR)	PA	Prior Authorization required.
everolimus 7.5 mg tablet (AFINITOR)	PA	Prior Authorization required.
FARYDAK 10 MG CAPSULE *(panobinostat lactate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FARYDAK 15 MG CAPSULE *(panobinostat lactate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FARYDAK 20 MG CAPSULE *(panobinostat lactate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GAVRETO 100 MG CAPSULE *(pralsetinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GILOTRIF 20 MG TABLET *(afatinib dimaleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GILOTRIF 30 MG TABLET *(afatinib dimaleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GILOTRIF 40 MG TABLET *(afatinib dimaleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GLEEVEC 100 MG TABLET *(imatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GLEEVEC 400 MG TABLET *(imatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 100 MG CAPSULE *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 100 MG TABLET *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 125 MG CAPSULE *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 125 MG TABLET *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 75 MG CAPSULE *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IBRANCE 75 MG TABLET *(palbociclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ICLUSIG 10 MG TABLET *(ponatinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ICLUSIG 15 MG TABLET *(ponatinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ICLUSIG 30 MG TABLET *(ponatinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ICLUSIG 45 MG TABLET *(ponatinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
IDHIFA 100 MG TABLET *(enasidenib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDHIFA 50 MG TABLET *(enasidenib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
imatinib mesylate 100 mg tab (GLEEVEC)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
imatinib mesylate 400 mg tab (GLEEVEC)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 140 MG CAPSULE *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 140 MG TABLET *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 280 MG TABLET *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 420 MG TABLET *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 560 MG TABLET *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IMBRUVICA 70 MG CAPSULE *(ibrutinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INLYTA 1 MG TABLET *(axitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INLYTA 5 MG TABLET *(axitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INREBIC 100 MG CAPSULE *(fedratinib dihydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KISQALI 200 MG DAILY DOSE *(ribociclib succinate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KISQALI 400 MG DAILY DOSE *(ribociclib succinate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KISQALI 600 MG DAILY DOSE *(ribociclib succinate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOSELUGO 10 MG CAPSULE *(selumetinib sulfate/vitamin e tpgs)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
KOSELUGO 25 MG CAPSULE *(selumetinib sulfate/vitamin e tpgs)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
lapatinib 250 mg tablet (TYKERB)	PA	Prior Authorization required.
LENVIMA 10 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 12 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 14 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 18 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 20 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 24 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 4 MG CAPSULE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LENVIMA 8 MG DAILY DOSE *(lenvatinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LORBRENA 100 MG TABLET *(lorlatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LORBRENA 25 MG TABLET *(lorlatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LYNPARZA 100 MG TABLET *(olaparib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LYNPARZA 150 MG TABLET *(olaparib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MEKINIST 0.5 MG TABLET *(trametinib dimethyl sulfoxide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
MEKINIST 2 MG TABLET *(trametinib dimethyl sulfoxide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MEKTOVI 15 MG TABLET *(binimetinib)*	PA	Prior Authorization required.
NERLYNX 40 MG TABLET *(neratinib maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NINLARO 2.3 MG CAPSULE *(ixazomib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NINLARO 3 MG CAPSULE *(ixazomib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NINLARO 4 MG CAPSULE *(ixazomib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PEMAZYRE 13.5 MG TABLET *(pemigatinib)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PEMAZYRE 4.5 MG TABLET *(pemigatinib)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PEMAZYRE 9 MG TABLET *(pemigatinib)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PIQRAY 200 MG DAILY DOSE *(alpelisib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PIQRAY 250 MG DAILY DOSE *(alpelisib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PIQRAY 300 MG DAILY DOSE *(alpelisib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
QINLOCK 50 MG TABLET *(ripretinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RETEVMO 40 MG CAPSULE *(selpercatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RETEVMO 80 MG CAPSULE *(selpercatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ROZLYTREK 100 MG CAPSULE *(entrectinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ROZLYTREK 200 MG CAPSULE *(entrectinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RUBRACA 200 MG TABLET *(rucaparib camsylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RUBRACA 250 MG TABLET *(rucaparib camsylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RUBRACA 300 MG TABLET *(rucaparib camsylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RYDAPT 25 MG CAPSULE *(midostaurin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 100 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 140 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 20 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 50 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 70 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPRYCEL 80 MG TABLET *(dasatinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
STIVARGA 40 MG TABLET *(regorafenib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TABRECTA 150 MG TABLET *(capmatinib hydrochloride)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
TABRECTA 200 MG TABLET *(capmatinib hydrochloride)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
TAFINLAR 50 MG CAPSULE *(dabrafenib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TAFINLAR 75 MG CAPSULE *(dabrafenib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TAGRISSO 40 MG TABLET *(osimertinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : ANTINEOPLASTIC ENZYME INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TAGRISSO 80 MG TABLET *(osimertinib mesylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TALZENNA 0.25 MG CAPSULE *(talazoparib tosylate)*	PA	Prior Authorization required.
TALZENNA 1 MG CAPSULE *(talazoparib tosylate)*	PA	Prior Authorization required.
TARCEVA 100 MG TABLET *(use erlotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TARCEVA 150 MG TABLET *(use erlotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TARCEVA 25 MG TABLET *(use erlotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TASIGNA 150 MG CAPSULE *(nilotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TASIGNA 200 MG CAPSULE *(nilotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TASIGNA 50 MG CAPSULE *(nilotinib hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TAZVERIK 200 MG TABLET *(tazemetostat hydrobromide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TIBSOVO 250 MG TABLET *(ivosidenib)*	PA	Prior Authorization required.
TUKYSA 150 MG TABLET *(tucatinib)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
TUKYSA 50 MG TABLET *(tucatinib)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
TURALIO 200 MG CAPSULE *(pexidartinib hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TYKERB 250 MG TABLET *(lapatinib ditosylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VERZENIO 100 MG TABLET *(abemaciclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VERZENIO 150 MG TABLET *(abemaciclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VERZENIO 200 MG TABLET *(abemaciclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VERZENIO 50 MG TABLET *(abemaciclib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VITRAKVI 100 MG CAPSULE *(larotrectinib sulfate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VITRAKVI 20 MG/ML SOLUTION *(larotrectinib sulfate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VITRAKVI 25 MG CAPSULE *(larotrectinib sulfate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VIZIMPRO 15 MG TABLET *(dacomitinib)*	PA	Prior Authorization required.
VIZIMPRO 30 MG TABLET *(dacomitinib)*	PA	Prior Authorization required.
VIZIMPRO 45 MG TABLET *(dacomitinib)*	PA	Prior Authorization required.
XALKORI 200 MG CAPSULE *(crizotinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XALKORI 250 MG CAPSULE *(crizotinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XOSPATA 40 MG TABLET *(gilteritinib fumarate)*	PA	Prior Authorization required.
ZEJULA 100 MG CAPSULE *(niraparib tosylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZELBORAF 240 MG TABLET *(vemurafenib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZOLINZA 100 MG CAPSULE *(vorinostat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYDELIG 100 MG TABLET *(idelalisib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYDELIG 150 MG TABLET *(idelalisib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZYKADIA 150 MG TABLET *(ceritinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : CHEMOTHERAPY RESCUE / ANTIDOTE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
leucovorin calcium 10 mg tab		
leucovorin calcium 15 mg tab		
leucovorin calcium 25 mg tab		
leucovorin calcium 5 mg tab		
MESNEX 400 MG TABLET *(mesna)*	SP	Restricted to specialty pharmacies.

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
bexarotene 75 mg capsule (TARGRETIN)	SP	Restricted to specialty pharmacies.
ERIVEDGE 150 MG CAPSULE *(vismodegib)*	SP	Restricted to specialty pharmacies.
HYCAMTIN 0.25 MG CAPSULE *(topotecan hcl)*	SP	Restricted to specialty pharmacies.
HYCAMTIN 1 MG CAPSULE *(topotecan hcl)*	SP	Restricted to specialty pharmacies.
hydroxyurea 500 mg capsule (HYDREA)		
MATULANE 50 MG CAPSULE *(procarbazine hcl)*	SP	Restricted to specialty pharmacies.
tretinoin 10 mg capsule (VESANOID)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DAURISMO 100 MG TABLET *(glasdegib maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DAURISMO 25 MG TABLET *(glasdegib maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HYDREA 500 MG CAPSULE *(use hydroxyurea)*	PA	Prior Authorization required.
INQOVI 35 MG-100 MG TABLET *(decitabine/cedazuridine)*	PA	Prior Authorization required
KISQALI FEMARA 200 MG CO-PACK *(ribociclib succinate/letrozole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KISQALI FEMARA 400 MG CO-PACK *(ribociclib succinate/letrozole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KISQALI FEMARA 600 MG CO-PACK *(ribociclib succinate/letrozole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LONSURF 15 MG-6.14 MG TABLET *(trifluridine/tipiracil hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LONSURF 20 MG-8.19 MG TABLET *(trifluridine/tipiracil hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ODOMZO 200 MG CAPSULE *(sonidegib phosphate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
POMALYST 1 MG CAPSULE *(pomalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
POMALYST 2 MG CAPSULE *(pomalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
POMALYST 3 MG CAPSULE *(pomalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
POMALYST 4 MG CAPSULE *(pomalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TARGRETIN 75 MG CAPSULE *(use bexarotene)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENCLEXTA 10 MG TAB (10MG X 2) *(venetoclax)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENCLEXTA 10 MG TABLET *(venetoclax)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENCLEXTA 100 MG TABLET *(venetoclax)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENCLEXTA 50 MG TABLET *(venetoclax)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENCLEXTA STARTING PACK *(venetoclax)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 100 MG ONCE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 40 MG ONCE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 40 MG TWICE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 60 MG ONCE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 60 MG TWICE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 80 MG ONCE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XPOVIO 80 MG TWICE WEEKLY DOSE *(selinexor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES : MITOTIC INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
etoposide 50 mg capsule (VEPESID)		
ANTIPARASITICS : ANTHELMINTICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
praziquantel 600 mg tablet (BILTRICIDE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
albendazole 200 mg tablet (ALBENZA)	PA	Prior Authorization required.
ALBENZA 200 MG TABLET *(albendazole)*	PA	Prior Authorization required.
benznidazole 100 mg tablet	PA	Prior Authorization required.
benznidazole 12.5 mg tablet	PA	Prior Authorization required.
BILTRICIDE 600 MG TABLET *(use praziquantel)*	PA	Prior Authorization required.
EGATEN 250 MG TABLET *(triclabendazole)*	PA	Prior Authorization required.
EMVERM 100 MG TABLET CHEW *(mebendazole)*	PA	Prior Authorization required.
ivermectin 3 mg tablet (STROMECTOL)	PA	Prior Authorization required.
STROMECTOL 3 MG TABLET *(ivermectin)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPARASITICS : ANTIMALARIALS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
atovaquone-proguanil 250-100 (MALARONE)		
atovaquone-proguanil 62.5-25 (MALARONE)		
chloroquine ph 250 mg tablet (CHLOROQUINE PHOSPHATE)		
chloroquine ph 500 mg tablet (ARALEN PHOSPHATE)		
hydroxychloroquine 200 mg tab (PLAQUENIL)		
mefloquine hcl 250 mg tablet (LARIAM)		
primaquine 26.3 mg tablet (PRIMAQUINE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
COARTEM TABLETS *(artemether/lumefantrine)*	PA	Prior Authorization required.
DARAPRIM 25 MG TABLET *(pyrimethamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KRINTAFEL 150 MG TABLET *(tafenoquine succinate)*	PA	Prior Authorization required.
MALARONE 250-100 MG TABLET *(use atovaquone/proguanil hcl)*	PA	Prior Authorization required.
MALARONE 62.5-25 MG PED TAB *(use atovaquone/proguanil hcl)*	PA	Prior Authorization required.
pyrimethamine 25 mg tablet (DARAPRIM)	PA	Prior Authorization Required.
QUALAQUIN 324 MG CAPSULE *(quinine sulfate)*	PA	Prior Authorization required.
quinine sulfate 324 mg capsule (QUALAQUIN)	PA	Prior Authorization required.
ANTIPARKINSON AND RELATED THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amantadine 100 mg capsule (SYMMETREL)		
amantadine 100 mg tablet (SYMMETREL)		
amantadine 100 mg/10 ml soln (SYMMETREL)		
amantadine 50 mg/5 ml solution (SYMMETREL)		
benztropine mes 0.5 mg tab (COGENTIN)		
benztropine mes 1 mg tablet (COGENTIN)		
benztropine mes 2 mg tablet (COGENTIN)		
bromocriptine 2.5 mg tablet (PARLODEL)		
bromocriptine 5 mg capsule (PARLODEL)		
carbidopa 25 mg tablet (LODOSYN)		
carbidopa-levo er 25-100 tab (SINEMET CR)		
carbidopa-levo er 50-200 tab (SINEMET CR)		
carbidopa-levodopa 10-100 tab (SINEMET 10-100)		

Drug List

ANTIPARKINSON AND RELATED THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
carbidopa-levodopa 25-100 tab (SINEMET 25-100)		
carbidopa-levodopa 25-250 tab (SINEMET 25-250)		
entacapone 200 mg tablet (COMTAN)		
pramipexole 0.125 mg tablet (MIRAPEX)		
pramipexole 0.25 mg tablet (MIRAPEX)		
pramipexole 0.5 mg tablet (MIRAPEX)		
pramipexole 0.75 mg tablet (MIRAPEX)		
pramipexole 1 mg tablet (MIRAPEX)		
pramipexole 1.5 mg tablet (MIRAPEX)		
ropinirole hcl 0.25 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 0.5 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 1 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 2 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 3 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 4 mg tablet (REQUIP)	QL	Limited to 90 EA per 30 days.
ropinirole hcl 5 mg tablet (REQUIP)	QL	Limited to 150 EA per 30 days.
selegiline hcl 5 mg capsule (ELDEPRYL)		
selegiline hcl 5 mg tablet (ELDEPRYL)		
trihexyphenidyl 2 mg tablet (ARTANE)		
trihexyphenidyl 2 mg/5 ml elx (ARTANE)		
trihexyphenidyl 5 mg tablet (ARTANE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
APOKYN 30 MG/3 ML CARTRIDGE *(apomorphine hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AZILECT 0.5 MG TABLET *(rasagiline mesylate)*	PA	Prior Authorization required.
AZILECT 1 MG TABLET *(rasagiline mesylate)*	PA	Prior Authorization required.
carbidopa-levo 10-100 mg odt (PARCOPA)	PA	Prior Authorization required.
carbidopa-levo 25-100 mg odt (PARCOPA)	PA	Prior Authorization required.
carbidopa-levo 25-250 mg odt (PARCOPA)	PA	Prior Authorization required.
carbidopa-levodopa 100 mg-enta (STALEVO 100)	PA	Prior Authorization required.
carbidopa-levodopa 125 mg-enta (STALEVO 125)	PA	Prior Authorization required.
carbidopa-levodopa 150 mg-enta (STALEVO 150)	PA	Prior Authorization required.
carbidopa-levodopa 200 mg-enta (STALEVO 200)	PA	Prior Authorization required.
carbidopa-levodopa 50 mg-enta (STALEVO 50)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPARKINSON AND RELATED THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
carbidopa-levodopa 75 mg-enta (STALEVO 75)	PA	Prior Authorization required.
COMTAN 200 MG TABLET *(use entacapone)*	PA	Prior Authorization required.
GOCOVRI ER 137 MG CAPSULE *(amantadine hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GOCOVRI ER 68.5 MG CAPSULE *(amantadine hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INBRIJA 42 MG INHALATION CAP *(levodopa)*	PA	Prior Authorization required.
KYNMOBI 10 MG SL FILM *(apomorphine hcl)*	PA	Prior Authorization required.
KYNMOBI 15 MG SL FILM *(apomorphine hcl)*	PA	Prior Authorization required.
KYNMOBI 20 MG SL FILM *(apomorphine hcl)*	PA	Prior Authorization required.
KYNMOBI 25 MG SL FILM *(apomorphine hcl)*	PA	Prior Authorization required.
KYNMOBI 30 MG SL FILM *(apomorphine hcl)*	PA	Prior Authorization required.
KYNMOBI TITRATION KIT *(apomorphine hcl)*	PA	Prior Authorization required.
LODOSYN 25 MG TABLET *(use carbidopa)*	PA	Prior Authorization required.
MIRAPEX ER 0.375 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 0.75 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 1.5 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 2.25 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 3 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 3.75 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
MIRAPEX ER 4.5 MG TABLET *(pramipexole di-hcl)*	PA	Prior Authorization required.
NEUPRO 1 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NEUPRO 2 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NEUPRO 3 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NEUPRO 4 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NEUPRO 6 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NEUPRO 8 MG/24 HR PATCH *(rotigotine)*	PA	Prior Authorization required.
NOURIANZ 20 MG TABLET *(istradefylline)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOURIANZ 40 MG TABLET *(istradefylline)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ONGENTYS 25 MG CAPSULE *(opicapone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ONGENTYS 50 MG CAPSULE *(opicapone)*	PA	Prior Authorization required.
OSMOLEX ER 129 MG TABLET *(amantadine hcl)*	PA	Prior Authorization required.
OSMOLEX ER 193 MG TABLET *(amantadine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPARKINSON AND RELATED THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OSMOLEX ER 258 MG TABLET *(amantadine hcl)*	PA	Prior Authorization required.
OSMOLEX ER 322 MG DAILY DOSE *(amantadine hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
PARLODEL 2.5 MG TABLET *(use bromocriptine mesylate)*	PA	Prior Authorization required.
PARLODEL 5 MG CAPSULE *(use bromocriptine mesylate)*	PA	Prior Authorization required.
pramipexole er 0.375 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 0.75 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 1.5 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 2.25 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 3 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 3.75 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
pramipexole er 4.5 mg tablet (MIRAPEX ER)	PA	Prior Authorization required.
rasagiline mesylate 0.5 mg tab (AZILECT)	PA	Prior Authorization required.
rasagiline mesylate 1 mg tab (AZILECT)	PA	Prior Authorization required.
ropinirole hcl er 12 mg tablet (REQUIP XL)	PA	Prior Authorization required.
ropinirole hcl er 2 mg tablet (REQUIP XL)	PA	Prior Authorization required.
ropinirole hcl er 4 mg tablet (REQUIP XL)	PA	Prior Authorization required.
ropinirole hcl er 6 mg tablet (REQUIP XL)	PA	Prior Authorization required.
ropinirole hcl er 8 mg tablet (REQUIP XL)	PA	Prior Authorization required.
RYTARY ER 23.75 MG-95 MG CAP *(carbidopa/levodopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RYTARY ER 36.25 MG-145 MG CAP *(carbidopa/levodopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RYTARY ER 48.75 MG-195 MG CAP *(carbidopa/levodopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RYTARY ER 61.25 MG-245 MG CAP *(carbidopa/levodopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SINEMET 10-100 MG TABLET *(use carbidopa/levodopa)*	PA	Prior Authorization required.
SINEMET 25-100 MG TABLET *(use carbidopa/levodopa)*	PA	Prior Authorization required.
SINEMET 25-250 MG TABLET *(use carbidopa/levodopa)*	PA	Prior Authorization required.
STALEVO 100 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.
STALEVO 125 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.
STALEVO 150 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.
STALEVO 200 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.
STALEVO 50 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPARKINSON AND RELATED THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
STALEVO 75 TABLET *(carbidopa/levodopa/entacapone)*	PA	Prior Authorization required.
TASMAR 100 MG TABLET *(tolcapone)*	PA	Prior Authorization required.
tolcapone 100 mg tablet (TASMAR)	PA	Prior Authorization required.
XADAGO 100 MG TABLET *(safinamide mesylate)*	PA	Prior Authorization required.
XADAGO 50 MG TABLET *(safinamide mesylate)*	PA	Prior Authorization required.
ZELAPAR 1.25 MG ODT TABLET *(selegiline hcl)*	PA	Prior Authorization required.
Antipsychotics (Neuroleptics)		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
fluphenazine 2.5 mg/ml vial (PROLIXIN)		
haloperidol dec 100 mg/ml amp (HALDOL DECANOATE 100)		
haloperidol dec 100 mg/ml vial (HALDOL DECANOATE 100)		
haloperidol dec 250 mg/5 ml vl (HALDOL DECANOATE 50)		
haloperidol dec 50 mg/ml vial (HALDOL DECANOATE 50)		
haloperidol dec 500 mg/5 ml vl (HALDOL DECANOATE 100)		
haloperidol decan 50 mg/ml amp (HALDOL DECANOATE 50)		
ANTIPSYCHOTICS / ANTIMANIC AGENTS : BENZISOXAZOLES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
risperidone 0.25 mg tablet (RISPERDAL)		
risperidone 0.5 mg tablet (RISPERDAL)		
risperidone 1 mg tablet (RISPERDAL)		
risperidone 1 mg/ml solution (RISPERDAL)		
risperidone 2 mg tablet (RISPERDAL)		
risperidone 3 mg tablet (RISPERDAL)		
risperidone 4 mg tablet (RISPERDAL)		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
INVEGA SUSTENNA 117 MG/0.75 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA SUSTENNA 156 MG/ML SYRG *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA SUSTENNA 234 MG/1.5 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA SUSTENNA 39 MG/0.25 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : BENZISOXAZOLES		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
INVEGA SUSTENNA 78 MG/0.5 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA TRINZA 273 MG/0.875 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA TRINZA 410 MG/1.315 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA TRINZA 546 MG/1.75 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA TRINZA 819 MG/2.625 ML *(paliperidone palmitate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FANAPT 1 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 10 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 12 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 2 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 4 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 6 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT 8 MG TABLET *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to members 8 years and older.
FANAPT TITRATION PACK *(iloperidone)*	PA,QL,AL	Prior Authorization required. Limited to 8 EA per 30 days. Limited to members 8 years and older.
INVEGA ER 1.5 MG TABLET *(paliperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA ER 3 MG TABLET *(paliperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA ER 6 MG TABLET *(paliperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
INVEGA ER 9 MG TABLET *(paliperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
paliperidone er 1.5 mg tablet (INVEGA)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
paliperidone er 3 mg tablet (INVEGA)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
paliperidone er 6 mg tablet (INVEGA)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
paliperidone er 9 mg tablet (INVEGA)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
PERSERIS ER 120 MG SYRINGE KIT *(risperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
PERSERIS ER 90 MG SYRINGE KIT *(risperidone)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
RISPERDAL 0.5 MG TABLET *(use risperidone)*	PA	Prior Authorization required.
RISPERDAL 1 MG TABLET *(use risperidone)*	PA	Prior Authorization required.
RISPERDAL 1 MG/ML SOLUTION *(use risperidone)*	PA	Prior Authorization required.
RISPERDAL 2 MG TABLET *(use risperidone)*	PA	Prior Authorization required.
RISPERDAL 3 MG TABLET *(use risperidone)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : BENZISOXAZOLES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
RISPERDAL 4 MG TABLET *(use risperidone)*	PA	Prior Authorization required.
RISPERDAL CONSTA 12.5 MG VIAL *(risperidone microspheres)*	PA	Prior Authorization required.
RISPERDAL CONSTA 25 MG VIAL *(risperidone microspheres)*	PA	Prior Authorization required.
RISPERDAL CONSTA 37.5 MG VIAL *(risperidone microspheres)*	PA	Prior Authorization required.
RISPERDAL CONSTA 50 MG VIAL *(risperidone microspheres)*	PA	Prior Authorization required.
risperidone 0.25 mg odt	PA	Prior Authorization required.
risperidone 0.5 mg odt (RISPERDAL M-TAB)	PA	Prior Authorization required.
risperidone 1 mg odt (RISPERDAL M-TAB)	PA	Prior Authorization required.
risperidone 2 mg odt (RISPERDAL M-TAB)	PA	Prior Authorization required.
risperidone 3 mg odt (RISPERDAL M-TAB)	PA	Prior Authorization required.
risperidone 4 mg odt (RISPERDAL M-TAB)	PA	Prior Authorization required.

ANTIPSYCHOTICS / ANTIMANIC AGENTS : DIBENZAPINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clozapine 100 mg tablet (CLOZARIL)		
clozapine 200 mg tablet (CLOZARIL)		
clozapine 25 mg tablet (CLOZARIL)		
clozapine 50 mg tablet (CLOZARIL)		
loxapine 10 mg capsule (LOXITANE)		
loxapine 25 mg capsule (LOXITANE)		
loxapine 5 mg capsule (LOXITANE)		
loxapine 50 mg capsule (LOXITANE)		
olanzapine 10 mg tablet (ZYPREXA)		
olanzapine 15 mg tablet (ZYPREXA)		
olanzapine 2.5 mg tablet (ZYPREXA)		
olanzapine 20 mg tablet (ZYPREXA)		
olanzapine 5 mg tablet (ZYPREXA)		
olanzapine 7.5 mg tablet (ZYPREXA)		
olanzapine odt 10 mg tablet (ZYPREXA ZYDIS)		
olanzapine odt 10 mg tablet (ZYPREXA ZYDIS)	AL	Limited to members age 8 and older.
olanzapine odt 15 mg tablet (ZYPREXA ZYDIS)		
olanzapine odt 20 mg tablet (ZYPREXA ZYDIS)		
olanzapine odt 5 mg tablet (ZYPREXA ZYDIS)		
quetiapine er 150 mg tablet (SEROQUEL XR)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : DIBENZAPINES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
quetiapine er 200 mg tablet (SEROQUEL XR)		
quetiapine er 300 mg tablet (SEROQUEL XR)		
quetiapine er 400 mg tablet (SEROQUEL XR)		
quetiapine er 50 mg tablet (SEROQUEL XR)		
quetiapine fumarate 100 mg tab (SEROQUEL)		
quetiapine fumarate 200 mg tab (SEROQUEL)		
quetiapine fumarate 25 mg tab (SEROQUEL)		
quetiapine fumarate 300 mg tab (SEROQUEL)		
quetiapine fumarate 400 mg tab (SEROQUEL)		
quetiapine fumarate 50 mg tab (SEROQUEL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADASUVE 10 MG INHALATION POWDR *(loxapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
asenapine 10 mg tablet sl (SAPHRIS)	PA,AL	Prior Authorization required. Limited to members age 8 and older.
asenapine 2.5 mg tablet sl (SAPHRIS)	PA,AL	Prior Authorization required. Limited to members age 8 and older.
asenapine 5 mg tablet sl (SAPHRIS)	PA,AL	Prior Authorization required. Limited to members age 8 and older.
clozapine odt 100 mg tablet (FAZACLO)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
clozapine odt 12.5 mg tablet (FAZACLO)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
clozapine odt 150 mg tablet (FAZACLO)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
clozapine odt 200 mg tablet (FAZACLO)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
clozapine odt 25 mg tablet (FAZACLO)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
CLOZARIL 100 MG TABLET *(use clozapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
CLOZARIL 200 MG TABLET *(use clozapine)*	PA	Prior Authorization required.
CLOZARIL 25 MG TABLET *(use clozapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
CLOZARIL 50 MG TABLET *(use clozapine)*	PA	Prior Authorization required.
FAZACLO 100 MG ODT *(clozapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
FAZACLO 12.5 MG ODT *(clozapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
olanzapine 10 mg vial (ZYPREXA)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
SAPHRIS 10 MG TAB SUBLINGUAL *(asenapine maleate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
SAPHRIS 2.5 MG TAB SUBLINGUAL *(asenapine maleate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
SAPHRIS 5 MG TAB SUBLINGUAL *(asenapine maleate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
SECUADO 3.8 MG/24 HR PATCH *(asenapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SECUADO 5.7 MG/24 HR PATCH *(asenapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : DIBENZAPINES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SECUADO 7.6 MG/24 HR PATCH *(asenapine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SEROQUEL 100 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL 200 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL 25 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL 300 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL 400 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL 50 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL XR 150 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL XR 200 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL XR 300 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL XR 400 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
SEROQUEL XR 50 MG TABLET *(use quetiapine fumarate)*	PA	Prior Authorization required.
VERSACLOZ 50 MG/ML SUSPENSION *(clozapine)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ZYPREXA 10 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA 10 MG VIAL *(olanzapine)*	PA	Prior Authorization required.
ZYPREXA 15 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA 2.5 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA 20 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA 5 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA 7.5 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA RELPREVV 210 MG VL KIT *(olanzapine pamoate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ZYPREXA RELPREVV 300 MG VL KIT *(olanzapine pamoate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ZYPREXA RELPREVV 405 MG VL KIT *(olanzapine pamoate)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ZYPREXA ZYDIS 10 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA ZYDIS 15 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA ZYDIS 20 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.
ZYPREXA ZYDIS 5 MG TABLET *(use olanzapine)*	PA	Prior Authorization required.

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
chlorpromazine 10 mg tablet (THORAZINE)	QL	Limited to 120 EA per 30 days.
chlorpromazine 100 mg tablet (THORAZINE)	QL	Limited to 120 EA per 30 days.
chlorpromazine 100 mg tablet (THORAZINE)	QL	Limited to 150 EA per 30 days.
chlorpromazine 200 mg tablet (THORAZINE)	QL	Limited to 120 EA per 30 days.
chlorpromazine 25 mg tablet (THORAZINE)	QL	Limited to 120 EA per 30 days.
chlorpromazine 50 mg tablet (THORAZINE)	QL	Limited to 120 EA per 30 days.
COMPRO 25 MG SUPPOSITORY *(prochlorperazine)*		
fluphenazine 1 mg tablet (PROLIXIN)		
fluphenazine 10 mg tablet (PROLIXIN)		
fluphenazine 2.5 mg tablet (PERMITIL)		
fluphenazine 2.5 mg/5 ml elix (PROLIXIN)		
fluphenazine 5 mg tablet (PROLIXIN)		
fluphenazine 5 mg/ml conc (PERMITIL)		
haloperidol 0.5 mg tablet (HALDOL)		
haloperidol 1 mg tablet (HALDOL)		
haloperidol 10 mg tablet (HALDOL)		
haloperidol 2 mg tablet (HALDOL)		
haloperidol 20 mg tablet (HALDOL)		
haloperidol 5 mg tablet (HALDOL)		
haloperidol lac 2 mg/ml conc (HALDOL)		
lithium 8 meq/5 ml solution (CIBALITH-S)		
lithium carbonate 150 mg cap		
lithium carbonate 300 mg cap (ESKALITH)		
lithium carbonate 300 mg tab (ESKALITH)		
lithium carbonate 600 mg cap		
lithium carbonate er 300 mg tb (LITHOBID)		
lithium carbonate er 450 mg tb (ESKALITH CR)		
perphenazine 16 mg tablet (TRILAFON)		
perphenazine 2 mg tablet (PERPHENAZINE)		
perphenazine 2 mg tablet (TRILAFON)		
perphenazine 4 mg tablet (TRILAFON)		
perphenazine 8 mg tablet (TRILAFON)		
prochlorperazine 10 mg tab (COMPAZINE)		
prochlorperazine 25 mg supp (COMPAZINE)		
prochlorperazine 5 mg tablet (COMPAZINE)		
thioridazine 10 mg tablet (MELLARIL)		
thioridazine 100 mg tablet (MELLARIL)		
thioridazine 25 mg tablet (MELLARIL)		
thioridazine 50 mg tablet (MELLARIL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
thiothixene 1 mg capsule (NAVANE)		
thiothixene 10 mg capsule (NAVANE)		
thiothixene 2 mg capsule (NAVANE)		
thiothixene 5 mg capsule (NAVANE)		
trifluoperazine 1 mg tablet (STELAZINE)		
trifluoperazine 10 mg tablet (STELAZINE)		
trifluoperazine 2 mg tablet (STELAZINE)		
trifluoperazine 5 mg tablet (STELAZINE)		
ziprasidone hcl 20 mg capsule (GEODON)	QL	Limited to 60 EA per 30 days.
ziprasidone hcl 40 mg capsule (GEODON)	QL	Limited to 60 EA per 30 days.
ziprasidone hcl 60 mg capsule (GEODON)	QL	Limited to 60 EA per 30 days.
ziprasidone hcl 80 mg capsule (GEODON)	QL	Limited to 60 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CAPLYTA 42 MG CAPSULE *(lumateperone tosylate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
EQUETRO 100 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization required.
EQUETRO 200 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization required.
EQUETRO 300 MG CAPSULE *(carbamazepine)*	PA	Prior Authorization required.
GEODON 20 MG CAPSULE *(use ziprasidone hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
GEODON 20 MG/ML VIAL *(ziprasidone mesylate)*	PA	Prior Authorization required.
GEODON 40 MG CAPSULE *(use ziprasidone hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
GEODON 60 MG CAPSULE *(use ziprasidone hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
GEODON 80 MG CAPSULE *(use ziprasidone hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
LATUDA 120 MG TABLET *(lurasidone hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
LATUDA 20 MG TABLET *(lurasidone hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
LATUDA 40 MG TABLET *(lurasidone hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
LATUDA 60 MG TABLET *(lurasidone hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
LATUDA 80 MG TABLET *(lurasidone hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
LITHOBID ER 300 MG TABLET *(use lithium carbonate)*	PA	Prior Authorization required.
molindone hcl 10 mg tablet (MOBAN)	PA	Prior Authorization required.
molindone hcl 25 mg tablet (MOBAN)	PA	Prior Authorization required.
molindone hcl 5 mg tablet (MOBAN)	PA	Prior Authorization required.
NUPLAZID 10 MG TABLET *(pimavanserin tartrate)*	PA,SP,AL	Restricted to specialty pharmacies. Prior Authorization required. Limited to members 8 years and older.
NUPLAZID 17 MG TABLET *(pimavanserin tartrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NUPLAZID 34 MG CAPSULE *(pimavanserin tartrate)*	PA,SP,AL	Restricted to specialty pharmacies. Prior Authorization required. Limited to members 8 years and older.
VRAYLAR 1.5 MG CAPSULE *(cariprazine hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
VRAYLAR 1.5 MG-3 MG PACK *(cariprazine hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
VRAYLAR 3 MG CAPSULE *(cariprazine hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
VRAYLAR 4.5 MG CAPSULE *(cariprazine hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
VRAYLAR 6 MG CAPSULE *(cariprazine hcl)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ziprasidone 20 mg/ml vial (GEODON)	PA,AL	Prior Authorization required.
ANTIPSYCHOTICS / ANTIMANIC AGENTS : QUINOLINONE DERIVATIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
aripiprazole 10 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
aripiprazole 15 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
aripiprazole 2 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
aripiprazole 20 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
aripiprazole 30 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
aripiprazole 5 mg tablet (ABILIFY)	QL,AL	Limited to 30 EA per 30 days; Limited to members age 6 and older.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ABILIFY MAINTENA ER 300 MG SYR *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MAINTENA ER 300 MG VL *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MAINTENA ER 400 MG SYR *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MAINTENA ER 400 MG VL *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ARISTADA ER 1064 MG/3.9 ML SYR *(aripiprazole lauroxil)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ARISTADA ER 441 MG/1.6 ML SYRN *(aripiprazole lauroxil)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ARISTADA ER 662 MG/2.4 ML SYRN *(aripiprazole lauroxil)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ARISTADA ER 882 MG/3.2 ML SYRN *(aripiprazole lauroxil)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ARISTADA INITIO ER 675 MG/2.4 *(aripiprazole lauroxil, submicronized)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ABILIFY 10 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.
ABILIFY 15 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIPSYCHOTICS / ANTIMANIC AGENTS : QUINOLINONE DERIVATIVES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ABILIFY 2 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.
ABILIFY 20 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.
ABILIFY 30 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.
ABILIFY 5 MG TABLET *(use aripiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to members 6 years and older.
ABILIFY MYCITE 10 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MYCITE 15 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MYCITE 2 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MYCITE 20 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MYCITE 30 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
ABILIFY MYCITE 5 MG KIT *(aripiprazole)*	PA,AL	Prior Authorization required. Limited to members 8 years and older.
aripiprazole 1 mg/ml solution (ABILIFY)	PA,QL,AL	Prior Authorization required. Limited to 600 mL per 30 days; Limited to members 6 years and older.
aripiprazole 1 mg/ml solution (ABILIFY)	PA,QL,AL	Prior Authorization required. Limited to members 6 years and older.
aripiprazole odt 10 mg tablet (ABILIFY DISCMELT)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
aripiprazole odt 15 mg tablet (ABILIFY DISCMELT)	PA,AL	Prior Authorization required. Limited to members 8 years and older.
REXULTI 0.25 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.
REXULTI 0.5 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.
REXULTI 1 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.
REXULTI 2 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.
REXULTI 3 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.
REXULTI 4 MG TABLET *(brexpiprazole)*	PA,QL,AL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to members 8 years and older.

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
abacavir 20 mg/ml solution (ZIAGEN)		
abacavir 300 mg tablet (ZIAGEN)	QL	Limited to 60 EA per 30 days.
abacavir 300 mg/15 ml solution (ZIAGEN)		
abacavir-lamivudine 600-300 mg (EPZICOM)		
abacavir-lamivudine-zidov tab (TRIZIVIR)		
APTIVUS 100 MG/ML SOLUTION *(tipranavir/vitamin e tpgs)*		
APTIVUS 250 MG CAPSULE *(tipranavir)*		
atazanavir sulfate 150 mg cap (REYATAZ)		
atazanavir sulfate 200 mg cap (REYATAZ)		
atazanavir sulfate 300 mg cap (REYATAZ)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ATRIPLA TABLET *(efavirenz/emtricitabine/tenofovir disoproxil fumarate)*		
BIKTARVY 50-200-25 MG TABLET *(bictegravir sodium/emtricitabine/tenofovir alafenamide fumar)*		
COMPLERA TABLET *(emtricitabine/rilpivirine hcl/tenofovir disoproxil fumarate)*		
CRIXIVAN 200 MG CAPSULE *(indinavir sulfate)*		
CRIXIVAN 400 MG CAPSULE *(indinavir sulfate)*		
DELSTRIGO 100-300-300 MG TAB *(doravirine/lamivudine/tenofovir disoproxil fumarate)*		
DESCOVY 200-25 MG TABLET *(emtricitabine/tenofovir alafenamide fumarate)*		
didanosine dr 250 mg capsule (VIDEX EC)		
didanosine dr 400 mg capsule (VIDEX EC)		
DOVATO 50-300 MG TABLET *(dolutegravir sodium/lamivudine)*		
EDURANT 25 MG TABLET *(rilpivirine hcl)*		
efavir-emtri-tenof 600-200-300 (ATRIPLA)		
efavirenz 200 mg capsule (SUSTIVA)		
efavirenz 50 mg capsule (SUSTIVA)		
efavirenz 600 mg tablet (SUSTIVA)		
emtricitabine 200 mg capsule (EMTRIVA)		
emtricitabine-tenofv 100-150mg (TRUVADA)		
emtricitabine-tenofv 133-200mg (TRUVADA)		
emtricitabine-tenofv 167-250mg (TRUVADA)		
emtricitabine-tenofv 200-300mg (TRUVADA)		
EMTRIVA 10 MG/ML SOLUTION *(emtricitabine)*		
EMTRIVA 200 MG CAPSULE *(emtricitabine)*		
fosamprenavir 700 mg tablet (LEXIVA)		
GENVOYA TABLET *(elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)*		
INTELENCE 100 MG TABLET *(etravirine)*		
INTELENCE 200 MG TABLET *(etravirine)*		
INTELENCE 25 MG TABLET *(etravirine)*		
INVIRASE 500 MG TABLET *(saquinavir mesylate)*		
ISENTRESS 100 MG POWDER PACKET *(raltegravir potassium)*		
ISENTRESS 100 MG TABLET CHEW *(raltegravir potassium)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ISENTRESS 25 MG TABLET CHEW *(raltegravir potassium)*		
ISENTRESS 400 MG TABLET *(raltegravir potassium)*		
ISENTRESS HD 600 MG TABLET *(raltegravir potassium)*		
KALETRA 100-25 MG TABLET *(lopinavir/ritonavir)*		
KALETRA 200-50 MG TABLET *(lopinavir/ritonavir)*		
lamivudine 10 mg/ml oral soln (EPIVIR)		
lamivudine 150 mg tablet (EPIVIR)		
lamivudine 300 mg tablet (EPIVIR)		
lamivudine-zidovudine tablet (COMBIVIR)		
LEXIVA 50 MG/ML SUSPENSION *(fosamprenavir calcium)*		
LEXIVA 700 MG TABLET *(fosamprenavir calcium)*		
lopinavir-ritonavir 80-20mg/ml (KALETRA)		
nevirapine 200 mg tablet (VIRAMUNE)		
nevirapine 50 mg/5 ml susp (VIRAMUNE)		
nevirapine er 100 mg tablet (VIRAMUNE XR)		
nevirapine er 400 mg tablet (VIRAMUNE XR)		
NORVIR 100 MG POWDER PACKET *(ritonavir)*		
NORVIR 100 MG TABLET *(ritonavir)*		
NORVIR 80 MG/ML SOLUTION *(ritonavir)*		
ODEFSEY TABLET *(emtricitabine/rilpivirine hcl/tenofovir alafenamide fumarate)*		
PREZISTA 100 MG/ML SUSPENSION *(darunavir ethanolate)*		
PREZISTA 150 MG TABLET *(darunavir ethanolate)*		
PREZISTA 600 MG TABLET *(darunavir ethanolate)*		
PREZISTA 75 MG TABLET *(darunavir ethanolate)*		
PREZISTA 800 MG TABLET *(darunavir ethanolate)*		
REYATAZ 150 MG CAPSULE *(atazanavir sulfate)*		
REYATAZ 200 MG CAPSULE *(atazanavir sulfate)*		
REYATAZ 300 MG CAPSULE *(atazanavir sulfate)*		
REYATAZ 50 MG POWDER PACKET *(atazanavir sulfate)*		
ritonavir 100 mg tablet (NORVIR)		
stavudine 15 mg capsule (ZERIT)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
stavudine 20 mg capsule (ZERIT)		
stavudine 30 mg capsule (ZERIT)		
stavudine 40 mg capsule (ZERIT)		
SUSTIVA 200 MG CAPSULE *(efavirenz)*		
SUSTIVA 50 MG CAPSULE *(efavirenz)*		
SUSTIVA 600 MG TABLET *(efavirenz)*		
SYMFI 600-300-300 MG TABLET *(efavirenz/lamivudine/tenofovir disoproxil fumarate)*		
SYMFI LO 400-300-300 MG TABLET *(efavirenz/lamivudine/tenofovir disoproxil fumarate)*		
tenofovir disop fum 300 mg tb (VIREAD)		
TIVICAY 10 MG TABLET *(dolutegravir sodium)*		
TIVICAY 25 MG TABLET *(dolutegravir sodium)*		
TIVICAY 50 MG TABLET *(dolutegravir sodium)*		
TIVICAY PD 5 MG TAB FOR SUSP *(dolutegravir sodium)*		
TRIUMEQ 600-50-300 MG TABLET *(abacavir sulfate/dolutegravir sodium/lamivudine)*		
TRUVADA 100 MG-150 MG TABLET *(emtricitabine/tenofovir disoproxil fumarate)*		
TRUVADA 133 MG-200 MG TABLET *(emtricitabine/tenofovir disoproxil fumarate)*		
TRUVADA 167 MG-250 MG TABLET *(emtricitabine/tenofovir disoproxil fumarate)*		
TRUVADA 200 MG-300 MG TABLET *(emtricitabine/tenofovir disoproxil fumarate)*		
VIDEX 2 GM PEDIATRIC SOLN *(didanosine)*		
VIRACEPT 250 MG TABLET *(nelfinavir mesylate)*		
VIRACEPT 625 MG TABLET *(nelfinavir mesylate)*		
VIRAMUNE 50 MG/5 ML SUSP *(nevirapine)*		
VIREAD 150 MG TABLET *(tenofovir disoproxil fumarate)*		
VIREAD 200 MG TABLET *(tenofovir disoproxil fumarate)*		
VIREAD 250 MG TABLET *(tenofovir disoproxil fumarate)*		
VIREAD 300 MG TABLET *(tenofovir disoproxil fumarate)*		
VIREAD POWDER *(tenofovir disoproxil fumarate)*		
ZIAGEN 20 MG/ML SOLUTION *(abacavir sulfate)*		
zidovudine 100 mg capsule (RETROVIR)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
zidovudine 300 mg tablet (RETROVIR)		
zidovudine 50 mg/5 ml syrup (RETROVIR)		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
TROGARZO 200 MG/1.33 ML VIAL *(ibalizumab-uiyk)*	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CIMDUO 300-300 MG TABLET *(lamivudine/tenofovir disoproxil fumarate)*	PA	Prior Authorization required.
COMBIVIR TABLET *(use lamivudine/zidovudine)*	PA	Prior Authorization required.
efavir-lamiv-tenof 400-300-300 (SYMFI LO)	PA	Prior Authorization required.
efavir-lamiv-tenof 600-300-300 (SYMFI)	PA	Prior Authorization required.
EPIVIR 10 MG/ML ORAL SOLN *(use lamivudine)*	PA	Prior Authorization required.
EPIVIR 150 MG TABLET *(use lamivudine)*	PA	Prior Authorization required.
EPIVIR 300 MG TABLET *(use lamivudine)*	PA	Prior Authorization required.
EPZICOM TABLET *(use abacavir sulfate/lamivudine)*	PA	Prior Authorization required.
EVOTAZ 300 MG-150 MG TABLET *(atazanavir sulfate/cobicistat)*	PA	Prior Authorization required.
FUZEON 90 MG VIAL *(enfuvirtide)*	PA	Prior Authorization required.
JULUCA 50-25 MG TABLET *(dolutegravir sodium/rilpivirine hcl)*	PA	Prior Authorization required.
KALETRA 80 MG-20 MG/ML SOLN *(use lopinavir/ritonavir)*	PA	Prior Authorization required.
PIFELTRO 100 MG TABLET *(doravirine)*	PA	Prior Authorization required.
PREZCOBIX 800 MG-150 MG TABLET *(darunavir ethanolate/cobicistat)*	PA	Prior Authorization required.
RETROVIR 10 MG/ML SYRUP *(use zidovudine)*	PA	Prior Authorization required.
RETROVIR 100 MG CAPSULE *(use zidovudine)*	PA	Prior Authorization required.
RUKOBIA ER 600 MG TABLET *(fostemsavir tromethamine)*	PA	Prior Authorization required.
SELZENTRY 150 MG TABLET *(maraviroc)*	PA	Prior Authorization required.
SELZENTRY 20 MG/ML ORAL SOLN *(maraviroc)*	PA	Prior Authorization required.
SELZENTRY 25 MG TABLET *(maraviroc)*	PA	Prior Authorization required.
SELZENTRY 300 MG TABLET *(maraviroc)*	PA	Prior Authorization required.
SELZENTRY 75 MG TABLET *(maraviroc)*	PA	Prior Authorization required.
STRIBILD TABLET *(elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil)*	PA	Prior Authorization required.

Drug List

ANTIVIRALS : ANTIRETROVIRALS (HIV)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SYMTUZA 800-150-200-10 MG TAB *(darunavir eth/cobicistat/emtricitabine/tenofovir alafenamide)*	PA	Prior Authorization required.
TEMIXYS 300-300 MG TABLET *(lamivudine/tenofovir disoproxil fumarate)*	PA	Prior Authorization required.
TRIZIVIR TABLET *(use abacavir sulfate/lamivudine/zidovudine)*	PA	Prior Authorization required.
TYBOST 150 MG TABLET *(cobicistat)*	PA	Prior Authorization required.
VIDEX EC 125 MG CAPSULE *(didanosine)*	PA	Prior Authorization required.
VIDEX EC 200 MG CAPSULE *(didanosine)*	PA	Prior Authorization required.
VIDEX EC 250 MG CAPSULE *(use didanosine)*	PA	Prior Authorization required.
VIDEX EC 400 MG CAPSULE *(use didanosine)*	PA	Prior Authorization required.
VIRAMUNE 200 MG TABLET *(use nevirapine)*	PA	Prior Authorization required.
VIRAMUNE XR 400 MG TABLET *(use nevirapine)*	PA	Prior Authorization required.
VOCABRIA 30 MG TABLET *(cabotegravir sodium)*	PA	Prior Authorization required.
ZIAGEN 300 MG TABLET *(use abacavir sulfate)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ANTIVIRALS : HEPATITIS B AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
entecavir 0.5 mg tablet (BARACLUDE)		
entecavir 1 mg tablet (BARACLUDE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
adefovir dipivoxil 10 mg tab (HEPSERA)	PA	Prior Authorization required.
BARACLUDE 0.05 MG/ML SOLUTION *(entecavir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BARACLUDE 0.5 MG TABLET *(use entecavir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BARACLUDE 1 MG TABLET *(use entecavir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPIVIR HBV 100 MG TABLET *(lamivudine)*	PA	Prior Authorization required.
EPIVIR HBV 25 MG/5 ML SOLN *(lamivudine)*	PA	Prior Authorization required.
HEPSERA 10 MG TABLET *(adefovir dipivoxil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
lamivudine hbv 100 mg tablet (EPIVIR HBV)	PA	Prior Authorization required.
VEMLIDY 25 MG TABLET *(tenofovir alafenamide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ANTIVIRALS : HEPATITIS C AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ribavirin 200 mg capsule (REBETOL)	SP	Restricted to specialty pharmacies.
ribavirin 200 mg tablet (COPEGUS)	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
MAVYRET 100-40 MG TABLET *(glecaprevir/pibrentasvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PEGINTRON 50 MCG KIT *(peginterferon alfa-2b)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
sofosbuvir-velpatasvir 400-100 (EPCLUSA)	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EPCLUSA 200 MG-50 MG TABLET *(sofosbuvir/velpatasvir)*	PA	Prior Authorization required.
EPCLUSA 400 MG-100 MG TABLET *(use sofosbuvir/velpatasvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HARVONI 33.75-150 MG PELLET PK *(ledipasvir/sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HARVONI 45-200 MG PELLET PACKT *(ledipasvir/sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HARVONI 45-200 MG TABLET *(ledipasvir/sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HARVONI 90-400 MG TABLET *(ledipasvir/sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ledipasvir-sofosbuvir 90-400mg (HARVONI)	PA	Prior Authorization required.
MODERIBA 400-400 MG DOSEPACK *(ribavirin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MODERIBA 600-600 MG DOSEPACK *(ribavirin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PEGASYS 180 MCG/0.5 ML SYRINGE *(peginterferon alfa-2a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PEGASYS 180 MCG/ML VIAL *(peginterferon alfa-2a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIBASPHERE RIBAPAK 200-400 MG *(ribavirin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIBASPHERE RIBAPAK 400-400 MG *(ribavirin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOVALDI 150 MG PELLET PACKET *(sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOVALDI 200 MG PELLET PACKET *(sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOVALDI 200 MG TABLET *(sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOVALDI 400 MG TABLET *(sofosbuvir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VIEKIRA PAK *(ombitasvir/paritaprevir/ritonavir/dasabuvir sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VOSEVI 400-100-100 MG TABLET *(sofosbuvir/velpatasvir/voxilaprevir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZEPATIER 50-100 MG TABLET *(elbasvir/grazoprevir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acyclovir 200 mg capsule (ZOVIRAX)		
acyclovir 200 mg/5 ml susp (ZOVIRAX)		
acyclovir 400 mg tablet (ZOVIRAX)		
acyclovir 800 mg tablet (ZOVIRAX)		
oseltamivir 6 mg/ml suspension (TAMIFLU)	QL,FL,DS	Limited to 120 EA per fill; Limited to 1 fill per 180 days.
oseltamivir phos 30 mg capsule (TAMIFLU)	QL,FL,DS	Limited to 10 EA per fill; Limited to 1 fill per 180 days.
oseltamivir phos 45 mg capsule (TAMIFLU)	QL,FL,DS	Limited to 10 EA per fill; Limited to 1 fill per 180 days.
oseltamivir phos 75 mg capsule (TAMIFLU)	QL,FL,DS	Limited to 10 EA per fill; Limited to 1 fill per 180 days.
RELENZA 5 MG DISKHALER *(zanamivir)*	DS	Limited to Days Supply Limit of 10 each per 30 days
ribavirin 6 gm inhalation vial (VIRAZOLE)	SP	Restricted to specialty pharmacies.
valacyclovir hcl 1 gram tablet (VALTREX)		
valacyclovir hcl 500 mg tablet (VALTREX)		
valganciclovir 450 mg tablet (VALCYTE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
famciclovir 125 mg tablet (FAMVIR)	PA	Prior Authorization required.
famciclovir 250 mg tablet (FAMVIR)	PA	Prior Authorization required.
famciclovir 500 mg tablet (FAMVIR)	PA	Prior Authorization required.
FLUMADINE 100 MG TABLET *(rimantadine hcl)*	PA	Prior Authorization required.
PREVYMIS 240 MG TABLET *(letermovir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PREVYMIS 480 MG TABLET *(letermovir)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
rimantadine hcl 100 mg tablet (FLUMADINE)	PA	Prior Authorization required.
SITAVIG 50 MG BUCCAL TABLET *(acyclovir)*	PA	Prior Authorization required.
TAMIFLU 30 MG CAPSULE *(use oseltamivir phosphate)*	PA,QL,FL,DS	Prior Authorization required. Limited to 10 EA per fill; Limited to 1 fill per 180 days.
TAMIFLU 45 MG CAPSULE *(use oseltamivir phosphate)*	PA,QL,FL,DS	Prior Authorization required. Limited to 10 EA per fill; Limited to 1 fill per 180 days.
TAMIFLU 6 MG/ML SUSPENSION *(use oseltamivir phosphate)*	PA,QL,FL,DS	Prior Authorization required. Limited to 120 mL per fill; Limited to 1 fill per 180 days.
TAMIFLU 75 MG CAPSULE *(use oseltamivir phosphate)*	PA,QL,FL,DS	Prior Authorization required. Limited to 10 EA per fill; Limited to 1 fill per 180 days.
VALCYTE 450 MG TABLET *(use valganciclovir hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VALCYTE 50 MG/ML SOLUTION *(valganciclovir hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
valganciclovir hcl 50 mg/ml (VALCYTE)	PA	Prior Authorization required.
VALTREX 1 GM CAPLET *(use valacyclovir hcl)*	PA	Prior Authorization required.
VALTREX 500 MG CAPLET *(use valacyclovir hcl)*	PA	Prior Authorization required.
VIRAZOLE 6 GM VIAL *(use ribavirin)*	PA	Prior Authorization required.
XOFLUZA 20 MG TAB (40 MG DOSE) *(baloxavir marboxil)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIVIRALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
XOFLUZA 40 MG TAB (80 MG DOSE) *(baloxavir marboxil)*	PA	Prior Authorization required.
ZOVIRAX 200 MG/5 ML SUSP *(use acyclovir)*	PA	Prior Authorization required.
Bulk Chemicals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CAFFEINE POWDER *(caffeine)*		
FLUPHENAZINE DECANOATE OIL *(fluphenazine decanoate)*		
LITHIUM CITRATE TETRAHYD POWD *(lithium citrate tetrahydrate)*		
PENTOSAN POLYSULFATE SOD POWD *(pentosan polysulfate sodium)*	PA	Prior Authorization required.
CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ACE INHIBITOR COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amlodipine-benazepril 10-20 mg (LOTREL)		
amlodipine-benazepril 10-40 mg (LOTREL)		
amlodipine-benazepril 2.5-10 (LOTREL)		
amlodipine-benazepril 5-10 mg (LOTREL)		
amlodipine-benazepril 5-20 mg (LOTREL)		
amlodipine-benazepril 5-40 mg (LOTREL)		
benazepril-hctz 10-12.5 mg tab (LOTENSIN HCT)		
benazepril-hctz 20-12.5 mg tab (LOTENSIN HCT)		
benazepril-hctz 20-25 mg tab (LOTENSIN HCT)		
benazepril-hctz 5-6.25 mg tab (LOTENSIN HCT)		
captopril-hctz 25-15 mg tablet (CAPOZIDE)		
captopril-hctz 25-25 mg tablet (CAPOZIDE)		
captopril-hctz 50-15 mg tablet (CAPOZIDE)		
captopril-hctz 50-25 mg tablet (CAPOZIDE)		
enalapril-hctz 10-25 mg tablet (VASERETIC)		
enalapril-hctz 5-12.5 mg tab (VASERETIC)		
fosinopril-hctz 10-12.5 mg tab (MONOPRIL HCT)		
fosinopril-hctz 20-12.5 mg tab (MONOPRIL HCT)		
lisinopril-hctz 10-12.5 mg tab (PRINZIDE)		
lisinopril-hctz 20-12.5 mg tab (ZESTORETIC)		
lisinopril-hctz 20-25 mg tab (ZESTORETIC)		
quinapril-hctz 10-12.5 mg tab (ACCURETIC)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ACE INHIBITOR COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
quinapril-hctz 20-12.5 mg tab (ACCURETIC)		
quinapril-hctz 20-25 mg tab (ACCURETIC)		
trandolapr-verapam er 1-240 mg (TARKA)		
trandolapr-verapam er 2-180 mg (TARKA)		
trandolapr-verapam er 2-240 mg (TARKA)		
trandolapr-verapam er 4-240 mg (TARKA)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACCURETIC 10-12.5 MG TABLET *(use quinapril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
ACCURETIC 20-12.5 MG TABLET *(use quinapril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
ACCURETIC 20-25 MG TABLET *(use quinapril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
LOTENSIN HCT 10-12.5 MG TABLET *(use benazepril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
LOTENSIN HCT 20-12.5 MG TABLET *(use benazepril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
LOTENSIN HCT 20-25 MG TABLET *(use benazepril hcl/hydrochlorothiazide)*	PA	Prior Authorization required.
LOTREL 10-20 MG CAPSULE *(use amlodipine besylate/benazepril hcl)*	PA	Prior Authorization required.
LOTREL 10-40 MG CAPSULE *(use amlodipine besylate/benazepril hcl)*	PA	Prior Authorization required.
LOTREL 5-10 MG CAPSULE *(use amlodipine besylate/benazepril hcl)*	PA	Prior Authorization required.
LOTREL 5-20 MG CAPSULE *(use amlodipine besylate/benazepril hcl)*	PA	Prior Authorization required.
TARKA ER 2-180 MG TABLET *(use trandolapril/verapamil hcl)*	PA	Prior Authorization required.
TARKA ER 2-240 MG TABLET *(use trandolapril/verapamil hcl)*	PA	Prior Authorization required.
TARKA ER 4-240 MG TABLET *(use trandolapril/verapamil hcl)*	PA	Prior Authorization required.
VASERETIC 10-25 MG TABLET *(use enalapril maleate/hydrochlorothiazide)*	PA	Prior Authorization required.
ZESTORETIC 10-12.5 MG TABLET *(use lisinopril/hydrochlorothiazide)*	PA	Prior Authorization required.
ZESTORETIC 20-12.5 MG TABLET *(use lisinopril/hydrochlorothiazide)*	PA	Prior Authorization required.
ZESTORETIC 20-25 MG TABLET *(use lisinopril/hydrochlorothiazide)*	PA	Prior Authorization required.
CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ACE INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
benazepril hcl 10 mg tablet (LOTENSIN)		
benazepril hcl 20 mg tablet (LOTENSIN)		
benazepril hcl 40 mg tablet (LOTENSIN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ACE INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
benazepril hcl 5 mg tablet (LOTENSIN)		
captopril 100 mg tablet (CAPOTEN)		
captopril 12.5 mg tablet (CAPOTEN)		
captopril 25 mg tablet (CAPOTEN)		
captopril 50 mg tablet (CAPOTEN)		
enalapril maleate 10 mg tab (VASOTEC)		
enalapril maleate 2.5 mg tab (VASOTEC)		
enalapril maleate 20 mg tab (VASOTEC)		
enalapril maleate 5 mg tablet (VASOTEC)		
fosinopril sodium 10 mg tab (MONOPRIL)		
fosinopril sodium 20 mg tab (MONOPRIL)		
fosinopril sodium 40 mg tab (MONOPRIL)		
lisinopril 10 mg tablet (ZESTRIL)		
lisinopril 2.5 mg tablet (ZESTRIL)		
lisinopril 20 mg tablet (PRINIVIL)		
lisinopril 30 mg tablet (ZESTRIL)		
lisinopril 40 mg tablet (ZESTRIL)		
lisinopril 5 mg tablet (ZESTRIL)		
moexipril hcl 15 mg tablet (UNIVASC)		
moexipril hcl 7.5 mg tablet (UNIVASC)		
quinapril 10 mg tablet (ACCUPRIL)		
quinapril 20 mg tablet (ACCUPRIL)		
quinapril 40 mg tablet (ACCUPRIL)		
quinapril 5 mg tablet (ACCUPRIL)		
ramipril 1.25 mg capsule (ALTACE)		
ramipril 10 mg capsule (ALTACE)		
ramipril 2.5 mg capsule (ALTACE)		
ramipril 5 mg capsule (ALTACE)		
trandolapril 1 mg tablet (MAVIK)		
trandolapril 2 mg tablet (MAVIK)		
trandolapril 4 mg tablet (MAVIK)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACCUPRIL 10 MG TABLET *(use quinapril hcl)*	PA	Prior Authorization required.
ACCUPRIL 20 MG TABLET *(use quinapril hcl)*	PA	Prior Authorization required.
ACCUPRIL 40 MG TABLET *(use quinapril hcl)*	PA	Prior Authorization required.
ACCUPRIL 5 MG TABLET *(use quinapril hcl)*	PA	Prior Authorization required.
ALTACE 1.25 MG CAPSULE *(use ramipril)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ACE INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALTACE 10 MG CAPSULE *(use ramipril)*	PA	Prior Authorization required.
ALTACE 2.5 MG CAPSULE *(use ramipril)*	PA	Prior Authorization required.
ALTACE 5 MG CAPSULE *(use ramipril)*	PA	Prior Authorization required.
EPANED 1 MG/ML ORAL SOLUTION *(enalapril maleate)*	PA	Prior Authorization required.
LOTENSIN 10 MG TABLET *(use benazepril hcl)*	PA	Prior Authorization required.
LOTENSIN 20 MG TABLET *(use benazepril hcl)*	PA	Prior Authorization required.
LOTENSIN 40 MG TABLET *(use benazepril hcl)*	PA	Prior Authorization required.
perindopril erbumine 2 mg tab (ACEON)	PA	Prior Authorization required.
perindopril erbumine 4 mg tab (ACEON)	PA	Prior Authorization required.
perindopril erbumine 8 mg tab (ACEON)	PA	Prior Authorization required.
PRINIVIL 20 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
QBRELIS 1MG/ML SOLUTION *(lisinopril)*	PA,QL	Prior Authorization required. Limited to 150 mL per 30 days.
VASOTEC 10 MG TABLET *(use enalapril maleate)*	PA	Prior Authorization required.
VASOTEC 2.5 MG TABLET *(use enalapril maleate)*	PA	Prior Authorization required.
VASOTEC 20 MG TABLET *(use enalapril maleate)*	PA	Prior Authorization required.
VASOTEC 5 MG TABLET *(use enalapril maleate)*	PA	Prior Authorization required.
ZESTRIL 10 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
ZESTRIL 2.5 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
ZESTRIL 20 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
ZESTRIL 30 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
ZESTRIL 40 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.
ZESTRIL 5 MG TABLET *(use lisinopril)*	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKER COMB		
Drug Name	**Drug Status**	**Criteria**
Preferred		
irbesartan-hctz 150-12.5 mg tb (AVALIDE)		
irbesartan-hctz 300-12.5 mg tb (AVALIDE)		
losartan-hctz 100-12.5 mg tab (HYZAAR)		
losartan-hctz 100-25 mg tab (HYZAAR)		
losartan-hctz 50-12.5 mg tab (HYZAAR)		
valsartan-hctz 160-12.5 mg tab (DIOVAN HCT)	QL	Limited to 30 EA per 30 days.
valsartan-hctz 160-25 mg tab (DIOVAN HCT)	QL	Limited to 30 EA per 30 days.
valsartan-hctz 320-12.5 mg tab (DIOVAN HCT)	QL	Limited to 30 EA per 30 days.
valsartan-hctz 320-25 mg tab (DIOVAN HCT)	QL	Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKER COMB		
Drug Name	**Drug Status**	**Criteria**
Preferred		
valsartan-hctz 80-12.5 mg tab (DIOVAN HCT)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amlod-valsa-hctz 10-160-12.5mg (EXFORGE HCT)	PA	Prior Authorization required.
amlod-valsa-hctz 10-160-25 mg (EXFORGE HCT)	PA	Prior Authorization required.
amlod-valsa-hctz 10-320-25 mg (EXFORGE HCT)	PA	Prior Authorization required.
amlod-valsa-hctz 5-160-12.5 mg (EXFORGE HCT)	PA	Prior Authorization required.
amlod-valsa-hctz 5-160-25 mg (EXFORGE HCT)	PA	Prior Authorization required.
amlodipine-olmesartan 10-20 mg (AZOR)	PA	Prior Authorization required.
amlodipine-olmesartan 10-40 mg (AZOR)	PA	Prior Authorization required.
amlodipine-olmesartan 5-20 mg (AZOR)	PA	Prior Authorization required.
amlodipine-olmesartan 5-40 mg (AZOR)	PA	Prior Authorization required.
amlodipine-valsartan 10-160 mg (EXFORGE)	PA	Prior Authorization required.
amlodipine-valsartan 10-320 mg (EXFORGE)	PA	Prior Authorization required.
amlodipine-valsartan 5-160 mg (EXFORGE)	PA	Prior Authorization required.
amlodipine-valsartan 5-320 mg (EXFORGE)	PA	Prior Authorization required.
ATACAND HCT 16-12.5 MG TAB *(candesartan cilexetil/hydrochlorothiazide)*	PA	Prior Authorization required.
ATACAND HCT 32-12.5 MG TAB *(candesartan cilexetil/hydrochlorothiazide)*	PA	Prior Authorization required.
ATACAND HCT 32-25 MG TABLET *(candesartan cilexetil/hydrochlorothiazide)*	PA	Prior Authorization required.
AVALIDE 150-12.5 MG TABLET *(use irbesartan/hydrochlorothiazide)*	PA	Prior Authorization required.
AVALIDE 300-12.5 MG TABLET *(use irbesartan/hydrochlorothiazide)*	PA	Prior Authorization required.
AZOR 10-20 MG TABLET *(amlodipine besylate/olmesartan medoxomil)*	PA	Prior Authorization required.
AZOR 10-40 MG TABLET *(amlodipine besylate/olmesartan medoxomil)*	PA	Prior Authorization required.
AZOR 5-20 MG TABLET *(amlodipine besylate/olmesartan medoxomil)*	PA	Prior Authorization required.
AZOR 5-40 MG TABLET *(amlodipine besylate/olmesartan medoxomil)*	PA	Prior Authorization required.
BENICAR HCT 20-12.5 MG TABLET *(olmesartan medoxomil/hydrochlorothiazide)*	PA	Prior Authorization required.
BENICAR HCT 40-12.5 MG TABLET *(olmesartan medoxomil/hydrochlorothiazide)*	PA	Prior Authorization required.
BENICAR HCT 40-25 MG TABLET *(olmesartan medoxomil/hydrochlorothiazide)*	PA	Prior Authorization required.
candesartan-hctz 16-12.5 mg tb (ATACAND HCT)	PA	Prior Authorization required.

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKER COMB		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
candesartan-hctz 32-12.5 mg tb (ATACAND HCT)	PA	Prior Authorization required.
candesartan-hctz 32-25 mg tab (ATACAND HCT)	PA	Prior Authorization required.
DIOVAN HCT 160-12.5 MG TAB *(use valsartan/hydrochlorothiazide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIOVAN HCT 160-25 MG TABLET *(use valsartan/hydrochlorothiazide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIOVAN HCT 320-12.5 MG TAB *(use valsartan/hydrochlorothiazide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIOVAN HCT 320-25 MG TABLET *(use valsartan/hydrochlorothiazide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
DIOVAN HCT 80-12.5 MG TABLET *(use valsartan/hydrochlorothiazide)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
EDARBYCLOR 40-12.5 MG TABLET *(azilsartan medoxomil/chlorthalidone)*	PA	Prior Authorization required.
EDARBYCLOR 40-25 MG TABLET *(azilsartan medoxomil/chlorthalidone)*	PA	Prior Authorization required.
EXFORGE 10-160 MG TABLET *(amlodipine besylate/valsartan)*	PA	Prior Authorization required.
EXFORGE 10-320 MG TABLET *(amlodipine besylate/valsartan)*	PA	Prior Authorization required.
EXFORGE 5-160 MG TABLET *(amlodipine besylate/valsartan)*	PA	Prior Authorization required.
EXFORGE 5-320 MG TABLET *(amlodipine besylate/valsartan)*	PA	Prior Authorization required.
EXFORGE HCT 10-160-12.5 MG TAB *(amlodipine besylate/valsartan/hydrochlorothiazide)*	PA	Prior Authorization required.
EXFORGE HCT 10-160-25 MG TAB *(amlodipine besylate/valsartan/hydrochlorothiazide)*	PA	Prior Authorization required.
EXFORGE HCT 10-320-25 MG TAB *(amlodipine besylate/valsartan/hydrochlorothiazide)*	PA	Prior Authorization required.
EXFORGE HCT 5-160-12.5 MG TAB *(amlodipine besylate/valsartan/hydrochlorothiazide)*	PA	Prior Authorization required.
EXFORGE HCT 5-160-25 MG TAB *(amlodipine besylate/valsartan/hydrochlorothiazide)*	PA	Prior Authorization required.
HYZAAR 100-12.5 TABLET *(use losartan potassium/hydrochlorothiazide)*	PA	Prior Authorization required.
HYZAAR 100-25 TABLET *(use losartan potassium/hydrochlorothiazide)*	PA	Prior Authorization required.
HYZAAR 50-12.5 TABLET *(use losartan potassium/hydrochlorothiazide)*	PA	Prior Authorization required.
MICARDIS HCT 40-12.5 MG TABLET *(telmisartan/hydrochlorothiazide)*	PA	Prior Authorization required.
MICARDIS HCT 80-12.5 MG TABLET *(telmisartan/hydrochlorothiazide)*	PA	Prior Authorization required.
MICARDIS HCT 80-25 MG TABLET *(telmisartan/hydrochlorothiazide)*	PA	Prior Authorization required.
olmesartan-hctz 20-12.5 mg tab (BENICAR HCT)	PA	Prior Authorization required.

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKER COMB		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
olmesartan-hctz 40-12.5 mg tab (BENICAR HCT)	PA	Prior Authorization required.
olmesartan-hctz 40-25 mg tab (BENICAR HCT)	PA	Prior Authorization required.
olmsrtn-amldpn-hctz 20-5-12.5 (TRIBENZOR)	PA	Prior Authorization required.
olmsrtn-amldpn-hctz 40-10-12.5 (TRIBENZOR)	PA	Prior Authorization required.
olmsrtn-amldpn-hctz 40-10-25mg (TRIBENZOR)	PA	Prior Authorization required.
olmsrtn-amldpn-hctz 40-5-12.5 (TRIBENZOR)	PA	Prior Authorization required.
olmsrtn-amldpn-hctz 40-5-25 mg (TRIBENZOR)	PA	Prior Authorization required.
telmisartan-amlodipine 40-10 (TWYNSTA)	PA	Prior Authorization required.
telmisartan-amlodipine 40-5 mg (TWYNSTA)	PA	Prior Authorization required.
telmisartan-amlodipine 80-10 (TWYNSTA)	PA	Prior Authorization required.
telmisartan-amlodipine 80-5 mg (TWYNSTA)	PA	Prior Authorization required.
telmisartan-hctz 40-12.5 mg tb (MICARDIS HCT)	PA	Prior Authorization required.
telmisartan-hctz 80-12.5 mg tb (MICARDIS HCT)	PA	Prior Authorization required.
telmisartan-hctz 80-25 mg tab (MICARDIS HCT)	PA	Prior Authorization required.
TRIBENZOR 20-5-12.5 MG TABLET *(olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)*	PA	Prior Authorization required.
TRIBENZOR 40-10-12.5 MG TABLET *(olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)*	PA	Prior Authorization required.
TRIBENZOR 40-10-25 MG TABLET *(olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)*	PA	Prior Authorization required.
TRIBENZOR 40-5-12.5 MG TABLET *(olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)*	PA	Prior Authorization required.
TRIBENZOR 40-5-25 MG TABLET *(olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)*	PA	Prior Authorization required.
CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
irbesartan 150 mg tablet (AVAPRO)		
irbesartan 300 mg tablet (AVAPRO)		
irbesartan 75 mg tablet (AVAPRO)		
losartan potassium 100 mg tab (COZAAR)		
losartan potassium 25 mg tab (COZAAR)		
losartan potassium 50 mg tab (COZAAR)		
valsartan 160 mg tablet (DIOVAN)		

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
valsartan 320 mg tablet (DIOVAN)		
valsartan 40 mg tablet (DIOVAN)		
valsartan 80 mg tablet (DIOVAN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ATACAND 16 MG TABLET *(candesartan cilexetil)*	PA	Prior Authorization required.
ATACAND 32 MG TABLET *(candesartan cilexetil)*	PA	Prior Authorization required.
ATACAND 4 MG TABLET *(candesartan cilexetil)*	PA	Prior Authorization required.
ATACAND 8 MG TABLET *(candesartan cilexetil)*	PA	Prior Authorization required.
AVAPRO 150 MG TABLET *(use irbesartan)*	PA	Prior Authorization required.
AVAPRO 300 MG TABLET *(use irbesartan)*	PA	Prior Authorization required.
AVAPRO 75 MG TABLET *(use irbesartan)*	PA	Prior Authorization required.
BENICAR 20 MG TABLET *(olmesartan medoxomil)*	PA	Prior Authorization required.
BENICAR 40 MG TABLET *(olmesartan medoxomil)*	PA	Prior Authorization required.
BENICAR 5 MG TABLET *(olmesartan medoxomil)*	PA	Prior Authorization required.
candesartan cilexetil 16 mg tb (ATACAND)	PA	Prior Authorization required.
candesartan cilexetil 32 mg tb (ATACAND)	PA	Prior Authorization required.
candesartan cilexetil 4 mg tab (ATACAND)	PA	Prior Authorization required.
candesartan cilexetil 8 mg tab (ATACAND)	PA	Prior Authorization required.
COZAAR 100 MG TABLET *(use losartan potassium)*	PA	Prior Authorization required.
COZAAR 25 MG TABLET *(use losartan potassium)*	PA	Prior Authorization required.
COZAAR 50 MG TABLET *(use losartan potassium)*	PA	Prior Authorization required.
DIOVAN 160 MG TABLET *(use valsartan)*	PA	Prior Authorization required.
DIOVAN 320 MG TABLET *(use valsartan)*	PA	Prior Authorization required.
DIOVAN 40 MG TABLET *(use valsartan)*	PA	Prior Authorization required.
DIOVAN 80 MG TABLET *(use valsartan)*	PA	Prior Authorization required.
EDARBI 40 MG TABLET *(azilsartan medoxomil)*	PA	Prior Authorization required.
EDARBI 80 MG TABLET *(azilsartan medoxomil)*	PA	Prior Authorization required.
MICARDIS 20 MG TABLET *(telmisartan)*	PA	Prior Authorization required.
MICARDIS 40 MG TABLET *(telmisartan)*	PA	Prior Authorization required.
MICARDIS 80 MG TABLET *(telmisartan)*	PA	Prior Authorization required.
olmesartan medoxomil 20 mg tab (BENICAR)	PA	Prior Authorization required.
olmesartan medoxomil 40 mg tab (BENICAR)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANGIOTENSIN II RECEPTOR BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
olmesartan medoxomil 5 mg tab (BENICAR)	PA	Prior Authorization required.
telmisartan 20 mg tablet (MICARDIS)	PA	Prior Authorization required.
telmisartan 40 mg tablet (MICARDIS)	PA	Prior Authorization required.
telmisartan 80 mg tablet (MICARDIS)	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANTIADRENERGICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clonidine 0.1 mg/day patch (CATAPRES-TTS 1)		
clonidine 0.2 mg/day patch (CATAPRES-TTS 2)		
clonidine 0.3 mg/day patch (CATAPRES-TTS 3)		
clonidine hcl 0.1 mg tablet (CATAPRES)		
clonidine hcl 0.2 mg tablet (CATAPRES)		
clonidine hcl 0.3 mg tablet (CATAPRES)		
doxazosin mesylate 1 mg tab (CARDURA)		
doxazosin mesylate 2 mg tab (CARDURA)		
doxazosin mesylate 4 mg tab (CARDURA)		
doxazosin mesylate 8 mg tab (CARDURA)		
guanfacine 1 mg tablet (TENEX)		
guanfacine 2 mg tablet (TENEX)		
methyldopa 250 mg tablet (ALDOMET)		
methyldopa 500 mg tablet (ALDOMET)		
prazosin 1 mg capsule (MINIPRESS)		
prazosin 2 mg capsule (MINIPRESS)		
prazosin 5 mg capsule (MINIPRESS)		
terazosin 1 mg capsule (HYTRIN)		
terazosin 10 mg capsule (HYTRIN)		
terazosin 2 mg capsule (HYTRIN)		
terazosin 5 mg capsule (HYTRIN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CARDURA 1 MG TABLET *(use doxazosin mesylate)*	PA	Prior Authorization required.
CARDURA 2 MG TABLET *(use doxazosin mesylate)*	PA	Prior Authorization required.
CARDURA 4 MG TABLET *(use doxazosin mesylate)*	PA	Prior Authorization required.
CARDURA 8 MG TABLET *(use doxazosin mesylate)*	PA	Prior Authorization required.
CATAPRES 0.1 MG TABLET *(use clonidine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : ANTIADRENERGICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CATAPRES 0.2 MG TABLET *(use clonidine hcl)*	PA	Prior Authorization required.
CATAPRES 0.3 MG TABLET *(use clonidine hcl)*	PA	Prior Authorization required.
CATAPRES-TTS 1 PATCH *(use clonidine)*	PA	Prior Authorization required.
CATAPRES-TTS 2 PATCH *(use clonidine)*	PA	Prior Authorization required.
CATAPRES-TTS 3 PATCH *(use clonidine)*	PA	Prior Authorization required.
MINIPRESS 1 MG CAPSULE *(use prazosin hcl)*	PA	Prior Authorization required.
MINIPRESS 2 MG CAPSULE *(use prazosin hcl)*	PA	Prior Authorization required.
MINIPRESS 5 MG CAPSULE *(use prazosin hcl)*	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : BETA-BLOCKER COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
atenolol-chlorthalidone 100-25 (TENORETIC 100)		
atenolol-chlorthalidone 50-25 (TENORETIC 50)		
bisoprolol-hctz 10-6.25 mg tab (ZIAC)		
bisoprolol-hctz 2.5-6.25 mg tb (ZIAC)		
bisoprolol-hctz 5-6.25 mg tab (ZIAC)		
metoprolol-hctz 100-25 mg tab (LOPRESSOR HCT)		
metoprolol-hctz 100-50 mg tab (LOPRESSOR HCT)		
metoprolol-hctz 50-25 mg tab (LOPRESSOR HCT)		
nadolol-bendroflu 80-5 mg tab (CORZIDE)		
propranolol-hctz 40-25 mg tab (INDERIDE-40/25)		
propranolol-hctz 80-25 mg tab (INDERIDE-80/25)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TENORETIC 100 TABLET *(use atenolol/chlorthalidone)*	PA	Prior Authorization required.
TENORETIC 50 TABLET *(use atenolol/chlorthalidone)*	PA	Prior Authorization required.
ZIAC 10-6.25 MG TABLET *(use bisoprolol fumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
ZIAC 2.5-6.25 MG TABLET *(use bisoprolol fumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
ZIAC 5-6.25 MG TABLET *(use bisoprolol fumarate/hydrochlorothiazide)*	PA	Prior Authorization required.

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : BETA-BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acebutolol 200 mg capsule (SECTRAL)		
acebutolol 400 mg capsule (SECTRAL)		
atenolol 100 mg tablet (TENORMIN)		
atenolol 25 mg tablet (TENORMIN)		
atenolol 50 mg tablet (TENORMIN)		
betaxolol 10 mg tablet (KERLONE)		
betaxolol 20 mg tablet (KERLONE)		
bisoprolol fumarate 10 mg tab (ZEBETA)		
bisoprolol fumarate 5 mg tab (ZEBETA)		
carvedilol 12.5 mg tablet (COREG)		
carvedilol 25 mg tablet (COREG)		
carvedilol 3.125 mg tablet (COREG)		
carvedilol 6.25 mg tablet (COREG)		
labetalol hcl 100 mg tablet (TRANDATE)		
labetalol hcl 200 mg tablet (TRANDATE)		
labetalol hcl 300 mg tablet (TRANDATE)		
metoprolol succ er 100 mg tab (TOPROL XL)	QL	Limited to 30 EA per 30 days.
metoprolol succ er 200 mg tab (TOPROL XL)	QL	Limited to 30 EA per 30 days.
metoprolol succ er 25 mg tab (TOPROL XL)	QL	Limited to 30 EA per 30 days.
metoprolol succ er 50 mg tab (TOPROL XL)	QL	Limited to 30 EA per 30 days.
metoprolol tartrate 100 mg tab (LOPRESSOR)		
metoprolol tartrate 25 mg tab		
metoprolol tartrate 37.5 mg tb		
metoprolol tartrate 50 mg tab (LOPRESSOR)		
metoprolol tartrate 75 mg tab		
nadolol 20 mg tablet (CORGARD)		
nadolol 40 mg tablet (CORGARD)		
nadolol 80 mg tablet (CORGARD)		
pindolol 10 mg tablet (VISKEN)		
pindolol 5 mg tablet (VISKEN)		
propranolol 10 mg tablet (INDERAL)		
propranolol 20 mg tablet (INDERAL)		
propranolol 20 mg/5 ml soln		
propranolol 40 mg tablet (INDERAL)		
propranolol 40 mg/5 ml soln		
propranolol 60 mg tablet (INDERAL)		
propranolol 80 mg tablet (INDERAL)		
propranolol er 120 mg capsule (INDERAL LA)		
propranolol er 160 mg capsule (INDERAL LA)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : BETA-BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
propranolol er 60 mg capsule (INDERAL LA)		
propranolol er 80 mg capsule (INDERAL LA)		
SORINE 120 MG TABLET *(sotalol hcl)*		
SORINE 160 MG TABLET *(sotalol hcl)*		
SORINE 240 MG TABLET *(sotalol hcl)*		
SORINE 80 MG TABLET *(sotalol hcl)*		
sotalol 120 mg tablet (BETAPACE)		
sotalol 160 mg tablet (BETAPACE)		
sotalol 240 mg tablet (BETAPACE)		
sotalol 80 mg tablet (BETAPACE)		
timolol maleate 10 mg tablet (BLOCADREN)		
timolol maleate 20 mg tablet (BLOCADREN)		
timolol maleate 5 mg tablet (BLOCADREN)		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
HEMANGEOL 4.28 MG/ML ORAL SOLN *(propranolol hcl)*	PA,AL	Prior Authorization required. Limited to members age 1 year and younger.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BETAPACE 120 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BETAPACE 160 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BETAPACE 80 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BETAPACE AF 120 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BETAPACE AF 160 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BETAPACE AF 80 MG TABLET *(use sotalol hcl)*	PA	Prior Authorization required.
BYSTOLIC 10 MG TABLET *(nebivolol hcl)*	PA	Prior Authorization required.
BYSTOLIC 2.5 MG TABLET *(nebivolol hcl)*	PA	Prior Authorization required.
BYSTOLIC 20 MG TABLET *(nebivolol hcl)*	PA	Prior Authorization required.
BYSTOLIC 5 MG TABLET *(nebivolol hcl)*	PA	Prior Authorization required.
carvedilol er 10 mg capsule (COREG CR)	PA	Prior Authorization required.
carvedilol er 20 mg capsule (COREG CR)	PA	Prior Authorization required.
carvedilol er 40 mg capsule (COREG CR)	PA	Prior Authorization required.
carvedilol er 80 mg capsule (COREG CR)	PA	Prior Authorization required.
COREG 12.5 MG TABLET *(use carvedilol)*	PA	Prior Authorization required.
COREG 25 MG TABLET *(use carvedilol)*	PA	Prior Authorization required.
COREG 3.125 MG TABLET *(use carvedilol)*	PA	Prior Authorization required.
COREG 6.25 MG TABLET *(use carvedilol)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : BETA-BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
COREG CR 10 MG CAPSULE *(carvedilol phosphate)*	PA	Prior Authorization required.
COREG CR 20 MG CAPSULE *(carvedilol phosphate)*	PA	Prior Authorization required.
COREG CR 40 MG CAPSULE *(carvedilol phosphate)*	PA	Prior Authorization required.
COREG CR 80 MG CAPSULE *(carvedilol phosphate)*	PA	Prior Authorization required.
CORGARD 20 MG TABLET *(use nadolol)*	PA	Prior Authorization required.
CORGARD 40 MG TABLET *(use nadolol)*	PA	Prior Authorization required.
CORGARD 80 MG TABLET *(use nadolol)*	PA	Prior Authorization required.
INDERAL LA 120 MG CAPSULE *(use propranolol hcl)*	PA	Prior Authorization required.
INDERAL LA 160 MG CAPSULE *(use propranolol hcl)*	PA	Prior Authorization required.
INDERAL LA 60 MG CAPSULE *(use propranolol hcl)*	PA	Prior Authorization required.
INDERAL LA 80 MG CAPSULE *(use propranolol hcl)*	PA	Prior Authorization required.
INDERAL XL 120 MG CAPSULE *(propranolol hcl)*	PA	Prior Authorization required.
INDERAL XL 80 MG CAPSULE *(propranolol hcl)*	PA	Prior Authorization required.
INNOPRAN XL 120 MG CAPSULE *(propranolol hcl)*	PA	Prior Authorization required.
INNOPRAN XL 80 MG CAPSULE *(propranolol hcl)*	PA	Prior Authorization required.
KAPSPARGO SPRINKLE 100 MG CAP *(metoprolol succinate)*	PA	Prior Authorization required.
KAPSPARGO SPRINKLE 200 MG CAP *(metoprolol succinate)*	PA	Prior Authorization required.
KAPSPARGO SPRINKLE 25 MG CAP *(metoprolol succinate)*	PA	Prior Authorization required.
KAPSPARGO SPRINKLE 50 MG CAP *(metoprolol succinate)*	PA	Prior Authorization required.
LOPRESSOR 100 MG TABLET *(use metoprolol tartrate)*	PA	Prior Authorization required.
LOPRESSOR 50 MG TABLET *(use metoprolol tartrate)*	PA	Prior Authorization required.
sotalol af 120 mg tablet (SORINE)	PA	Prior Authorization required.
sotalol af 160 mg tablet (SORINE)	PA	Prior Authorization required.
sotalol af 80 mg tablet (SORINE)	PA	Prior Authorization required.
SOTYLIZE 5 MG/ML ORAL SOLUTION *(sotalol hcl)*	PA	Prior Authorization required.
TENORMIN 100 MG TABLET *(use atenolol)*	PA	Prior Authorization required.
TENORMIN 25 MG TABLET *(use atenolol)*	PA	Prior Authorization required.
TENORMIN 50 MG TABLET *(use atenolol)*	PA	Prior Authorization required.
TOPROL XL 100 MG TABLET *(use metoprolol succinate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TOPROL XL 200 MG TABLET *(use metoprolol succinate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : BETA-BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TOPROL XL 25 MG TABLET *(use metoprolol succinate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TOPROL XL 50 MG TABLET *(use metoprolol succinate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : CALCIUM CHANNEL BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amlodipine besylate 10 mg tab (NORVASC)	QL	Limited to 30 EA per 30 days.
amlodipine besylate 2.5 mg tab (NORVASC)	QL	Limited to 30 EA per 30 days.
amlodipine besylate 5 mg tab (NORVASC)	QL	Limited to 30 EA per 30 days.
CARTIA XT 120 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
CARTIA XT 180 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
CARTIA XT 240 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
CARTIA XT 300 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
DILT XR 120 MG CAPSULE *(diltiazem hcl)*		
DILT XR 180 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
DILT XR 240 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
diltiazem 120 mg tablet (CARDIZEM)		
diltiazem 12hr er 120 mg cap (CARDIZEM SR)	QL	Limited to 60 EA per 30 days.
diltiazem 12hr er 60 mg cap (CARDIZEM SR)	QL	Limited to 60 EA per 30 days.
diltiazem 12hr er 90 mg cap (CARDIZEM SR)	QL	Limited to 60 EA per 30 days.
diltiazem 24h er(cd) 120 mg cp (CARDIZEM CD)	QL	Limited to 30 EA per 30 days.
diltiazem 24h er(cd) 180 mg cp (CARDIZEM CD)	QL	Limited to 30 EA per 30 days.
diltiazem 24h er(cd) 240 mg cp (CARDIZEM CD)	QL	Limited to 30 EA per 30 days.
diltiazem 24h er(cd) 300 mg cp (CARDIZEM CD)	QL	Limited to 30 EA per 30 days.
diltiazem 24h er(cd) 360 mg cp (CARDIZEM CD)	QL	Limited to 30 EA per 30 days.
diltiazem 24h er(la) 180 mg tb (CARDIZEM LA)		
diltiazem 24h er(la) 240 mg tb (CARDIZEM LA)		
diltiazem 24h er(la) 300 mg tb (CARDIZEM LA)		
diltiazem 24h er(la) 360 mg tb (CARDIZEM LA)		
diltiazem 24h er(la) 420 mg tb (CARDIZEM LA)		
diltiazem 24h er(xr) 120 mg cp (DILT-XR)		
diltiazem 24h er(xr) 180 mg cp (DILT-XR)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : CALCIUM CHANNEL BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
diltiazem 24h er(xr) 240 mg cp (DILT-XR)		
diltiazem 24hr er 120 mg cap (TAZTIA XT)	QL	Limited to 30 EA per 30 days.
diltiazem 24hr er 180 mg cap (TAZTIA XT)	QL	Limited to 30 EA per 30 days.
diltiazem 24hr er 240 mg cap (TIAZAC)	QL	Limited to 30 EA per 30 days.
diltiazem 24hr er 300 mg cap (TIAZAC)	QL	Limited to 30 EA per 30 days.
diltiazem 24hr er 360 mg cap (TIAZAC)	QL	Limited to 30 EA per 30 days.
diltiazem 24hr er 420 mg cap (TIAZAC)	QL	Limited to 30 EA per 30 days.
diltiazem 30 mg tablet (CARDIZEM)		
diltiazem 60 mg tablet (CARDIZEM)		
diltiazem 90 mg tablet (CARDIZEM)		
felodipine er 10 mg tablet (PLENDIL)	QL	Limited to 30 EA per 30 days.
felodipine er 2.5 mg tablet (PLENDIL)	QL	Limited to 30 EA per 30 days.
felodipine er 5 mg tablet (PLENDIL)	QL	Limited to 30 EA per 30 days.
MATZIM LA 180 MG TABLET *(diltiazem hcl)*		
MATZIM LA 240 MG TABLET *(diltiazem hcl)*		
MATZIM LA 300 MG TABLET *(diltiazem hcl)*		
MATZIM LA 360 MG TABLET *(diltiazem hcl)*		
MATZIM LA 420 MG TABLET *(diltiazem hcl)*		
nifedipine 10 mg capsule (ADALAT)		
nifedipine 10 mg capsule (PROCARDIA)		
nifedipine 20 mg capsule (PROCARDIA)	QL	Limited to 30 EA per 30 days.
nifedipine er 30 mg tablet (ADALAT CC)	QL	Limited to 30 EA per 30 days.
nifedipine er 30 mg tablet (PROCARDIA XL)	QL	Limited to 30 EA per 30 days.
nifedipine er 60 mg tablet (ADALAT CC)	QL	Limited to 30 EA per 30 days.
nifedipine er 60 mg tablet (PROCARDIA XL)	QL	Limited to 30 EA per 30 days.
nifedipine er 90 mg tablet (ADALAT CC)	QL	Limited to 30 EA per 30 days.
nifedipine er 90 mg tablet (PROCARDIA XL)	QL	Limited to 30 EA per 30 days.
nimodipine 30 mg capsule (NIMOTOP)		
TAZTIA XT 120 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TAZTIA XT 180 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TAZTIA XT 240 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TAZTIA XT 300 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TAZTIA XT 360 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TIADYLT ER 120 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TIADYLT ER 180 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TIADYLT ER 240 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : CALCIUM CHANNEL BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
TIADYLT ER 300 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TIADYLT ER 360 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
TIADYLT ER 420 MG CAPSULE *(diltiazem hcl)*	QL	Limited to 30 EA per 30 days.
verapamil 120 mg tablet (CALAN)		
verapamil 360 mg cap pellet (VERELAN)		
verapamil 40 mg tablet (CALAN)		
verapamil 80 mg tablet (CALAN)		
verapamil er 120 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
verapamil er 120 mg tablet (CALAN SR)	QL	Limited to 30 EA per 30 days.
verapamil er 180 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
verapamil er 180 mg tablet (CALAN SR)	QL	Limited to 30 EA per 30 days.
verapamil er 240 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
verapamil er 240 mg tablet (CALAN SR)	QL	Limited to 30 EA per 30 days.
verapamil er pm 100 mg capsule (VERELAN PM)	QL	Limited to 30 EA per 30 days.
verapamil er pm 200 mg capsule (VERELAN PM)	QL	Limited to 30 EA per 30 days.
verapamil er pm 300 mg capsule (VERELAN PM)		
verapamil sr 120 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
verapamil sr 180 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
verapamil sr 240 mg capsule (VERELAN)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADALAT CC 30 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ADALAT CC 60 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ADALAT CC 90 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CALAN SR 120 MG CAPLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CALAN SR 180 MG CAPLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CALAN SR 240 MG CAPLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CARDIZEM 120 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM 30 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM 60 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM CD 120 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CARDIZEM CD 180 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : CALCIUM CHANNEL BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CARDIZEM CD 240 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CARDIZEM CD 300 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
CARDIZEM CD 360 MG CAPSULE *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 120 MG TABLET *(diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 180 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 240 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 300 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 360 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
CARDIZEM LA 420 MG TABLET *(use diltiazem hcl)*	PA	Prior Authorization required.
isradipine 2.5 mg capsule (DYNACIRC)	PA	Prior Authorization required.
isradipine 5 mg capsule (DYNACIRC)	PA	Prior Authorization required.
KATERZIA 1 MG/ML SUSPENSION *(amlodipine benzoate)*	PA	Prior Authorization required.
nicardipine 20 mg capsule (CARDENE)	PA	Prior Authorization required.
nicardipine 30 mg capsule (CARDENE)	PA	Prior Authorization required.
nisoldipine er 17 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 20 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 25.5 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 30 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 34 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 40 mg tablet (SULAR)	PA	Prior Authorization required.
nisoldipine er 8.5 mg tablet (SULAR)	PA	Prior Authorization required.
NORVASC 10 MG TABLET *(use amlodipine besylate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NORVASC 2.5 MG TABLET *(use amlodipine besylate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NORVASC 5 MG TABLET *(use amlodipine besylate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NYMALIZE 30 MG/10 ML SOLUTION *(nimodipine)*	PA	Prior Authorization required.
NYMALIZE 30 MG/5 ML ORAL SYRNG *(nimodipine)*	PA,QL	Prior Authorization Required. Limited to 8 mL per day.
NYMALIZE 60 MG/10 ML ORAL SYRN *(nimodipine)*	PA,QL	Prior Authorization Required. Limited to 8 mL per day.
NYMALIZE 60 MG/20 ML SOLUTION *(nimodipine)*	PA	Prior Authorization required.
PROCARDIA 10 MG CAPSULE *(use nifedipine)*	PA	Prior Authorization required.
PROCARDIA XL 30 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
PROCARDIA XL 60 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : CALCIUM CHANNEL BLOCKERS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PROCARDIA XL 90 MG TABLET *(use nifedipine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
SULAR ER 17 MG TABLET *(nisoldipine)*	PA	Prior Authorization required.
SULAR ER 34 MG TABLET *(nisoldipine)*	PA	Prior Authorization required.
SULAR ER 8.5 MG TABLET *(nisoldipine)*	PA	Prior Authorization required.
TIAZAC ER 120 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TIAZAC ER 180 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TIAZAC ER 240 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TIAZAC ER 300 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TIAZAC ER 360 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
TIAZAC ER 420 MG CAPSULE *(use diltiazem hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN 120 MG CAP PELLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN 180 MG CAP PELLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN 240 MG CAP PELLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN 360 MG CAP PELLET *(use verapamil hcl)*	PA	Prior Authorization required.
VERELAN PM 100 MG CAP PELLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN PM 200 MG CAP PELLET *(use verapamil hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
VERELAN PM 300 MG CAP PELLET *(use verapamil hcl)*	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
DEMSER 250 MG CAPSULE *(metyrosine)*	SP	Restricted to specialty pharmacies.
hydralazine 10 mg tablet (APRESOLINE)		
hydralazine 100 mg tablet (APRESOLINE)		
hydralazine 25 mg tablet (APRESOLINE)		
hydralazine 50 mg tablet (APRESOLINE)		
methyldopa-hctz 250-15 mg tab (ALDORIL-15)		
methyldopa-hctz 250-25 mg tab (ALDORIL-25)		
metyrosine 250 mg capsule (DEMSER)	SP	Restricted to specialty pharmacies.
minoxidil 10 mg tablet (LONITEN)		
minoxidil 2.5 mg tablet (LONITEN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS - ANTIHYPERTENSIVES : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
aliskiren 150 mg tablet (TEKTURNA)	PA	Prior Authorization required.
aliskiren 300 mg tablet (TEKTURNA)	PA	Prior Authorization required.
eplerenone 25 mg tablet (INSPRA)	PA	Prior Authorization required.
eplerenone 50 mg tablet (INSPRA)	PA	Prior Authorization required.
INSPRA 25 MG TABLET *(eplerenone)*	PA	Prior Authorization required.
INSPRA 50 MG TABLET *(eplerenone)*	PA	Prior Authorization required.
phenoxybenzamine hcl 10 mg cap (DIBENZYLINE)	PA	Prior Authorization required.
TEKTURNA 150 MG TABLET *(aliskiren hemifumarate)*	PA	Prior Authorization required.
TEKTURNA 300 MG TABLET *(aliskiren hemifumarate)*	PA	Prior Authorization required.
TEKTURNA HCT 150-12.5 MG TAB *(aliskiren hemifumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
TEKTURNA HCT 150-25 MG TABLET *(aliskiren hemifumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
TEKTURNA HCT 300-12.5 MG TAB *(aliskiren hemifumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
TEKTURNA HCT 300-25 MG TABLET *(aliskiren hemifumarate/hydrochlorothiazide)*	PA	Prior Authorization required.
VECAMYL 2.5 MG TABLET *(mecamylamine hcl)*	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS - CARDIOTONICS : CARDIAC GLYCOSIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
DIGITEK 125 MCG TABLET *(digoxin)*		
DIGITEK 250 MCG TABLET *(digoxin)*		
DIGOX 125 MCG TABLET *(digoxin)*		
DIGOX 250 MCG TABLET *(digoxin)*		
digoxin 0.05 mg/ml solution (LANOXIN)		
digoxin 0.125 mg tablet (DIGITEK)		
digoxin 0.125 mg/2.5 ml soln (LANOXIN)		
digoxin 0.25 mg tablet (DIGITEK)		
digoxin 125 mcg tablet (DIGITEK)		
digoxin 250 mcg tablet (DIGITEK)		

CARDIOVASCULAR AGENTS : ANTIANGINAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
DILATRATE-SR 40 MG CAPSULE *(isosorbide dinitrate)*		
isosorbide dinitrate 10 mg tab (ISORDIL)		
isosorbide dinitrate 20 mg tab (ISORDIL)		
isosorbide dinitrate 30 mg tab (ISORDIL)		
isosorbide dinitrate 40 mg tab (ISORDIL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS : ANTIANGINAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
isosorbide dinitrate 5 mg tab (ISORDIL TITRADOSE)		
isosorbide mononit 10 mg tab (MONOKET)		
isosorbide mononit 20 mg tab (MONOKET)		
isosorbide mononit er 120 mg (IMDUR)		
isosorbide mononit er 30 mg tb (IMDUR)		
isosorbide mononit er 60 mg tb (IMDUR)		
MINITRAN 0.1 MG/HR PATCH *(nitroglycerin)*		
MINITRAN 0.2 MG/HR PATCH *(nitroglycerin)*		
MINITRAN 0.4 MG/HR PATCH *(nitroglycerin)*		
MINITRAN 0.6 MG/HR PATCH *(nitroglycerin)*		
NITRO-BID 2% OINTMENT *(nitroglycerin)*		
nitroglycerin 0.1 mg/hr patch (MINITRAN)		
nitroglycerin 0.1 mg/hr patch (NITRO-DUR)		
nitroglycerin 0.2 mg/hr patch (MINITRAN)		
nitroglycerin 0.2 mg/hr patch (NITRO-DUR)		
nitroglycerin 0.3 mg tablet sl (NITROSTAT)		
nitroglycerin 0.4 mg tablet sl (NITROSTAT)		
nitroglycerin 0.4 mg/hr patch (MINITRAN)		
nitroglycerin 0.4 mg/hr patch (NITRO-DUR)		
nitroglycerin 0.6 mg tablet sl (NITROSTAT)		
nitroglycerin 0.6 mg/hr patch (MINITRAN)		
nitroglycerin 0.6 mg/hr patch (NITRO-DUR)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
GONITRO 0.4 MG SUBLINGUAL PWD *(nitroglycerin)*	PA	Prior Authorization required.
ISORDIL 40 MG TABLET *(use isosorbide dinitrate)*	PA	Prior Authorization required.
ISORDIL TITRADOSE 5 MG TAB *(use isosorbide dinitrate)*	PA	Prior Authorization required.
NITRO-DUR 0.1 MG/HR PATCH *(use nitroglycerin)*	PA	Prior Authorization required.
NITRO-DUR 0.2 MG/HR PATCH *(use nitroglycerin)*	PA	Prior Authorization required.
NITRO-DUR 0.3 MG/HR PATCH *(nitroglycerin)*	PA	Prior Authorization required.
NITRO-DUR 0.4 MG/HR PATCH *(use nitroglycerin)*	PA	Prior Authorization required.
NITRO-DUR 0.6 MG/HR PATCH *(use nitroglycerin)*	PA	Prior Authorization required.
NITRO-DUR 0.8 MG/HR PATCH *(nitroglycerin)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS : ANTIANGINAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
nitroglycerin 400 mcg spray (NITROLINGUAL)	PA	Prior Authorization required.
NITROLINGUAL 400 MCG SPRAY *(nitroglycerin)*	PA	Prior Authorization required.
NITROMIST 400 MCG SPRAY *(nitroglycerin)*	PA	Prior Authorization required.
NITROSTAT 0.3 MG TABLET SL *(use nitroglycerin)*	PA	Prior Authorization required.
NITROSTAT 0.4 MG TABLET SL *(use nitroglycerin)*	PA	Prior Authorization required.
NITROSTAT 0.6 MG TABLET SL *(use nitroglycerin)*	PA	Prior Authorization required.
RANEXA ER 1,000 MG TABLET *(ranolazine)*	PA	Prior Authorization required.
RANEXA ER 500 MG TABLET *(ranolazine)*	PA	Prior Authorization required.
ranolazine er 1,000 mg tablet (RANEXA)	PA	Prior Authorization required.
ranolazine er 500 mg tablet (RANEXA)	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS : ANTIARRHYTHMICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
amiodarone hcl 100 mg tablet (PACERONE)		
amiodarone hcl 200 mg tablet (CORDARONE)		
amiodarone hcl 200 mg tablet (PACERONE)		
amiodarone hcl 400 mg tablet (PACERONE)		
disopyramide 100 mg capsule (NORPACE)		
disopyramide 150 mg capsule (NORPACE)		
dofetilide 125 mcg capsule (TIKOSYN)		
dofetilide 250 mcg capsule (TIKOSYN)		
dofetilide 500 mcg capsule (TIKOSYN)		
flecainide acetate 100 mg tab (TAMBOCOR)		
flecainide acetate 150 mg tab (TAMBOCOR)		
flecainide acetate 50 mg tab (TAMBOCOR)		
mexiletine 150 mg capsule (MEXITIL)		
mexiletine 200 mg capsule (MEXITIL)		
mexiletine 250 mg capsule (MEXITIL)		
NORPACE CR 100 MG CAPSULE *(disopyramide phosphate)*		
NORPACE CR 150 MG CAPSULE *(disopyramide phosphate)*		
PACERONE 100 MG TABLET *(amiodarone hcl)*		
PACERONE 200 MG TABLET *(amiodarone hcl)*		
PACERONE 400 MG TABLET *(amiodarone hcl)*		

Drug List

CARDIOVASCULAR AGENTS : ANTIARRHYTHMICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
propafenone hcl 150 mg tablet (RYTHMOL)		
propafenone hcl 225 mg tab (RYTHMOL)		
propafenone hcl 300 mg tab (RYTHMOL)		
quinidine gluc er 324 mg tab (QUINAGLUTE)		
quinidine sulfate 200 mg tab (QUIN-TAB 200)		
quinidine sulfate 300 mg tab (CIN-QUIN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
MULTAQ 400 MG TABLET *(dronedarone hcl)*	PA	Prior Authorization required.
NORPACE 100 MG CAPSULE *(use disopyramide phosphate)*	PA	Prior Authorization required.
NORPACE 150 MG CAPSULE *(use disopyramide phosphate)*	PA	Prior Authorization required.
propafenone hcl er 225 mg cap (RYTHMOL SR)	PA	Prior Authorization required.
propafenone hcl er 325 mg cap (RYTHMOL SR)	PA	Prior Authorization required.
propafenone hcl er 425 mg cap (RYTHMOL SR)	PA	Prior Authorization required.
RYTHMOL SR 225 MG CAPSULE *(propafenone hcl)*	PA	Prior Authorization required.
RYTHMOL SR 325 MG CAPSULE *(propafenone hcl)*	PA	Prior Authorization required.
RYTHMOL SR 425 MG CAPSULE *(propafenone hcl)*	PA	Prior Authorization required.
TIKOSYN 125 MCG CAPSULE *(use dofetilide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TIKOSYN 250 MCG CAPSULE *(use dofetilide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TIKOSYN 500 MCG CAPSULE *(use dofetilide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CARDIOVASCULAR AGENTS : DIURETICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acetazolamide 125 mg tablet (DIAMOX)		
acetazolamide 250 mg tablet (DIAMOX)	QL	Limited to 60 EA per 30 days.
acetazolamide er 500 mg cap (DIAMOX SEQUELS)	QL	Limited to 120 EA per 30 days.
amiloride hcl 5 mg tablet (MIDAMOR)		
amiloride hcl-hctz 5-50 mg tab (MODURETIC)		
bumetanide 0.5 mg tablet (BUMEX)		
bumetanide 1 mg tablet (BUMEX)		
bumetanide 2 mg tablet (BUMEX)		
chlorthalidone 25 mg tablet (HYGROTON)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS : DIURETICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
chlorthalidone 50 mg tablet (HYGROTON)		
DIURIL 250 MG/5 ML ORAL SUSP *(chlorothiazide)*		
ethacrynic acid 25 mg tablet (EDECRIN)		
furosemide 10 mg/ml solution (LASIX)		
furosemide 20 mg tablet (LASIX)		
furosemide 40 mg tablet (LASIX)		
furosemide 40 mg/4 ml oral sol		
furosemide 40 mg/5 ml soln		
furosemide 80 mg tablet (LASIX)		
hydrochlorothiazide 12.5 mg cp (MICROZIDE)		
hydrochlorothiazide 12.5 mg tb		
hydrochlorothiazide 25 mg tab (HYDRODIURIL)		
hydrochlorothiazide 25 mg tab (ORETIC)		
hydrochlorothiazide 50 mg tab (HYDRODIURIL)		
indapamide 1.25 mg tablet (LOZOL)		
indapamide 2.5 mg tablet (LOZOL)		
methazolamide 25 mg tablet (NEPTAZANE)		
methazolamide 50 mg tablet (NEPTAZANE)		
metolazone 10 mg tablet (ZAROXOLYN)		
metolazone 2.5 mg tablet (ZAROXOLYN)		
metolazone 5 mg tablet (ZAROXOLYN)		
spironolactone 100 mg tablet (ALDACTONE)		
spironolactone 25 mg tablet (ALDACTONE)		
spironolactone 50 mg tablet (ALDACTONE)		
spironolactone-hctz 25-25 tab (ALDACTAZIDE)		
torsemide 10 mg tablet (DEMADEX)		
torsemide 100 mg tablet (DEMADEX)		
torsemide 20 mg tablet (DEMADEX)		
torsemide 5 mg tablet (DEMADEX)		
triamterene 100 mg capsule (DYRENIUM)		
triamterene 50 mg capsule (DYRENIUM)		
triamterene-hctz 37.5-25 mg cp (DYAZIDE)		
triamterene-hctz 37.5-25 mg tb (MAXZIDE-25 MG)		
triamterene-hctz 75-50 mg tab (MAXZIDE)		

Drug List

CARDIOVASCULAR AGENTS : DIURETICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALDACTAZIDE 25-25 TABLET *(use spironolactone/hydrochlorothiazide)*	PA	Prior Authorization required.
ALDACTAZIDE 50-50 TABLET *(spironolactone/hydrochlorothiazide)*	PA	Prior Authorization required.
ALDACTONE 100 MG TABLET *(use spironolactone)*	PA	Prior Authorization required.
ALDACTONE 25 MG TABLET *(use spironolactone)*	PA	Prior Authorization required.
ALDACTONE 50 MG TABLET *(use spironolactone)*	PA	Prior Authorization required.
CAROSPIR 25 MG/5 ML SUSPENSION *(spironolactone)*	PA	Prior Authorization required.
DYAZIDE 37.5-25 CAPSULE *(use triamterene/hydrochlorothiazide)*	PA	Prior Authorization required.
EDECRIN 25 MG TABLET *(use ethacrynic acid)*	PA	Prior Authorization required.
KEVEYIS 50 MG TABLET *(dichlorphenamide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LASIX 20 MG TABLET *(use furosemide)*	PA	Prior Authorization required.
LASIX 40 MG TABLET *(use furosemide)*	PA	Prior Authorization required.
LASIX 80 MG TABLET *(use furosemide)*	PA	Prior Authorization required.
MAXZIDE 37.5 MG-25 MG TABLET *(use triamterene/hydrochlorothiazide)*	PA	Prior Authorization required.
MAXZIDE 75 MG-50 MG TABLET *(use triamterene/hydrochlorothiazide)*	PA	Prior Authorization required.

CARDIOVASCULAR AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BIDIL 20 MG-37.5 MG TABLET *(isosorbide dinitrate/hydralazine hcl)*		
midodrine hcl 10 mg tablet (PROAMATINE)		
midodrine hcl 2.5 mg tablet (PROAMATINE)		
midodrine hcl 5 mg tablet (PROAMATINE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amlodipine-atorvast 10-10 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 10-20 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 10-40 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 10-80 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 2.5-10 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 2.5-20 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 2.5-40 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 5-10 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 5-20 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 5-40 mg (CADUET)	PA	Prior Authorization required.
amlodipine-atorvast 5-80 mg (CADUET)	PA	Prior Authorization required.

Drug List

CARDIOVASCULAR AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CADUET 10 MG-10 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 10 MG-20 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 10 MG-40 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 10 MG-80 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 5 MG-10 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 5 MG-20 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 5 MG-40 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CADUET 5 MG-80 MG TABLET *(amlodipine besylate/atorvastatin calcium)*	PA	Prior Authorization required.
CIALIS 5 MG TABLET *(tadalafil)*	PA	Prior Authorization required.
CORLANOR 5 MG TABLET *(ivabradine hcl)*	PA	Prior Authorization required.
CORLANOR 5 MG/5 ML ORAL SOLN *(ivabradine hcl)*	PA	Prior Authorization required.
CORLANOR 7.5 MG TABLET *(ivabradine hcl)*	PA	Prior Authorization required.
ENTRESTO 24 MG-26 MG TABLET *(sacubitril/valsartan)*	PA	Prior Authorization required.
ENTRESTO 49 MG-51 MG TABLET *(sacubitril/valsartan)*	PA	Prior Authorization required.
ENTRESTO 97 MG-103 MG TABLET *(sacubitril/valsartan)*	PA	Prior Authorization required.
NORTHERA 100 MG CAPSULE *(droxidopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORTHERA 200 MG CAPSULE *(droxidopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORTHERA 300 MG CAPSULE *(droxidopa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tadalafil 5 mg tablet (CIALIS)	PA	Prior Authorization required.
VYNDAMAX 61 MG CAPSULE *(tafamidis)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VYNDAQEL 20 MG CAPSULE *(tafamidis meglumine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CARDIOVASCULAR AGENTS : PULMONARY HYPERTENSION		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ADCIRCA 20 MG TABLET *(tadalafil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALYQ 20 MG TABLET *(tadalafil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
epoprostenol sodium 0.5 mg vl (FLOLAN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
epoprostenol sodium 0.5 mg vl (VELETRI)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
epoprostenol sodium 1.5 mg vl (FLOLAN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
epoprostenol sodium 1.5 mg vl (VELETRI)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FLOLAN 0.5 MG VIAL *(epoprostenol sodium (glycine))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FLOLAN 1.5 MG VIAL *(epoprostenol sodium (glycine))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS : PULMONARY HYPERTENSION		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
LETAIRIS 10 MG TABLET *(ambrisentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LETAIRIS 5 MG TABLET *(ambrisentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVATIO 10 MG/ML ORAL SUSP *(sildenafil citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
sildenafil 20 mg tablet (REVATIO)	PA	Prior Authorization required.
tadalafil 20 mg tablet (ADCIRCA)	PA	Prior Authorization required.
TRACLEER 125 MG TABLET *(bosentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TRACLEER 32 MG TABLET FOR SUSP *(bosentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TRACLEER 62.5 MG TABLET *(bosentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ADEMPAS 0.5 MG TABLET *(riociguat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADEMPAS 1 MG TABLET *(riociguat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADEMPAS 1.5 MG TABLET *(riociguat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADEMPAS 2 MG TABLET *(riociguat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADEMPAS 2.5 MG TABLET *(riociguat)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ambrisentan 10 mg tablet (LETAIRIS)	PA	Prior Authorization required.
ambrisentan 5 mg tablet (LETAIRIS)	PA	Prior Authorization required.
bosentan 125 mg tablet (TRACLEER)	PA	Prior Authorization required.
bosentan 62.5 mg tablet (TRACLEER)	PA	Prior Authorization required.
OPSUMIT 10 MG TABLET *(macitentan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENITRAM ER 0.125 MG TABLET *(treprostinil diolamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENITRAM ER 0.25 MG TABLET *(treprostinil diolamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENITRAM ER 1 MG TABLET *(treprostinil diolamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENITRAM ER 2.5 MG TABLET *(treprostinil diolamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENITRAM ER 5 MG TABLET *(treprostinil diolamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REMODULIN 1 MG/ML VIAL *(treprostinil sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REMODULIN 10 MG/ML VIAL *(treprostinil sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REMODULIN 2.5 MG/ML VIAL *(treprostinil sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REMODULIN 5 MG/ML VIAL *(treprostinil sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVATIO 10 MG/12.5 ML VIAL *(sildenafil citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVATIO 20 MG TABLET *(use sildenafil citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
sildenafil 10 mg/12.5 ml vial (REVATIO)	PA	Prior Authorization required.
sildenafil 10 mg/ml oral susp (REVATIO)	PA	Prior Authorization required.
treprostinil 100 mg/20 ml vial (REMODULIN)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CARDIOVASCULAR AGENTS : PULMONARY HYPERTENSION		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
treprostinil 20 mg/20 ml vial (REMODULIN)	PA	Prior Authorization required.
treprostinil 200 mg/20 ml vial (REMODULIN)	PA	Prior Authorization required.
treprostinil 50 mg/20 ml vial (REMODULIN)	PA	Prior Authorization required.
TYVASO 1.74 MG/2.9 ML SOLUTION *(treprostinil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TYVASO INHALATION REFILL KIT *(treprostinil/nebulizer accessories)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TYVASO INHALATION STARTER KIT *(treprostinil/nebulizer and accessories)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TYVASO INSTITUTIONAL START KIT *(treprostinil/nebulizer and accessories)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 1,000 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 1,200 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 1,400 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 1,600 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 200 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 200-800 TITRATION PACK *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 400 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 600 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
UPTRAVI 800 MCG TABLET *(selexipag)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VELETRI 0.5 MG VIAL *(use epoprostenol sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VELETRI 1.5 MG VIAL *(use epoprostenol sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENTAVIS 10 MCG/1 ML SOLUTION *(iloprost tromethamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VENTAVIS 20 MCG/1 ML SOLUTION *(iloprost tromethamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CNS Stimulants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
caffeine cit 60 mg/3 ml oral (CAFCIT)		
caffeine cit 60 mg/3 ml vial (CAFCIT)		
CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AFIRMELLE-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ALTAVERA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ALYACEN 1-35 28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ALYACEN 7-7-7-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AMETHIA 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AMETHIA LO TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AMETHYST 90-20 MCG TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ANNOVERA VAGINAL RING *(segesterone acetate/ethinyl estradiol)*	QL,AL	Limited to 1 EA per 365 days; Limited to members between the ages of 10 and 55.
APRI 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ARANELLE 28 TABLET *(norethindrone-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
ASHLYNA 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUBRA EQ-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUBRA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUROVELA 1 MG-20 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUROVELA 21 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUROVELA 24 FE 1 MG-20 MCG TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUROVELA FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AUROVELA FE 1.5 MG-30 MCG TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AVIANE-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AYUNA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
AZURETTE 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
BALCOLTRA TABLET *(levonorgestrel/ethinyl estradiol/ferrous bisglycinate)*	AL	Limited to members between the ages of 10 and 55.
BALZIVA 28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
BEKYREE 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
BEYAZ 28 TABLET *(drospirenone/ethinyl estradiol/levomefolate calcium)*	AL	Limited to members between the ages of 10 and 55.
BLISOVI 24 FE TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
BLISOVI FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
BLISOVI FE 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BRIELLYN TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CAMRESE 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CAMRESE LO TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CAZIANT 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
CHARLOTTE 24 FE CHEWABLE TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
CHATEAL EQ-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CHATEAL-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CRYSELLE-28 TABLET *(norgestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CYCLAFEM 1-35-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CYCLAFEM 7-7-7-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CYRED 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CYRED EQ 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
DASETTA 1-35-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
DASETTA 7/7/7-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
DAYSEE 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
desogest-eth estra 0.15-0.03mg (APRI)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
desogestr-eth estrad eth estra (AZURETTE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
drosp-ee-levomef 3-0.02-0.451 (BEYAZ)	AL	Limited to members between the ages of 10 and 55.
drosp-ee-levomef 3-0.03-0.451 (SAFYRAL)	AL	Limited to members between the ages of 10 and 55.
drospirenone-ee 3-0.02 mg tab (GIANVI)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
drospirenone-ee 3-0.03 mg tab (OCELLA)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ELINEST-28 TABLET *(norgestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ELURYNG VAGINAL RING *(etonogestrel/ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
EMOQUETTE 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ENPRESSE-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ENSKYCE 28 TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ESTARYLLA 0.25-0.035 MG TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ESTROSTEP FE-28 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ethynodiol-eth estra 1mg-35mcg (KELNOR 1 -35)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ethynodiol-eth estra 1mg-50mcg (KELNOR 1 -50)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
etonogestrel-ee vaginal ring (ELURYNG)	AL	Limited to members between the ages of 10 and 55.
FALMINA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
FAYOSIM TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
FEMYNOR 28 TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
GEMMILY 1 MG-20 MCG CAPSULE *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55 years
GENERESS FE CHEWABLE TABLET *(norethindrone-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
GIANVI 3 MG-0.02 MG TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
HAILEY 21 1.5 MG-30 MCG TAB *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
HAILEY 24 FE 1 MG-20 MCG TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
HAILEY FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
HAILEY FE 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
ICLEVIA 0.15 MG-0.03 MG TABLET *(levonorgestrel/ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
INTROVALE 0.15-0.03 MG TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ISIBLOOM 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JAIMIESS 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JASMIEL 3 MG-0.02 MG TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JOLESSA 0.15 MG-0.03 MG TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JULEBER 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JUNEL 1 MG-20 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JUNEL 1.5 MG-30 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JUNEL FE 1 MG-20 MCG TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JUNEL FE 1.5 MG-30 MCG TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
JUNEL FE 24 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KAITLIB FE CHEWABLE TABLET *(norethindrone-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KALLIGA 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KARIVA 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KELNOR 1-35 28 TABLET *(ethynodiol diacetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KELNOR 1-50 TABLET *(ethynodiol diacetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
KURVELO-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL	Limited to 90 EA per 30 days.
KURVELO-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARIN 1.5 MG-30 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARIN 21 1-20 TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARIN 24 FE 1 MG-20 MCG TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARIN FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARIN FE 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LARISSIA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LAYOLIS FE CHEWABLE TABLET *(norethindrone-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LEENA 28 TABLET *(norethindrone-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
LESSINA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LEVONEST-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levono-e estrad 0.15-0.03-0.01 (CAMRESE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-e estrad 0.1-0.02-0.01 (CAMRESE LO)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-eth estra 0.09-0.02 mg (LYBREL)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-eth estrad 0.1-0.02 mg (AFIRMELLE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-eth estrad 0.15-0.03 (ICLEVIA)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-eth estrad 0.15-0.03 (NORDETTE-28)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonor-eth estrad triphasic (ENPRESSE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
levonorg 0.15mg-ee 20-25-30mcg (QUARTETTE)	AL	Limited to members between the ages of 10 and 55.
LEVORA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
LILLOW-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LO LOESTRIN FE 1-10 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
LO-ZUMANDIMINE 3 MG-0.02 MG TB *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOESTRIN 21 1-20 TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOESTRIN 21 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOESTRIN FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOESTRIN FE 1.5-30 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOJAIMIESS 0.1-0.02-0.01 TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LORYNA 3 MG-0.02 MG TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOSEASONIQUE TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LOW-OGESTREL-28 TABLET *(norgestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LUTERA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
MARLISSA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
MELODETTA 24 FE CHEWABLE TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
MERZEE 1 MG-20 MCG CAPSULE *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
MIBELAS 24 FE CHEWABLE TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
MICROGESTIN 21 1-20 TABLET *(norethindrone acetate-ethinyl estradiol)*		
MICROGESTIN 21 1-20 TABLET *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to members between the ages of 10 and 55. Limited to 30 EA per 30 days.
MICROGESTIN 21 1.5-30 TAB *(norethindrone acetate-ethinyl estradiol)*	QL,AL	Limited to members between the ages of 10 and 55. Limited to 30 EA per 30 days.
MICROGESTIN 24 FE 1 MG-20 MCG *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
MICROGESTIN FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to members between the ages of 10 and 55. Limited to 30 EA per 30 days.
MICROGESTIN FE 1.5-30 TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to members between the ages of 10 and 55. Limited to 30 EA per 30 days.
MILI 0.25-0.035 MG TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
MINASTRIN 24 FE CHEWABLE TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
MIRCETTE 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
MONO-LINYAH 28 TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
NATAZIA 28 TABLET *(estradiol valerate/dienogest)*	AL	Limited to members between the ages of 10 and 55.
NECON 0.5-35-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
NIKKI 3 MG-0.02 MG TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
noret-estr-fe 0.4-0.035(21)-75 (FEMCON FE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
noreth-ee-fe 1.5-0.03mg(21)-75 (MICROGESTIN FE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
noreth-estrad-fe 1-0.02(21)-75 (AUROVELA FE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
noreth-estrad-fe 1-0.02(24)-75 (CHARLOTTE 24 FE)	AL	Limited to members between the ages of 10 and 55.
noreth-estrad-fe 1-0.02(24)-75 (GEMMILY)	AL	Limited to members between the ages of 10 and 55.
noreth-estrad-fe 1-0.02(24)-75 (MINASTRIN 24 FE)	AL	Limited to members between the ages of 10 and 55.
norethin-ee 1.5-0.03 mg(21) tb (MICROGESTIN)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norethin-estra-fe 0.8-0.025 mg (GENERESS FE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norethind-eth estrad 1-0.02 mg (MICROGESTIN)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norg-ee 0.18-0.215-0.25/0.025 (TRINESSA LO)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norg-ee 0.18-0.215-0.25/0.035 (ORTHO TRI-CYCLEN)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norg-ethin estra 0.25-0.035 mg (ESTARYLLA)	AL	Limited to members between the ages of 10 and 55.
norg-ethin estra 0.25-0.035 mg (ORTHO-CYCLEN)	AL	Limited to members between the ages of 10 and 55.
NORTREL 0.5-35-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
NORTREL 1-35 21 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
NORTREL 1-35 28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
NORTREL 7-7-7-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
NUVARING VAGINAL RING *(etonogestrel/ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
NYLIA 7-7-7-28 TABLET *(norethindrone-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
NYMYO 0.25-0.035 MG (28) TAB *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
OCELLA 3 MG-0.03 MG TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ORSYTHIA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PHILITH 0.4-0.035 MG TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PIMTREA 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PIRMELLA 1-35 28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PIRMELLA 1-35-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PIRMELLA 7-7-7-28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PORTIA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PREVIFEM TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
QUARTETTE TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
RECLIPSEN 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
RIVELSA TABLET *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
SAFYRAL TABLET *(drospirenone/ethinyl estradiol/levomefolate calcium)*	AL	Limited to members between the ages of 10 and 55.
SEASONIQUE 0.15-0.03-0.01 TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SETLAKIN 0.15 MG-0.03 MG TAB *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SIMLIYA 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SIMPESSE 0.15-0.03-0.01 MG TAB *(levonorgestrel/ethinyl estradiol and ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SPRINTEC 28 DAY TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
SRONYX 0.10-0.02 MG TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SYEDA 28 TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TARINA 24 FE 1 MG-20 MCG TAB *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TARINA FE 1-20 EQ TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TARINA FE 1-20 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TAYTULLA 1 MG-20 MCG CAPSULE *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	AL	Limited to members between the ages of 10 and 55.
TILIA FE 28 TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
TRI FEMYNOR 28 TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-ESTARYLLA TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LEGEST FE-28 DAY TABLET *(norethindrone acetate-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LINYAH TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LO-ESTARYLLA TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LO-MARZIA TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LO-MILI TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-LO-SPRINTEC TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-MILI 28 TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-NYMYO 28 TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-PREVIFEM TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-SPRINTEC TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-VYLIBRA 28 TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRI-VYLIBRA LO TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRINESSA TABLET *(norgestimate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TRIVORA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TWIRLA 120-30 MCG/DAY PATCH *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
TYBLUME 0.1-0.02 MG TABLET *(levonorgestrel/ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
TYDEMY 3-0.03-0.451 MG TABLET *(drospirenone/ethinyl estradiol/levomefolate calcium)*	AL	Limited to members between the ages of 10 and 55.
VELIVET 28 DAY TABLET *(desogestrel-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
VIENVA-28 TABLET *(levonorgestrel/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
VIORELE 28 DAY TABLET *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
VOLNEA 0.15-0.02-0.01 MG TAB *(desogestrel-ethinyl estradiol/ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
VYFEMLA 0.4 MG-0.035 MG TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
VYLIBRA 28 TABLET *(norgestimate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
WERA 0.5/0.035 MG 28 TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

Drug List

CONTRACEPTIVES : COMBINATION CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
WYMZYA FE 0.4-0.035 MG CHEW TB *(norethindrone-ethinyl estradiol/ferrous fumarate)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
XULANE PATCH *(norelgestromin/ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55.
YASMIN 28 TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
YAZ 28 TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ZARAH TABLET *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ZENCHENT 0.4 MG-35 MCG TABLET *(norethindrone-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ZOVIA 1-35 TABLET *(ethynodiol diacetate-ethinyl estradiol)*	AL	Limited to members between the ages of 10 and 55 years
ZOVIA 1-35E TABLET *(ethynodiol diacetate-ethinyl estradiol)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ZUMANDIMINE 3 MG-0.03 MG TAB *(ethinyl estradiol/drospirenone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

CONTRACEPTIVES : EMERGENCY CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ELLA 30 MG TABLET *(ulipristal acetate)*	QL,AL	Limited to 3 EA per fill. Limited to members between the ages of 10 and 55.

CONTRACEPTIVES : PROGESTIN CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CAMILA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
DEBLITANE 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
DEPO-PROVERA 150 MG/ML SYRINGE *(medroxyprogesterone acetate)*	QL,AL	Limited to 1 mL per 84 days; Limited to members between the ages of 10 and 55.
DEPO-PROVERA 150 MG/ML VIAL *(medroxyprogesterone acetate)*	QL,AL	Limited to 1 mL per 84 days; Limited to members between the ages of 10 and 55.
DEPO-SUBQ PROVERA 104 SYRINGE *(medroxyprogesterone acetate)*	AL	Limited to members between the ages of 10 and 55.
ERRIN 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
HEATHER 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
INCASSIA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JENCYCLA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
JOLIVETTE TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LYLEQ 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
LYZA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
medroxyprogesterone 150 mg/ml (DEPO-PROVERA)	QL,AL	Limited to 1 mL per 84 days; Limited to members between the ages of 10 and 55.
NORA-BE TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
norethindrone 0.35 mg tablet (NORA-BE)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CONTRACEPTIVES : PROGESTIN CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
NORLYDA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
ORTHO MICRONOR 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SHAROBEL 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
SLYND 4 MG TABLET *(drospirenone)*	AL	Limited to members between the ages of 10 and 55.
TULANA 0.35 MG TABLET *(norethindrone)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
CORTICOSTEROIDS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
DECADRON 0.5 MG/5 ML ELIXIR *(dexamethasone)*		
DECADRON 0.75 MG TABLET *(dexamethasone)*		
DECADRON 4 MG TABLET *(dexamethasone)*		
DECADRON 6 MG TABLET *(dexamethasone)*		
dexamethasone 0.5 mg tablet (DECADRON)		
dexamethasone 0.5 mg/5 ml elx (DECADRON)		
dexamethasone 0.5 mg/5 ml liq (CONCEDEX)		
dexamethasone 0.75 mg tablet (DECADRON)		
dexamethasone 1 mg tablet		
dexamethasone 1.5 mg tablet (DECADRON)		
dexamethasone 10 day 1.5 mg tb (DEXPAK)		
dexamethasone 13 day 1.5 mg tb (DEXPAK)		
dexamethasone 2 mg tablet		
dexamethasone 4 mg tablet (DECADRON)		
dexamethasone 6 day 1.5 mg tab (DEXPAK)		
dexamethasone 6 day 1.5 mg tab (HIDEX)		
dexamethasone 6 mg tablet (DECADRON)		
DEXAMETHASONE INTENSOL 1 MG/ML *(dexamethasone)*		
fludrocortisone 0.1 mg tablet (FLORINEF ACETATE)		
hydrocortisone 10 mg tablet (CORTEF)		
hydrocortisone 20 mg tablet (CORTEF)		
hydrocortisone 5 mg tablet (CORTEF)		
methylprednisolone 16 mg tab (MEDROL)		
methylprednisolone 32 mg tab (MEDROL)		
methylprednisolone 4 mg dosepk (MEDROL)		
methylprednisolone 4 mg tablet (MEDROL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CORTICOSTEROIDS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
methylprednisolone 8 mg tab (MEDROL)		
MILLIPRED 5 MG TABLET *(prednisolone)*		
MILLIPRED DP 5 MG 12-DAY PACK *(prednisolone)*		
MILLIPRED DP 5 MG 6-DAY PACK *(prednisolone)*		
prednisolone 10 mg/5 ml soln (MILLIPRED)		
prednisolone 15 mg/5 ml soln (ORAPRED)		
prednisolone 15 mg/5 ml soln (PRELONE)		
prednisolone 20 mg/5 ml soln (VERIPRED 20)		
prednisolone 5 mg/5 ml soln (PEDIAPRED)		
prednisolone sod ph 25 mg/5 ml		
prednisone 1 mg tablet (METICORTEN)		
prednisone 10 mg tab dose pack (STERAPRED DS)		
prednisone 10 mg tablet (DELTASONE)		
prednisone 2.5 mg tablet (DELTASONE)		
prednisone 20 mg tablet (DELTASONE)		
prednisone 5 mg tab dose pack (STERAPRED)		
prednisone 5 mg tablet (DELTASONE)		
prednisone 5 mg/5 ml solution		
prednisone 50 mg tablet (DELTASONE)		
PREDNISONE INTENSOL 5 MG/ML *(prednisone)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALKINDI SPRINKLE 0.5 MG CAP *(hydrocortisone)*	PA	Prior Authorization required.
ALKINDI SPRINKLE 1 MG CAPSULE *(hydrocortisone)*	PA	Prior Authorization required.
ALKINDI SPRINKLE 2 MG CAPSULE *(hydrocortisone)*	PA	Prior Authorization required.
ALKINDI SPRINKLE 5 MG CAPSULE *(hydrocortisone)*	PA	Prior Authorization required.
budesonide ec 3 mg capsule (ENTOCORT EC)	PA	Prior Authorization required.
budesonide er 9 mg tablet (UCERIS)	PA	Prior Authorization required.
CORTEF 10 MG TABLET *(use hydrocortisone)*	PA	Prior Authorization required.
CORTEF 20 MG TABLET *(use hydrocortisone)*	PA	Prior Authorization required.
CORTEF 5 MG TABLET *(use hydrocortisone)*	PA	Prior Authorization required.
cortisone 25 mg tablet (CORTONE ACETATE)	PA	Prior Authorization required.
EMFLAZA 18 MG TABLET *(deflazacort)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

CORTICOSTEROIDS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EMFLAZA 22.75 MG/ML ORAL SUSP *(deflazacort)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EMFLAZA 30 MG TABLET *(deflazacort)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EMFLAZA 36 MG TABLET *(deflazacort)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EMFLAZA 6 MG TABLET *(deflazacort)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENTOCORT EC 3 MG CAPSULE *(budesonide)*	PA	Prior Authorization required.
HEMADY 20 MG TABLET *(dexamethasone)*	PA	Prior Authorization required.
MEDROL 16 MG TABLET *(use methylprednisolone)*	PA	Prior Authorization required.
MEDROL 2 MG TABLET *(methylprednisolone)*	PA	Prior Authorization required.
MEDROL 32 MG TABLET *(use methylprednisolone)*	PA	Prior Authorization required.
MEDROL 4 MG DOSEPAK *(use methylprednisolone)*	PA	Prior Authorization required.
MEDROL 4 MG TABLET *(use methylprednisolone)*	PA	Prior Authorization required.
MEDROL 8 MG TABLET *(use methylprednisolone)*	PA	Prior Authorization required.
ORTIKOS ER 6 MG CAPSULE *(budesonide)*	PA	Prior Authorization required.
ORTIKOS ER 9 MG CAPSULE *(budesonide)*	PA	Prior Authorization required.
prednisolone odt 10 mg tablet (ORAPRED ODT)	PA	Prior Authorization required.
prednisolone odt 15 mg tablet (ORAPRED ODT)	PA	Prior Authorization required.
prednisolone odt 30 mg tablet (ORAPRED ODT)	PA	Prior Authorization required.
RAYOS DR 1 MG TABLET *(prednisone)*	PA	Prior Authorization required.
RAYOS DR 2 MG TABLET *(prednisone)*	PA	Prior Authorization required.
RAYOS DR 5 MG TABLET *(prednisone)*	PA	Prior Authorization required.
TAPERDEX 12 DAY 1.5 MG TABLET *(dexamethasone)*	PA	Prior Authorization required.
TAPERDEX 6 DAY 1.5 MG TABLET *(use dexamethasone)*	PA	Prior Authorization required.
TAPERDEX 7 DAY 1.5 MG TAB PACK *(dexamethasone)*	PA	Prior Authorization required.
UCERIS 9 MG ER TABLET *(budesonide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

DERMATOLOGICALS : ACNE PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AKTIPAK 3%-5% GEL POUCH *(erythromycin base/benzoyl peroxide)*		
AVITA 0.025% CREAM *(tretinoin)*	AL	Limited to members age 10 and older.
AVITA 0.025% GEL *(tretinoin)*	AL	Limited to members age 10 and older.
CLINDACIN ETZ 1% PLEDGET *(clindamycin phosphate)*	AL	Limited to members age 10 and older.
CLINDACIN P 1% PLEDGETS *(clindamycin phosphate)*	AL	Limited to members age 10 and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : ACNE PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clindamycin ph 1% gel (CLEOCIN T)	AL	Limited to members age 10 and older.
clindamycin ph 1% solution (CLEOCIN T)	AL	Limited to members age 10 and older.
clindamycin phos 1% pledget (CLEOCIN T)	AL	Limited to members age 10 and older.
clindamycin phosp 1% lotion (CLEOCIN T)	AL	Limited to members age 10 and older.
clindamycin phosphate 1% gel (CLINDAGEL)	AL	Limited to members age 10 and older.
erythromycin 2% gel (ERYGEL)	AL	Limited to members age 10 and older.
erythromycin 2% solution (A-T-S)	AL	Limited to members age 10 and older.
erythromycin-benzoyl gel (BENZAMYCIN)	AL	Limited to members age 10 and older.
tretinoin 0.01% gel (RETIN-A)	AL	Limited to members age 10 and older.
tretinoin 0.025% cream (AVITA)	AL	Limited to members age 10 and older.
tretinoin 0.025% gel (AVITA)	AL	Limited to members age 10 and older.
tretinoin 0.05% cream (RETIN-A)	AL	Limited to members age 10 and older.
tretinoin 0.05% gel (ATRALIN)	AL	Limited to members age 10 and older.
tretinoin 0.1% cream (RETIN-A)	AL	Limited to members age 10 and older.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ABSORICA 10 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA 20 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA 25 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA 30 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA 35 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA 40 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ABSORICA LD 16 MG CAPSULE *(isotretinoin, micronized)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ABSORICA LD 24 MG CAPSULE *(isotretinoin, micronized)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ABSORICA LD 32 MG CAPSULE *(isotretinoin, micronized)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ABSORICA LD 8 MG CAPSULE *(isotretinoin, micronized)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ACANYA GEL PUMP *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ACZONE 5% GEL *(dapsone)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ACZONE 7.5% GEL PUMP *(dapsone)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene 0.1% cream (DIFFERIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene 0.1% gel (DIFFERIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene 0.1% solution (DIFFERIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene 0.3% gel (DIFFERIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene 0.3% gel pump (DIFFERIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
adapalene-bnzyl perox 0.1-2.5% (EPIDUO)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
AKLIEF 0.005% CREAM *(trifarotene)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 20.
ALTRENO 0.05% LOTION *(tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.

Drug List

DERMATOLOGICALS : ACNE PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AMNESTEEM 10 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
AMNESTEEM 20 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
AMNESTEEM 40 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
AMZEEQ 4% FOAM *(minocycline hcl)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 20.
ARAZLO 0.045% LOTION *(tazarotene)*	PA,AL	Prior Authorization Required. Limited to members between the ages of 10 and 20.
ATRALIN 0.05% GEL *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
AZELEX 20% CREAM *(azelaic acid)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BENZACLIN GEL *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BENZACLIN GEL 35G PUMP *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BENZACLIN GEL 50G PUMP *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BENZAMYCIN GEL *(use erythromycin base/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BP 10-1 WASH *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
BP CLEANSING WASH *(sulfacetamide sodium/sulfur/urea)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
CLARAVIS 10 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
CLARAVIS 20 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
CLARAVIS 30 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
CLARAVIS 40 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
CLEOCIN T 1% GEL *(use clindamycin phosphate)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
CLEOCIN T 1% LOTION *(use clindamycin phosphate)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clind ph-benzoyl pero 1.2-2.5% (ACANYA)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clind ph-benzoyl perox 1.2-5% (NEUAC)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clinda-benzoyl perox 1-5% pump (BENZACLIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clinda-tretinoin 1.2%-0.025% (VELTIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
CLINDACIN ETZ KIT *(clindamycin phosphate/skin cleanser comb no.19)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
CLINDACIN PAC KIT *(clindamycin phosphate/skin cleanser comb no.19)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
CLINDAGEL 1% GEL *(use clindamycin phosphate)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clindamycin phosphate 1% foam (EVOCLIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
clindamycin-benzoyl perox 1-5% (BENZACLIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
dapsone 5% gel (ACZONE)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
dapsone 7.5% gel pump (ACZONE)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
DIFFERIN 0.1% CREAM *(adapalene)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
DIFFERIN 0.1% LOTION *(adapalene)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
DIFFERIN 0.3% GEL PUMP *(adapalene)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.

Drug List

DERMATOLOGICALS : ACNE PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EPIDUO 0.1-2.5% GEL PUMP *(adapalene/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
EPIDUO FORTE 0.3-2.5% GEL PUMP *(adapalene/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ERY 2% PADS *(erythromycin base in ethanol)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ERYGEL 2% GEL *(use erythromycin base in ethanol)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
erythromycin 2% pledgets (ERY)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
EVOCLIN 1% FOAM *(clindamycin phosphate)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
FABIOR 0.1% FOAM *(tazarotene)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
isotretinoin 10 mg capsule (ABSORICA)	PA,AL	Prior Authorization required. Limited to members age 12 and older.
isotretinoin 20 mg capsule (ABSORICA)	PA,AL	Prior Authorization required. Limited to members age 12 and older.
isotretinoin 30 mg capsule (ABSORICA)	PA,AL	Prior Authorization required. Limited to members age 12 and older.
isotretinoin 40 mg capsule (ABSORICA)	PA,AL	Prior Authorization required. Limited to members age 12 and older.
KLARON 10% LOTION *(sulfacetamide sodium)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
MYORISAN 10 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
MYORISAN 20 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
MYORISAN 30 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
MYORISAN 40 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
NEUAC 1.2-5% KIT *(clindamycin phosphate/benzoyl peroxide/emollient comb no.94)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
NEUAC GEL *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ONEXTON 1.2%-3.75% GEL *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ONEXTON GEL PUMP *(clindamycin phosphate/benzoyl peroxide)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A 0.01% GEL *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A 0.025% CREAM *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A 0.025% GEL *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A 0.05% CREAM *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A 0.1% CREAM *(use tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO 0.04% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO 0.1% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO PUMP 0.04% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO PUMP 0.06% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO PUMP 0.08% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
RETIN-A MICRO PUMP 0.1% GEL *(tretinoin microspheres)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sod sulface-sulf 9.8-4.8% clsr (PLEXION)	PA,AL	Prior Authorization required. Limited to members age 10 and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : ACNE PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
sod sulface-sulfur 9-4.5% wash (SUMADAN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sod sulfacet-sulfur 10-2% clsr (AVAR LS)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sod sulfacet-sulfur 10-4% pad (SUMAXIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sod sulfacet-sulfur 10-5% clsr (AVAR)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sodium sulf-sulfur cleanser (ROSULA)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sodium sulfacet-sulfur wash (SUMAXIN)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sodium sulfacetamide 10% lotn (KLARON)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SSS 10-5 CREAM *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SSS 10-5 FOAM *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sulfacetamide sod 10% top susp (KLARON)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sulfacetamide-sulfur 10-2% crm (AVAR-E LS)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sulfacetamide-sulfur 10-5% crm (CLENIA)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
sulfacetamide-sulfur 8-4% susp (SUMAXIN TS)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMADAN 9%-4.5% WASH *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMADAN KIT *(sulfacetamide sodium/sulfur/skin cleanser comb no.23)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMADAN XLT KIT *(sulfacetamide sodium/sulfur/avobenzone/octinoxate/octyl sal)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMAXIN 9%-4% WASH *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 20.
SUMAXIN CLEANSING PADS *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMAXIN CP KIT *(sulfacetamide sodium/sulfur/skin cleanser comb no.23)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
SUMAXIN TS TOPICAL SUSPENSION *(sulfacetamide sodium/sulfur)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
TRETIN-X 0.075% CREAM *(tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
tretinoin gel micro 0.04% pump (RETIN-A MICRO PUMP)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
tretinoin gel micro 0.04% tube (RETIN-A MICRO)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
tretinoin gel micro 0.1% pump (RETIN-A MICRO PUMP)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
tretinoin gel micro 0.1% tube (RETIN-A MICRO)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ZENATANE 10 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ZENATANE 20 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ZENATANE 30 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ZENATANE 40 MG CAPSULE *(isotretinoin)*	PA,AL	Prior Authorization required. Limited to members age 12 and older.
ZIANA GEL *(clindamycin phosphate/tretinoin)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.

Drug List

DERMATOLOGICALS : ANTIBIOTICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CORTISPORIN OINTMENT *(neomycin/bacitracin/polymyxin b/hydrocortisone)*		
gentamicin 0.1% cream (GARAMYCIN)	QL	Limited to 30 g per 30 days.
gentamicin 0.1% ointment (GARAMYCIN)		
mupirocin 2% oint topical syrg (CENTANY)	AL	Limited to members age 20 and younger.
mupirocin 2% ointment (CENTANY)	AL	Limited to members age 20 and younger.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CENTANY 2% OINTMENT *(use mupirocin)*	PA,AL	Prior Authorization required. Limited to members age 20 and younger.
CENTANY AT 2% OINTMENT KIT *(mupirocin)*	PA	Prior Authorization required.
CORTISPORIN CREAM *(neomycin sulfate/polymyxin b sulfate/hydrocortisone)*	PA	Prior Authorization required.
mupirocin 2% cream (BACTROBAN)	PA,AL	Prior Authorization required. Limited to members age 20 and younger.
NEO-SYNALAR 0.5%-0.025% CREAM *(neomycin sulfate/fluocinolone acetonide)*	PA	Prior Authorization required.
NEO-SYNALAR 0.5-0.025% CRM KIT *(neomycin sulfate/fluocinolone acetonide/emollient comb no.65)*	PA	Prior Authorization required.
XEPI 1% CREAM *(ozenoxacin)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
DERMATOLOGICALS : ANTIFUNGALS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
clotrimazole 1% topical cream (LOTRIMIN AF)		
econazole nitrate 1% cream (SPECTAZOLE)		
ketoconazole 2% cream (KURIC)		
ketoconazole 2% shampoo (NIZORAL)	QL	Limited to 120 mL per 30 days.
NYAMYC 100,000 UNITS/GM POWDER *(nystatin)*		
nystatin 100,000 unit/gm cream (MYCOSTATIN)		
nystatin 100,000 unit/gm oint (MYCOSTATIN)		
nystatin 100,000 unit/gm oint (NYSTEX)		
nystatin 100,000 unit/gm powd (NYAMYC)		
NYSTOP 100,000 UNITS/GM POWDER *(nystatin)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CICLODAN 0.77% CREAM *(ciclopirox olamine)*	PA	Prior Authorization required.
CICLODAN 0.77% CREAM KIT *(ciclopirox olamine/skin cleanser combination no.28)*	PA	Prior Authorization required.
CICLODAN 8% KIT *(ciclopirox/urea/camphor/menthol/eucalyptol)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : ANTIFUNGALS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CICLODAN 8% SOLUTION *(ciclopirox)*	PA	Prior Authorization required.
ciclopirox 0.77% cream (LOPROX)	PA	Prior Authorization required.
ciclopirox 0.77% gel (LOPROX)	PA	Prior Authorization required.
ciclopirox 0.77% topical susp (LOPROX)	PA	Prior Authorization required.
ciclopirox 1% shampoo (LOPROX)	PA	Prior Authorization required.
ciclopirox 8% solution (PENLAC)	PA	Prior Authorization required.
ciclopirox 8% treatment kit (CICLODAN)	PA	Prior Authorization required.
clotrimazole 1% solution (LOTRIMIN AF)	PA	Prior Authorization required.
clotrimazole-betamethasone crm (LOTRISONE)	PA	Prior Authorization required.
clotrimazole-betamethasone lot (LOTRISONE)	PA	Prior Authorization required.
ECONASIL 1% KIT *(econazole nitrate/gauze bandage/silicone, adhesive)*	PA	Prior Authorization required.
ERTACZO 2% CREAM *(sertaconazole nitrate)*	PA	Prior Authorization required.
EXELDERM 1% CREAM *(sulconazole nitrate)*	PA	Prior Authorization required.
EXELDERM 1% SOLUTION *(sulconazole nitrate)*	PA	Prior Authorization required.
EXTINA 2% FOAM *(ketoconazole)*	PA	Prior Authorization required.
JUBLIA 10% TOPICAL SOLUTION *(efinaconazole)*	PA	Prior Authorization required.
KERYDIN 5% TOPICAL SOLUTION *(tavaborole)*	PA	Prior Authorization required.
ketoconazole 2% foam (EXTINA)	PA	Prior Authorization required.
KETODAN 2% FOAM *(ketoconazole)*	PA	Prior Authorization required.
KETODAN 2% FOAM KIT *(ketoconazole/skin cleanser combination no.28)*	PA	Prior Authorization required.
LOPROX 0.77% CREAM *(ciclopirox olamine)*	PA	Prior Authorization required.
LOPROX 0.77% CREAM KIT *(ciclopirox olamine/skin cleanser combination no.40)*	PA	Prior Authorization required.
LOPROX 0.77% SUSPENSION KIT *(ciclopirox olamine/skin cleanser combination no.40)*	PA	Prior Authorization required.
LOPROX 0.77% TOPICAL SUSP *(ciclopirox olamine)*	PA	Prior Authorization required.
LOPROX 1% SHAMPOO *(ciclopirox)*	PA	Prior Authorization required.
luliconazole 1% cream (LUZU)	PA	Prior Authorization required.
LUZU 1% CREAM *(luliconazole)*	PA	Prior Authorization required.
MENTAX 1% CREAM *(butenafine hcl)*	PA	Prior Authorization required.
miconazole-zinc-petro 0.25-15% (VUSION)	PA	Prior Authorization required.
naftifine hcl 1% cream (NAFTIN)	PA	Prior Authorization required.
naftifine hcl 1% gel (NAFTIN)	PA	Prior Authorization required.
naftifine hcl 2% cream (NAFTIN)	PA	Prior Authorization required.
NAFTIN 1% GEL *(naftifine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : ANTIFUNGALS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NAFTIN 2% GEL *(naftifine hcl)*	PA	Prior Authorization required.
nystatin-triamcinolone cream (MYCOGEN II)	PA	Prior Authorization required.
nystatin-triamcinolone ointm (MYCOLOG II)	PA	Prior Authorization required.
oxiconazole nitrate 1% cream (OXISTAT)	PA	Prior Authorization required.
OXISTAT 1% CREAM *(oxiconazole nitrate)*	PA	Prior Authorization required.
OXISTAT 1% LOTION *(oxiconazole nitrate)*	PA	Prior Authorization required.
tavaborole 5% topical solution (KERYDIN)	PA	Prior Authorization required.
VUSION OINTMENT *(miconazole nitrate/zinc oxide/petrolatum,white)*	PA	Prior Authorization required.
ZOLPAK 1% KIT *(econazole nitrate/transparent dressing)*	PA	Prior Authorization required.

DERMATOLOGICALS : ANTIPSORIATICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
calcipotriene 0.005% cream (DOVONEX)		
calcipotriene 0.005% ointment (CALCITRENE)		
calcipotriene 0.005% solution (DOVONEX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
acitretin 10 mg capsule (SORIATANE)	PA	Prior Authorization required.
acitretin 17.5 mg capsule (SORIATANE)	PA	Prior Authorization required.
acitretin 25 mg capsule (SORIATANE)	PA	Prior Authorization required.
calcitriol 3 mcg/g ointment (VECTICAL)	PA	Prior Authorization required.
COSENTYX 150 MG/ML PEN INJECT *(secukinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COSENTYX 150 MG/ML SYRINGE *(secukinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COSENTYX 300 MG DOSE-2 PENS *(secukinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COSENTYX 300 MG DOSE-2 SYRINGE *(secukinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DOVONEX 0.005% CREAM *(use calcipotriene)*	PA	Prior Authorization required.
ILUMYA 100 MG/ML SYRINGE *(tildrakizumab-asmn)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
methoxsalen 10 mg capsule (OXSORALEN-ULTRA)	PA	Prior Authorization required.
methoxsalen 10 mg softgel (OXSORALEN-ULTRA)	PA	Prior Authorization required.
OXSORALEN-ULTRA 10 MG CAP *(methoxsalen)*	PA	Prior Authorization required.
SILIQ 210 MG/1.5 ML SYRINGE *(brodalumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SKYRIZI 150 MG DOSE KIT-2 SYRN *(risankizumab-rzaa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SORIATANE 10 MG CAPSULE *(acitretin)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : ANTIPSORIATICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SORIATANE 25 MG CAPSULE *(acitretin)*	PA	Prior Authorization required.
SORILUX 0.005% FOAM *(calcipotriene)*	PA	Prior Authorization required.
STELARA 45 MG/0.5 ML SYRINGE *(ustekinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
STELARA 45 MG/0.5 ML VIAL *(ustekinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
STELARA 90 MG/ML SYRINGE *(ustekinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TALTZ 80 MG/ML AUTOINJ (2-PK) *(ixekizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TALTZ 80 MG/ML AUTOINJ (3-PK) *(ixekizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TALTZ 80 MG/ML AUTOINJECTOR *(ixekizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TALTZ 80 MG/ML SYRINGE *(ixekizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tazarotene 0.1% cream (TAZORAC)	PA	Prior Authorization required.
TAZORAC 0.05% CREAM *(tazarotene)*	PA	Prior Authorization required.
TAZORAC 0.05% GEL *(tazarotene)*	PA	Prior Authorization required.
TAZORAC 0.1% CREAM *(tazarotene)*	PA	Prior Authorization required.
TAZORAC 0.1% GEL *(tazarotene)*	PA	Prior Authorization required.
TREMFYA 100 MG/ML INJECTOR *(guselkumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TREMFYA 100 MG/ML SYRINGE *(guselkumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VECTICAL 3 MCG/G OINTMENT *(calcitriol)*	PA	Prior Authorization required.

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Preferred		
alclometasone dipr 0.05% oint (ACLOVATE)		
alclometasone dipro 0.05% crm (ACLOVATE)		
betamethasone va 0.1% cream (BETA-VAL)		
betamethasone va 0.1% lotion (BETA-VAL)		
betamethasone valer 0.1% ointm (VALISONE)		
clobetasol 0.05% cream (TEMOVATE)		
clobetasol 0.05% gel (TEMOVATE)		
clobetasol 0.05% ointment (TEMOVATE)		
clobetasol 0.05% solution (TEMOVATE)		
clobetasol emollient 0.05% crm (TEMOVATE EMOLLIENT)		
desonide 0.05% cream (DESOWEN)		
desonide 0.05% ointment (TRIDESILON)		
diflorasone 0.05% cream (PSORCON)		
diflorasone 0.05% ointment (APEXICON)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Preferred		
fluocinolone 0.01% body oil (DERMA-SMOOTHE-FS)		
fluocinolone 0.01% cream (SYNALAR)		
fluocinolone 0.01% scalp oil (DERMA-SMOOTHE-FS)		
fluocinolone 0.01% solution (SYNALAR)		
fluocinolone 0.025% cream (SYNALAR)		
fluocinolone 0.025% ointment (SYNALAR)		
fluocinonide 0.05% cream (LIDEX)		
fluocinonide 0.05% gel (LIDEX)		
fluocinonide 0.05% ointment (LIDEX)		
fluocinonide 0.05% solution (LIDEX)		
fluocinonide 0.1% cream (VANOS)		
fluocinonide-e 0.05% cream (LIDEX-E)		
fluticasone prop 0.005% oint (CUTIVATE)		
fluticasone prop 0.05% cream (CUTIVATE)		
halobetasol prop 0.05% cream (ULTRAVATE)		
halobetasol prop 0.05% ointmnt (ULTRAVATE)		
hydrocortisone 1% cream (ALA-CORT)		
hydrocortisone 1% ointment (CORTIZONE-10)		
hydrocortisone 2.5% cream (ALA-CORT)		
hydrocortisone 2.5% lotion (HYTONE)		
hydrocortisone 2.5% ointment (HYTONE)		
hydrocortisone val 0.2% cream (WESTCORT)	QL	Limited to 45 g per 30 days.
hydrocortisone val 0.2% ointmt (WESTCORT)	QL	Limited to 45 g per 30 days.
mometasone furoate 0.1% cream (ELOCON)		
mometasone furoate 0.1% oint (ELOCON)		
mometasone furoate 0.1% soln (ELOCON)		
triamcinolone 0.025% cream (ARISTOCORT)		
triamcinolone 0.025% lotion (KENALOG)		
triamcinolone 0.025% oint (KENALOG)		
triamcinolone 0.1% cream (KENALOG)		
triamcinolone 0.1% lotion (KENALOG)		
triamcinolone 0.1% ointment (KENALOG)		
triamcinolone 0.5% cream (KENALOG)		
triamcinolone 0.5% ointment (ARISTOCORT HP)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
amcinonide 0.1% cream (CYCLOCORT)	PA	Prior Authorization required.
amcinonide 0.1% lotion (CYCLOCORT)	PA	Prior Authorization required.
APEXICON E 0.05% CREAM *(diflorasone diacetate/emollient base)*	PA	Prior Authorization required.
BESER 0.05% KIT *(fluticasone propionate/emollient combination no.65)*	PA	Prior Authorization required.
BESER 0.05% LOTION *(fluticasone propionate)*	PA	Prior Authorization required.
betamethasone dp 0.05% crm (DIPROSONE)	PA	Prior Authorization required.
betamethasone dp 0.05% crm (MAXIVATE)	PA	Prior Authorization required.
betamethasone dp 0.05% lot (MAXIVATE)	PA	Prior Authorization required.
betamethasone dp 0.05% oint (MAXIVATE)	PA	Prior Authorization required.
betamethasone dp aug 0.05% crm (DIPROLENE AF)	PA	Prior Authorization required.
betamethasone dp aug 0.05% gel (DIPROLENE)	PA	Prior Authorization required.
betamethasone dp aug 0.05% lot (DIPROLENE)	PA	Prior Authorization required.
betamethasone dp aug 0.05% oin (DIPROLENE)	PA	Prior Authorization required.
betamethasone valer 0.12% foam (LUXIQ)	PA	Prior Authorization required.
BRYHALI 0.01% LOTION *(halobetasol propionate)*	PA	Prior Authorization required.
calcipotriene-betameth dp oint (TACLONEX)	PA	Prior Authorization required.
calcipotriene-betameth dp susp (TACLONEX)	PA	Prior Authorization required.
CAPEX SHAMPOO *(fluocinolone acetonide)*	PA	Prior Authorization required.
clobetasol 0.05% shampoo (CLOBEX)	PA	Prior Authorization required.
clobetasol 0.05% topical lotn (CLOBEX)	PA	Prior Authorization required.
clobetasol emollnt 0.05% foam (OLUX-E)	PA	Prior Authorization required.
clobetasol emulsion 0.05% foam (OLUX-E)	PA	Prior Authorization required.
clobetasol prop 0.05% foam (OLUX)	PA	Prior Authorization required.
clobetasol prop 0.05% spray (CLOBEX)	PA	Prior Authorization required.
CLOBEX 0.05% SHAMPOO *(clobetasol propionate)*	PA	Prior Authorization required.
CLOBEX 0.05% SPRAY *(clobetasol propionate)*	PA	Prior Authorization required.
clocortolone 0.1% cream pump (CLODERM)	PA	Prior Authorization required.
clocortolone pivalate 0.1% crm (CLODERM)	PA	Prior Authorization required.
CLODAN 0.05% KIT *(clobetasol propionate/skin cleanser combination no.28)*	PA	Prior Authorization required.
CLODAN 0.05% SHAMPOO *(clobetasol propionate)*	PA	Prior Authorization required.
CLODERM 0.1% CREAM *(clocortolone pivalate)*	PA	Prior Authorization required.
CLODERM 0.1% CREAM PUMP *(clocortolone pivalate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CORDRAN 4 MCG/SQ CM TAPE LARGE *(flurandrenolide)*	PA	Prior Authorization required.
CUTIVATE 0.05% LOTION *(fluticasone propionate)*	PA	Prior Authorization required.
DERMA-SMOOTHE-FS BODY OIL *(use fluocinolone acetonide)*	PA	Prior Authorization required.
DERMA-SMOOTHE-FS SCALP OIL *(use fluocinolone acetonide/shower cap)*	PA	Prior Authorization required.
DESONATE 0.05% GEL *(desonide)*	PA	Prior Authorization required.
desonide 0.05% lotion (DESOWEN)	PA	Prior Authorization required.
desoximetasone 0.05% cream (TOPICORT)	PA	Prior Authorization required.
desoximetasone 0.05% gel (TOPICORT)	PA	Prior Authorization required.
desoximetasone 0.05% ointment (TOPICORT)	PA	Prior Authorization required.
desoximetasone 0.25% cream (TOPICORT)	PA	Prior Authorization required.
desoximetasone 0.25% ointment (TOPICORT)	PA	Prior Authorization required.
desoximetasone 0.25% spray (TOPICORT)	PA	Prior Authorization required.
DIPROLENE 0.05% OINTMENT *(betamethasone dipropionate/propylene glycol)*	PA	Prior Authorization required.
DUOBRII 0.01%-0.045% LOTION *(halobetasol propionate/tazarotene)*	PA	Prior Authorization required.
ENSTILAR 0.005%-0.064% FOAM *(calcipotriene/betamethasone dipropionate)*	PA	Prior Authorization required.
EPIFOAM FOAM *(hydrocortisone acetate/pramoxine hcl)*	PA	Prior Authorization required.
FLUOPAR 0.1%-5% CREAM KIT *(fluocinonide/dimethicone)*	PA	Prior Authorization required.
flurandrenolide 0.05% cream (CORDRAN)	PA	Prior Authorization required.
flurandrenolide 0.05% lotion (CORDRAN)	PA	Prior Authorization required.
flurandrenolide 0.05% ointment (CORDRAN)	PA	Prior Authorization required.
fluticasone prop 0.05% lotion (CUTIVATE)	PA	Prior Authorization required.
halcinonide 0.1% cream (HALOG)	PA	Prior Authorization required.
halobetasol prop 0.05% foam (LEXETTE)	PA	Prior Authorization required.
HALOG 0.1% CREAM *(halcinonide)*	PA	Prior Authorization required.
HALOG 0.1% OINTMENT *(halcinonide)*	PA	Prior Authorization required.
HALOG 0.1% SOLUTION *(halcinonide)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
hydrocort buty 0.1% lipid crm (LOCOID LIPOCREAM)	PA	Prior Authorization required.
hydrocort buty 0.1% lipo cream (LOCOID LIPOCREAM)	PA	Prior Authorization required.
hydrocortisone buty 0.1% cream (LOCOID)	PA	Prior Authorization required.
hydrocortisone butyr 0.1% lotn (LOCOID)	PA	Prior Authorization required.
hydrocortisone butyr 0.1% oint (LOCOID)	PA	Prior Authorization required.
hydrocortisone butyr 0.1% soln (LOCOID)	PA	Prior Authorization required.
IMPEKLO 0.05% LOTION *(clobetasol propionate)*	PA	Prior Authorization required.

Drug List

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
KENALOG 0.147 MG/GRAM SPRAY *(triamcinolone acetonide)*	PA	Prior Authorization required.
LEXETTE 0.05% FOAM *(halobetasol propionate)*	PA	Prior Authorization required.
LOCOID 0.1% LIPOCREAM *(hydrocortisone butyrate/emollient base)*	PA	Prior Authorization required.
LOCOID 0.1% LOTION *(hydrocortisone butyrate)*	PA	Prior Authorization required.
LUXIQ 0.12% FOAM *(betamethasone valerate)*	PA	Prior Authorization required.
OLUX 0.05% FOAM *(clobetasol propionate)*	PA	Prior Authorization required.
OLUX-E 0.05% FOAM *(clobetasol propionate/emollient base)*	PA	Prior Authorization required.
PANDEL 0.1% CREAM *(hydrocortisone probutate)*	PA	Prior Authorization required.
prednicarbate 0.1% cream (DERMATOP)	PA	Prior Authorization required.
prednicarbate 0.1% ointment (DERMATOP)	PA	Prior Authorization required.
PSORCON 0.05% CREAM *(use diflorasone diacetate)*	PA	Prior Authorization required.
SYNALAR 0.01% SOLUTION *(use fluocinolone acetonide)*	PA	Prior Authorization required.
SYNALAR 0.025% CREAM *(use fluocinolone acetonide)*	PA	Prior Authorization required.
SYNALAR 0.025% CREAM KIT *(fluocinolone acetonide/emollient combination no.65)*	PA	Prior Authorization required.
SYNALAR 0.025% OINTMENT *(use fluocinolone acetonide)*	PA	Prior Authorization required.
SYNALAR 0.025% OINTMENT KIT *(fluocinolone acetonide/emollient combination no.65)*	PA	Prior Authorization required.
SYNALAR TS 0.01% KIT *(fluocinolone acetonide/skin cleanser comb no.28)*	PA	Prior Authorization required.
TACLONEX 0.005%-0.064% SUSPENS *(calcipotriene/betamethasone dipropionate)*	PA	Prior Authorization required.
TACLONEX OINTMENT *(calcipotriene/betamethasone dipropionate)*	PA	Prior Authorization required.
TASOPROL 0.05% KIT *(clobetasol propionate/gauze bandage/silicone, adhesive)*	PA	Prior Authorization required.
TEMOVATE 0.05% CREAM *(use clobetasol propionate)*	PA	Prior Authorization required.
TEMOVATE 0.05% OINTMENT *(use clobetasol propionate)*	PA	Prior Authorization required.
TEXACORT 2.5% SOLUTION *(hydrocortisone)*	PA	Prior Authorization required.
TOPICORT 0.05% CREAM *(desoximetasone)*	PA	Prior Authorization required.
TOPICORT 0.05% GEL *(desoximetasone)*	PA	Prior Authorization required.
TOPICORT 0.05% OINTMENT *(desoximetasone)*	PA	Prior Authorization required.
TOPICORT 0.25% CREAM *(desoximetasone)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : CORTICOSTEROIDS - TOPICAL		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TOPICORT 0.25% OINTMENT *(desoximetasone)*	PA	Prior Authorization required.
TOPICORT 0.25% SPRAY *(desoximetasone)*	PA	Prior Authorization required.
TOVET 0.05% FOAM KIT *(clobetasol propionate/emollient combination no.65)*	PA	Prior Authorization required.
TOVET EMOLLIENT 0.05% FOAM *(clobetasol propionate/emollient base)*	PA	Prior Authorization required.
triamcinolone 0.05% ointment (TRIANEX)	PA	Prior Authorization required.
triamcinolone 0.147 mg/g spray (KENALOG)	PA	Prior Authorization required.
TRIANEX 0.05% OINTMENT *(triamcinolone acetonide)*	PA	Prior Authorization required.
TRILOCICLO KIT *(ciclopirox/triamcinolone acetonide)*	PA	Prior Authorization Required.
ULTRAVATE 0.05% CREAM *(use halobetasol propionate)*	PA	Prior Authorization required.
ULTRAVATE 0.05% LOTION *(halobetasol propionate)*	PA	Prior Authorization required.
ULTRAVATE 0.05% OINTMENT *(use halobetasol propionate)*	PA	Prior Authorization required.
ULTRAVATE X CREAM COMBO PACK *(halobetasol propionate/lactic acid)*	PA	Prior Authorization required.
ULTRAVATE X OINTMENT COMBO PAC *(halobetasol propionate/lactic acid)*	PA	Prior Authorization required.
VANOS 0.1% CREAM *(use fluocinonide)*	PA	Prior Authorization required.

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ammonium lactate 12% lotion (GERI-HYDROLAC)		
CONDYLOX 0.5% GEL *(podofilox)*		
GLYDO 2% JELLY SYRINGE *(lidocaine hcl)*	QL	Limited to 20 mL per 30 days.
imiquimod 5% cream packet (ALDARA)	AL	Limited to members age 10 and older.
LEVULAN KERASTICK *(aminolevulinic acid hcl)*		
lidocaine 3% cream (LIDAMANTLE)		
lidocaine 5% ointment		
lidocaine 5% patch (LIDODERM)		
lidocaine hcl 2% jel urojet ac (XYLOCAINE)	QL	Limited to 20 mL per 30 days.
lidocaine hcl 2% jelly (ANESTACON)	QL	Limited to 30 mL per 30 days.
lidocaine hcl 2% jelly uro-jet (XYLOCAINE)	QL	Limited to 20 mL per 30 days.
lidocaine hcl 4% solution (XYLOCAINE)	QL	Limited to 50 mL per 30 days.
mafenide acetate 50 gm powd pk (SULFAMYLON)		
metronidazole 0.75% cream (METROCREAM)	QL	Limited to 45 g per 30 days.
metronidazole 0.75% lotion (METROLOTION)		

Drug List

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
metronidazole top 1% gel pump (METROGEL)		
metronidazole topical 0.75% gl (ROSADAN)		
metronidazole topical 1% gel (METROGEL)		
PANRETIN 0.1% GEL *(alitretinoin)*		
podofilox 0.5% topical soln (CONDYLOX)		
ROSADAN 0.75% CREAM *(metronidazole)*	QL	Limited to 45 g per 30 days.
ROSADAN 0.75% GEL *(metronidazole)*		
salicylic acid 27.5% liquid (VIRASAL)		
salicylic acid 6% gel (KERALYT)		
selenium sulfide 2.5% lotion		
silver sulfadiazine 1% cream (THERMAZENE)		
SSD 1% CREAM *(silver sulfadiazine)*		
SULFAMYLON 8.5% CREAM *(mafenide acetate)*		
TARGRETIN 1% GEL *(bexarotene)*	SP	Restricted to specialty pharmacies.
urea 39% cream (ALUVEA)		
urea 40% cream (UREACIN 40)		
urea 40% lotion (CARMOL 40)		
urea 41% cream (UTOPIC)		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ELIDEL 1% CREAM *(pimecrolimus)*	PA	Prior Authorization required.
EUCRISA 2% OINTMENT *(crisaborole)*	PA	Prior Authorization required.
pimecrolimus 1% cream (ELIDEL)	PA	Prior Authorization required.
PROTOPIC 0.03% OINTMENT *(tacrolimus)*	PA	Prior Authorization required.
PROTOPIC 0.1% OINTMENT *(tacrolimus)*	PA	Prior Authorization required.
tacrolimus 0.03% ointment (PROTOPIC)	PA	Prior Authorization required.
tacrolimus 0.1% ointment (PROTOPIC)	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
acyclovir 5% cream (ZOVIRAX)	PA	Prior Authorization required.
acyclovir 5% ointment (ZOVIRAX)	PA	Prior Authorization required.
ALDARA 5% CREAM *(use imiquimod)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
AMELUZ 10% GEL *(aminolevulinic acid hcl)*	PA	Prior Authorization required.
ammonium lactate 12% cream (LAC-HYDRIN)	PA	Prior Authorization required.
APRIZIO PAK II 2.5%-2.5% CRM *(lidocaine/prilocaine)*	PA	Prior Authorization required.
azelaic acid 15% gel (FINACEA)	PA	Prior Authorization required.
BENSAL HP 3% OINTMENT *(salicylic acid)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BPCO OINTMENT *(balsam peru/castor oil)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
BPCO OINTMENT *(balsam peru/castor oil)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
CARAC 0.5% CREAM *(fluorouracil)*	PA	Prior Authorization required.
DENAVIR 1% CREAM *(penciclovir)*	PA	Prior Authorization required.
diclofenac 1.5% topical soln (KLOFENSAID II)	PA	Prior Authorization required.
diclofenac epolamine 1.3% ptch (FLECTOR)	PA	Prior Authorization required.
diclofenac sodium 1% gel (ARTHRITIS PAIN)	PA	Prior Authorization required.
diclofenac sodium 3% gel (SOLARAZE)	PA	Prior Authorization required.
DICLOFEX DC PACK *(diclofenac sodium/capsicum oleoresin)*	PA	Prior Authorization required.
DICLOTREX 1.5%-4%-10% KIT *(diclofenac sodium/menthol/camphor)*	PA	Prior Authorization required
doxepin 5% cream (PRUDOXIN)	PA	Prior Authorization required.
doxycycline ir-dr 40 mg cap (ORACEA)	PA	Prior Authorization required.
EFUDEX 5% CREAM *(fluorouracil)*	PA	Prior Authorization required.
EMPRICAINE-II 2.5%-2.5% CRM KT *(lidocaine/prilocaine)*	PA	Prior Authorization required.
FINACEA 15% FOAM *(azelaic acid)*	PA	Prior Authorization required.
FINACEA 15% GEL *(azelaic acid)*	PA	Prior Authorization required.
FLECTOR 1.3% PATCH *(diclofenac epolamine)*	PA	Prior Authorization required.
fluorouracil 0.5% cream (CARAC)	PA	Prior Authorization required.
fluorouracil 2% topical soln (EFUDEX)	PA	Prior Authorization required.
fluorouracil 5% cream (EFUDEX)	PA	Prior Authorization required.
fluorouracil 5% topical soln (EFUDEX)	PA	Prior Authorization required.
HYCLODEX 0.012% SPRAY SOLUTION *(hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)*	PA	Prior Authorization required.
HYLATOPICPLUS CREAM *(emollient combination no.53)*	PA	Prior Authorization required.
HYLATOPICPLUS LOTION *(emollient combination no.53)*	PA	Prior Authorization required.
HYPOCYN 0.01% SPRAY SOLUTION *(hypochlorous acid/sodium chloride)*	PA	Prior Authorization required.
imiquimod 3.75% cream (ZYCLARA)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
imiquimod 3.75% cream pump (ZYCLARA)	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ivermectin 1% cream (SOOLANTRA)	PA	Prior Authorization required.
LICART 1.3% PATCH *(diclofenac epolamine)*	PA	Prior Authorization required.
lidocaine-prilocaine cream (EMLA)	PA	Prior Authorization required.
LIDODERM 5% PATCH *(use lidocaine)*	PA	Prior Authorization required.
LIDOZION 3% LOTION *(lidocaine hcl)*	PA	Prior Authorization required.
METROCREAM 0.75% CREAM *(use metronidazole)*	PA,QL	Prior Authorization required. Limited to 45 g per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
METROGEL TOPICAL 1% GEL *(use metronidazole)*	PA	Prior Authorization required.
MIRVASO 0.33% GEL PUMP *(brimonidine tartrate)*	PA	Prior Authorization required.
NORITATE 1% CREAM *(metronidazole)*	PA	Prior Authorization required.
NUVAIL NAIL 16% SOLUTION *(poly-ureaurethane)*	PA	Prior Authorization required.
NUVAKAAN-II KIT *(lidocaine/prilocaine/silicone, adhesive)*	PA	Prior Authorization required.
ORACEA 40 MG CAPSULE *(doxycycline monohydrate)*	PA	Prior Authorization required.
OVACE PLUS 9.8% LOTION *(sulfacetamide sodium)*	PA	Prior Authorization required.
PENNSAID 2% PUMP *(diclofenac sodium)*	PA	Prior Authorization required.
PENNSAID 2% SOLUTION PACKET *(diclofenac sodium)*	PA	Prior Authorization required.
PICATO 0.015% GEL *(ingenol mebutate)*	PA	Prior Authorization required.
PICATO 0.05% GEL *(ingenol mebutate)*	PA	Prior Authorization required.
PLIAGLIS 7%-7% CREAM *(lidocaine/tetracaine)*	PA	Prior Authorization required.
PODOCON-25 LIQUID *(podophyllum resin)*	PA	Prior Authorization required.
PRILO PATCH II KIT *(lidocaine/prilocaine)*	PA	Prior Authorization Required.
PRIZOPAK II 2.5%-2.5% CRM KIT *(lidocaine/prilocaine)*	PA	Prior Authorization required.
PRIZOTRAL-II 2.5%-2.5%-3.88% *(lidocaine/prilocaine/lidocaine hcl)*	PA	Prior Authorization required.
PRUDOXIN 5% CREAM *(doxepin hcl)*	PA	Prior Authorization required.
QBREXZA 2.4% CLOTH *(glycopyrronium tosylate)*	PA	Prior Authorization required.
QUTENZA 8% KIT (1 PATCH) *(capsaicin/skin cleanser)*	PA	Prior Authorization required.
QUTENZA 8% KIT (2 PATCH) *(capsaicin/skin cleanser)*	PA	Prior Authorization required.
REGRANEX 0.01% GEL *(becaplermin)*	PA	Prior Authorization required.
RHOFADE 1% CREAM *(oxymetazoline hcl)*	PA	Prior Authorization required.
ROSADAN 0.75% CREAM KIT *(metronidazole/skin cleanser combination no.23)*	PA	Prior Authorization required.
ROSADAN 0.75% GEL KIT *(metronidazole/skin cleanser combination no.23)*	PA	Prior Authorization required.
SALEX 6% SHAMPOO *(salicylic acid)*	PA	Prior Authorization required.
salicylic acid 6% foam (SALVAX)	PA	Prior Authorization required.
SANTYL OINTMENT *(collagenase clostridium histolyticum)*	PA	Prior Authorization required.
selenium sulfide 2.25% shampoo (SELSEB)	PA	Prior Authorization required.
selenium sulfide 2.3% shampoo (SELRX)	PA	Prior Authorization required.
SILVADENE 1% CREAM *(use silver sulfadiazine)*	PA	Prior Authorization required.
silver nitrate 0.5% soln	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
silver nitrate applicator	PA	Prior Authorization required.
sod sulfacetam 10% clnsng gel (OVACE PLUS WASH)	PA	Prior Authorization required.
sodium sulfacetamide 10% wash (OVACE)	PA	Prior Authorization required.
SOOLANTRA 1% CREAM *(ivermectin)*	PA	Prior Authorization required.
SULFAMYLON POWDER PACKET *(use mafenide acetate)*	PA	Prior Authorization required.
SYNERA PATCH *(lidocaine/tetracaine)*	PA	Prior Authorization required.
TETRIX CREAM *(protectives combination no.2)*	PA	Prior Authorization required.
TOLAK 4% CREAM *(fluorouracil)*	PA	Prior Authorization required.
urea 35% foam (HYDRO 35)	PA	Prior Authorization required.
VALCHLOR 0.016% GEL *(mechlorethamine hcl)*	PA	Prior Authorization required.
VENNGEL ONE 1% KIT *(diclofenac sodium)*	PA	Prior Authorization Required.
VEREGEN 15% OINTMENT *(sinecatechins)*	PA	Prior Authorization required.
VOLTAREN 1% GEL *(diclofenac sodium)*	PA	Prior Authorization required.
XERESE 5%-1% CREAM *(acyclovir/hydrocortisone)*	PA	Prior Authorization required.
ZILXI 1.5% FOAM *(minocycline hcl)*	PA	Prior Authorization required.
ZONALON 5% CREAM *(doxepin hcl)*	PA	Prior Authorization required.
ZOVIRAX 5% CREAM *(acyclovir)*	PA	Prior Authorization required.
ZOVIRAX 5% OINTMENT *(acyclovir)*	PA	Prior Authorization required.
ZTLIDO 1.8% TOPICAL SYSTEM *(lidocaine)*	PA	Prior Authorization required.
ZYCLARA 2.5% CREAM PUMP *(imiquimod)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ZYCLARA 3.75% CREAM *(imiquimod)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.
ZYCLARA 3.75% CREAM PUMP *(imiquimod)*	PA,AL	Prior Authorization required. Limited to members age 10 and older.

DERMATOLOGICALS : SCABICIDES & PEDICULICIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
EURAX 10% CREAM *(crotamiton)*		
NATROBA 0.9% TOPICAL SUSP *(spinosad)*	QL	Limited to 120 mL per 30 days.
permethrin 5% cream (ELIMITE)	QL	Limited to 60 g per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CROTAN 10% LOTION *(crotamiton)*	PA	Prior Authorization required.
ELIMITE 5% CREAM *(use permethrin)*	PA,QL	Prior Authorization required. Limited to 60 g per 30 days.
EURAX 10% LOTION *(crotamiton)*	PA	Prior Authorization required.
ivermectin 0.5% lotion (SKLICE)	PA	Prior Authorization Required.
lindane 1% shampoo (KWELL)	PA	Prior Authorization required.
malathion 0.5% lotion (PRIODERM)	PA	Prior Authorization required.

Drug List

DERMATOLOGICALS : SCABICIDES & PEDICULICIDES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OVIDE 0.5% LOTION *(malathion)*	PA	Prior Authorization required.
SKLICE 0.5% LOTION *(ivermectin)*	PA	Prior Authorization required.
spinosad 0.9% topical susp (NATROBA)	PA,QL	Prior Authorization required. Limited to 120 mL per 30 days.
Diabetic Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
chlorpropamide 100 mg tablet (DIABINESE)		
chlorpropamide 250 mg tablet (DIABINESE)		
DIGESTIVE ENZYMES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CREON DR 12,000 UNITS CAPSULE *(lipase/protease/amylase)*		
CREON DR 24,000 UNITS CAPSULE *(lipase/protease/amylase)*		
CREON DR 3,000 UNITS CAPSULE *(lipase/protease/amylase)*		
CREON DR 36,000 UNITS CAPSULE *(lipase/protease/amylase)*		
CREON DR 6,000 UNITS CAPSULE *(lipase/protease/amylase)*		
PANCREAZE DR 10,500 UNIT CAP *(lipase/protease/amylase)*		
PANCREAZE DR 16,800 UNIT CAP *(lipase/protease/amylase)*		
PANCREAZE DR 2,600 UNIT CAP *(lipase/protease/amylase)*		
PANCREAZE DR 21,000 UNIT CAP *(lipase/protease/amylase)*		
PANCREAZE DR 4,200 UNIT CAP *(lipase/protease/amylase)*		
ZENPEP DR 10,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 15,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 20,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 25,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 3,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 40,000 UNIT CAPSULE *(lipase/protease/amylase)*		
ZENPEP DR 5,000 UNIT CAPSULE *(lipase/protease/amylase)*		

Drug List

DIGESTIVE ENZYMES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PERTZYE DR 16,000 UNIT CAPSULE *(lipase/protease/amylase)*	PA	Prior Authorization required.
PERTZYE DR 24,000 UNIT CAPSULE *(lipase/protease/amylase)*	PA	Prior Authorization required.
PERTZYE DR 4,000 UNIT CAPSULE *(lipase/protease/amylase)*	PA	Prior Authorization required.
PERTZYE DR 8,000 UNIT CAPSULE *(lipase/protease/amylase)*	PA	Prior Authorization required.
VIOKACE 10,440-39,150 UNITS TB *(lipase/protease/amylase)*	PA	Prior Authorization required.
VIOKACE 20,880-78,300 UNITS TB *(lipase/protease/amylase)*	PA	Prior Authorization required.

ENDOCRINE AND METABOLIC AGENTS : BONE DENSITY REGULATORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
alendronate sod 70 mg/75 ml (FOSAMAX)		
alendronate sodium 10 mg tab (FOSAMAX)	QL	Limited to 30 EA per 30 days.
alendronate sodium 35 mg tab (FOSAMAX)	QL	Limited to 4 EA per 28 days.
alendronate sodium 40 mg tab (FOSAMAX)		
alendronate sodium 5 mg tablet (FOSAMAX)		
alendronate sodium 70 mg tab (FOSAMAX)	QL	Limited to 4 EA per 28 days.
calcitonin-salmon 200 units sp (MIACALCIN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTONEL 150 MG TABLET *(risedronate sodium)*	PA	Prior Authorization required.
ACTONEL 35 MG TABLET *(risedronate sodium)*	PA	Prior Authorization required.
ATELVIA DR 35 MG TABLET *(risedronate sodium)*	PA	Prior Authorization required.
BINOSTO 70 MG TABLET EFF *(alendronate sodium)*	PA	Prior Authorization required.
BONIVA 150 MG TABLET *(ibandronate sodium)*	PA	Prior Authorization required.
FOSAMAX 70 MG TABLET *(use alendronate sodium)*	PA,QL	Prior Authorization required. Limited to 4 EA per 28 days.
FOSAMAX PLUS D 70 MG-2,800 IU *(alendronate sodium/cholecalciferol (vitamin d3))*	PA	Prior Authorization required.
FOSAMAX PLUS D 70 MG-5,600 IU *(alendronate sodium/cholecalciferol (vitamin d3))*	PA	Prior Authorization required.
ibandronate sodium 150 mg tab (BONIVA)	PA	Prior Authorization required.
risedronate sod dr 35 mg tab (ATELVIA)	PA	Prior Authorization required.
risedronate sodium 150 mg tab (ACTONEL)	PA	Prior Authorization required.
risedronate sodium 30 mg tab (ACTONEL)	PA	Prior Authorization required.
risedronate sodium 35 mg tab (ACTONEL)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ENDOCRINE AND METABOLIC AGENTS : BONE DENSITY REGULATORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
risedronate sodium 5 mg tablet (ACTONEL)	PA	Prior Authorization required.

ENDOCRINE AND METABOLIC AGENTS : GROWTH HORMONES		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
GENOTROPIN 12 MG CARTRIDGE *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN 5 MG CARTRIDGE *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 0.2 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 0.4 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 0.6 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 0.8 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 1 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 1.2 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 1.4 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 1.6 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 1.8 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GENOTROPIN MINIQUICK 2 MG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
HUMATROPE 12 MG CARTRIDGE *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMATROPE 24 MG CARTRIDGE *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMATROPE 5 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMATROPE 6 MG CARTRIDGE *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORDITROPIN FLEXPRO 10 MG/1.5 *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORDITROPIN FLEXPRO 15 MG/1.5 *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORDITROPIN FLEXPRO 30 MG/3 ML *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NORDITROPIN FLEXPRO 5 MG/1.5 *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUTROPIN AQ NUSPIN 10 INJECTOR *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUTROPIN AQ NUSPIN 20 INJECTOR *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUTROPIN AQ NUSPIN 5 INJECTOR *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ENDOCRINE AND METABOLIC AGENTS : GROWTH HORMONES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OMNITROPE 10 MG/1.5 ML CRTG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OMNITROPE 5 MG/1.5 ML CRTG *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OMNITROPE 5.8 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SAIZEN 5 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SAIZEN 8.8 MG SAIZENPREP CART *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SAIZEN 8.8 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SEROSTIM 4 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SEROSTIM 5 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SEROSTIM 6 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZOMACTON 10 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZOMACTON 5 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZORBTIVE 8.8 MG VIAL *(somatropin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENDOCRINE AND METABOLIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cabergoline 0.5 mg tablet (DOSTINEX)		
desmopressin 0.01% solution (MINIRIN)		
desmopressin 0.01% spray (MINIRIN)		
desmopressin 10 mcg/0.1 ml spr (DDAVP)		
desmopressin acetate 0.1 mg tb (DDAVP)	QL	Limited to 180 EA per 30 days.
desmopressin acetate 0.2 mg tb (DDAVP)	QL	Limited to 180 EA per 30 days.
nitisinone 10 mg capsule (ORFADIN)		
nitisinone 2 mg capsule (ORFADIN)		
nitisinone 5 mg capsule (ORFADIN)		
ORFADIN 10 MG CAPSULE *(nitisinone)*	SP	Restricted to specialty pharmacies.
ORFADIN 2 MG CAPSULE *(nitisinone)*	SP	Restricted to specialty pharmacies.
ORFADIN 20 MG CAPSULE *(nitisinone)*	SP	Restricted to specialty pharmacies.
ORFADIN 5 MG CAPSULE *(nitisinone)*	SP	Restricted to specialty pharmacies.
STIMATE 1.5 MG/ML NASAL SPRAY *(desmopressin acetate)*	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ORILISSA 150 MG TABLET *(elagolix sodium)*	PA	Prior Authorization required.
ORILISSA 200 MG TABLET *(elagolix sodium)*	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BUPHENYL 500 MG TABLET *(sodium phenylbutyrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ENDOCRINE AND METABOLIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BUPHENYL POWDER *(sodium phenylbutyrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BYNFEZIA 2,500 MCG/ML PEN *(octreotide acetate)*	PA	Prior Authorization required.
CARBAGLU 200 MG DISPER TABLET *(carglumic acid)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CARNITOR 100 MG/ML ORAL SOLN *(levocarnitine (with sugar))*	PA	Prior Authorization required.
CARNITOR 330 MG TABLET *(levocarnitine)*	PA	Prior Authorization required.
CARNITOR SF 100 MG/ML ORAL SOL *(levocarnitine)*	PA	Prior Authorization required.
cinacalcet hcl 30 mg tablet (SENSIPAR)	PA	Prior Authorization required.
cinacalcet hcl 60 mg tablet (SENSIPAR)	PA	Prior Authorization required.
cinacalcet hcl 90 mg tablet (SENSIPAR)	PA	Prior Authorization required.
CYSTADANE 1 GRAM/1.7 ML POWDER *(betaine)*	PA	Prior Authorization required.
DDAVP 0.01% NASAL SPRAY *(use desmopressin acetate (non-refrigerated))*	PA	Prior Authorization required.
DDAVP 0.1 MG TABLET *(use desmopressin acetate)*	PA,QL	Prior Authorization required. Limited to 180 EA per 30 days.
DDAVP 0.2 MG TABLET *(use desmopressin acetate)*	PA,QL	Prior Authorization required. Limited to 180 EA per 30 days.
DDAVP 10 MCG/0.1 ML SOLUTION *(desmopressin acetate)*	PA	Prior Authorization required.
EGRIFTA 1 MG VIAL *(tesamorelin acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EGRIFTA SV 2 MG VIAL *(tesamorelin acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EVISTA 60 MG TABLET *(raloxifene hcl)*	PA	Prior Authorization required.
GALAFOLD 123 MG CAPSULE *(migalastat hcl)*	PA	Prior Authorization required.
INCRELEX 40 MG/4 ML VIAL *(mecasermin)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ISTURISA 1 MG TABLET *(osilodrostat phosphate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ISTURISA 10 MG TABLET *(osilodrostat phosphate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ISTURISA 5 MG TABLET *(osilodrostat phosphate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
JYNARQUE 15 MG TABLET *(tolvaptan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JYNARQUE 15 MG-15 MG TABLET *(tolvaptan)*	PA	Prior Authorization Required.
JYNARQUE 30 MG TABLET *(tolvaptan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JYNARQUE 30 MG-15 MG TABLET *(tolvaptan)*	PA	Prior Authorization Required.
JYNARQUE 45 MG-15 MG TABLET *(tolvaptan)*	PA	Prior Authorization required.
JYNARQUE 60 MG-30 MG TABLET *(tolvaptan)*	PA	Prior Authorization required.
JYNARQUE 90 MG-30 MG TABLET *(tolvaptan)*	PA	Prior Authorization required.
KUVAN 100 MG POWDER PACKET *(sapropterin dihydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ENDOCRINE AND METABOLIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
KUVAN 100 MG TABLET *(sapropterin dihydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KUVAN 500 MG POWDER PACKET *(sapropterin dihydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
levocarnitine 1 g/10 ml soln (CARNITOR)	PA	Prior Authorization required.
levocarnitine 330 mg tablet (CARNITOR)	PA	Prior Authorization required.
levocarnitine sf 1 g/10 ml sol (CARNITOR SF)	PA	Prior Authorization required.
MIFEPREX 200 MG TABLET *(mifepristone)*	PA	Prior Authorization required.
mifepristone 200 mg tablet (MIFEPREX)	PA	Prior Authorization required.
MYCAPSSA DR 20 MG CAPSULE *(octreotide acetate)*	PA	Prior Authorization required.
NITYR 10 MG TABLET *(nitisinone)*	PA	Prior Authorization required.
NITYR 2 MG TABLET *(nitisinone)*	PA	Prior Authorization required.
NITYR 5 MG TABLET *(nitisinone)*	PA	Prior Authorization required.
NOCDURNA 27.7 MCG TABLET SL *(desmopressin acetate)*	PA	Prior Authorization required.
NOCDURNA 55.3 MCG TABLET SL *(desmopressin acetate)*	PA	Prior Authorization required.
octreotide 1,000 mcg/5 ml vial (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide 1,000 mcg/ml vial (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide 5,000 mcg/5 ml vial (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 0.05 mg/ml vl (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 100 mcg/ml amp (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 100 mcg/ml syr	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 100 mcg/ml vl (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 200 mcg/ml vl (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 50 mcg/ml amp (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 50 mcg/ml syr	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 50 mcg/ml vial (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 500 mcg/ml amp (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 500 mcg/ml syr	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
octreotide acet 500 mcg/ml vl (SANDOSTATIN)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORFADIN 4 MG/ML SUSPENSION *(nitisinone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OSPHENA 60 MG TABLET *(ospemifene)*	PA	Prior Authorization required.
raloxifene hcl 60 mg tablet (EVISTA)	PA	Prior Authorization required.
RAVICTI 1.1 GRAM/ML LIQUID *(glycerol phenylbutyrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

ENDOCRINE AND METABOLIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SAMSCA 15 MG TABLET *(tolvaptan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SAMSCA 30 MG TABLET *(tolvaptan)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN 0.05 MG/ML AMPUL *(octreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN 0.1 MG/ML AMPUL *(octreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN 0.5 MG/ML AMPUL *(octreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN LAR DEPOT 10 MG KT *(octreotide acetate, microspheres)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN LAR DEPOT 20 MG KT *(octreotide acetate, microspheres)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDOSTATIN LAR DEPOT 30 MG KT *(octreotide acetate, microspheres)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
sapropterin 100 mg powder pkt (KUVAN)	PA	Prior Authorization required.
sapropterin 100 mg tablet (KUVAN)	PA	Prior Authorization required.
sapropterin 500 mg powder pkt (KUVAN)	PA	Prior Authorization required.
SENSIPAR 30 MG TABLET *(cinacalcet hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SENSIPAR 60 MG TABLET *(cinacalcet hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SENSIPAR 90 MG TABLET *(cinacalcet hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR 0.3 MG/ML AMPULE *(pasireotide diaspartate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR 0.6 MG/ML AMPULE *(pasireotide diaspartate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR 0.9 MG/ML AMPULE *(pasireotide diaspartate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 10 MG KIT *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 20 MG KIT *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 20 MG VIAL *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 30 MG KIT *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 40 MG KIT *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 40 MG VIAL *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 60 MG KIT *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIGNIFOR LAR 60 MG VIAL *(pasireotide pamoate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
sodium phenylbutyrate 500mg tb (BUPHENYL)	PA	Prior Authorization required.
sodium phenylbutyrate powder (BUPHENYL)	PA	Prior Authorization required.
SOMATULINE DEPOT 120 MG/0.5 ML *(lanreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOMATULINE DEPOT 60 MG/0.2 ML *(lanreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SOMATULINE DEPOT 90 MG/0.3 ML *(lanreotide acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ENDOCRINE AND METABOLIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SYNAREL 2 MG/ML NASAL SPRAY *(nafarelin acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tolvaptan 15 mg tablet (SAMSCA)	PA	Prior Authorization required.
tolvaptan 30 mg tablet (SAMSCA)	PA	Prior Authorization required.

ENDOCRINE AND METABOLIC AGENTS : VITAMIN D ANALOGS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
calcitriol 0.25 mcg capsule (ROCALTROL)		
calcitriol 0.5 mcg capsule (ROCALTROL)		
calcitriol 1 mcg/ml solution (ROCALTROL)		
doxercalciferol 0.5 mcg cap (HECTOROL)		
doxercalciferol 1 mcg capsule (HECTOROL)		
doxercalciferol 2.5 mcg cap (HECTOROL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
paricalcitol 1 mcg capsule (ZEMPLAR)	PA	Prior Authorization required.
paricalcitol 2 mcg capsule (ZEMPLAR)	PA	Prior Authorization required.
paricalcitol 4 mcg capsule (ZEMPLAR)	PA	Prior Authorization required.
RAYALDEE ER 30 MCG CAPSULE *(calcifediol)*	PA	Prior Authorization required.
ROCALTROL 0.25 MCG CAPSULE *(use calcitriol)*	PA	Prior Authorization required.
ROCALTROL 0.5 MCG CAPSULE *(use calcitriol)*	PA	Prior Authorization required.
ROCALTROL 1 MCG/ML ORAL SOLN *(use calcitriol)*	PA	Prior Authorization required.
ZEMPLAR 1 MCG CAPSULE *(paricalcitol)*	PA	Prior Authorization required.
ZEMPLAR 2 MCG CAPSULE *(paricalcitol)*	PA	Prior Authorization required.

ESTROGENS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AMABELZ 0.5 MG-0.1 MG TABLET *(estradiol/norethindrone acetate)*		
AMABELZ 1 MG-0.5 MG TABLET *(estradiol/norethindrone acetate)*		
COMBIPATCH 0.05-0.14 MG PTCH *(estradiol/norethindrone acetate)*		
COMBIPATCH 0.05-0.25 MG PTCH *(estradiol/norethindrone acetate)*		
DOTTI 0.025 MG PATCH *(estradiol)*		
DOTTI 0.0375 MG PATCH *(estradiol)*		
DOTTI 0.05 MG PATCH *(estradiol)*		
DOTTI 0.075 MG PATCH *(estradiol)*		
DOTTI 0.1 MG PATCH *(estradiol)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ESTROGENS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
estradiol 0.025 mg patch(1/wk) (CLIMARA)		
estradiol 0.025 mg patch(2/wk) (ALORA)		
estradiol 0.0375mg patch(1/wk) (CLIMARA)		
estradiol 0.0375mg patch(2/wk) (MINIVELLE)		
estradiol 0.05 mg patch (1/wk) (CLIMARA)		
estradiol 0.05 mg patch (2/wk) (MINIVELLE)		
estradiol 0.06 mg patch (1/wk) (CLIMARA)		
estradiol 0.075 mg patch(1/wk) (CLIMARA)		
estradiol 0.075 mg patch(2/wk) (ALORA)		
estradiol 0.1 mg patch (1/wk) (CLIMARA)		
estradiol 0.1 mg patch (2/wk) (ALORA)		
estradiol 0.5 mg tablet (ESTRACE)		
estradiol 1 mg tablet (ESTRACE)		
estradiol 2 mg tablet (ESTRACE)		
estradiol-noreth 0.5-0.1 mg tb (ACTIVELLA)		
estradiol-noreth 1-0.5 mg tab (ACTIVELLA)		
LOPREEZA 0.5 MG-0.1 MG TABLET *(estradiol/norethindrone acetate)*		
LOPREEZA 1 MG-0.5 MG TABLET *(estradiol/norethindrone acetate)*		
LYLLANA 0.025 MG PATCH *(estradiol)*		
LYLLANA 0.0375 MG PATCH *(estradiol)*		
LYLLANA 0.05 MG PATCH *(estradiol)*		
LYLLANA 0.075 MG PATCH *(estradiol)*		
LYLLANA 0.1 MG PATCH *(estradiol)*		
MENEST 0.3 MG TABLET *(estrogens,esterified)*		
MENEST 0.625 MG TABLET *(estrogens,esterified)*		
MENEST 1.25 MG TABLET *(estrogens,esterified)*		
MENEST 2.5 MG TABLET *(estrogens,esterified)*		
MIMVEY 1-0.5 MG TABLET *(estradiol/norethindrone acetate)*		
MIMVEY LO 0.5-0.1 MG TABLET *(estradiol/norethindrone acetate)*		
PREMARIN 0.3 MG TABLET *(estrogens, conjugated)*		
PREMARIN 0.45 MG TABLET *(estrogens, conjugated)*		
PREMARIN 0.625 MG TABLET *(estrogens, conjugated)*		
PREMARIN 0.9 MG TABLET *(estrogens, conjugated)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ESTROGENS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
PREMARIN 1.25 MG TABLET *(estrogens, conjugated)*		
PREMPHASE 0.625-5 MG TABLET *(estrogens, conjugated/medroxyprogesterone acetate)*	QL	Limited to 30 EA per 30 days.
PREMPRO 0.3 MG-1.5 MG TABLET *(estrogens, conjugated/medroxyprogesterone acetate)*		
PREMPRO 0.45-1.5 MG TABLET *(estrogens, conjugated/medroxyprogesterone acetate)*		
PREMPRO 0.625-2.5 MG TABLET *(estrogens, conjugated/medroxyprogesterone acetate)*	QL	Limited to 30 EA per 30 days.
PREMPRO 0.625-5 MG TABLET *(estrogens, conjugated/medroxyprogesterone acetate)*	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTIVELLA 1 MG-0.5 MG TABLET *(use estradiol/norethindrone acetate)*	PA	Prior Authorization required.
ALORA 0.025 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
ALORA 0.05 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
ALORA 0.075 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
ALORA 0.1 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
ANGELIQ 0.25 MG-0.5 MG TABLET *(drospirenone/estradiol)*	PA	Prior Authorization required.
ANGELIQ 0.5 MG-1 MG TABLET *(drospirenone/estradiol)*	PA	Prior Authorization required.
BIJUVA 1 MG-100 MG CAPSULE *(estradiol/progesterone)*	PA	Prior Authorization required.
CLIMARA 0.025 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA 0.0375 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA 0.05 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA 0.06 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA 0.075 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA 0.1 MG/DAY PATCH *(use estradiol)*	PA	Prior Authorization required.
CLIMARA PRO PATCH *(estradiol/levonorgestrel)*	PA	Prior Authorization required.
DIVIGEL 0.25 MG GEL PACKET *(estradiol)*	PA	Prior Authorization required.
DIVIGEL 0.5 MG GEL PACKET *(estradiol)*	PA	Prior Authorization required.
DIVIGEL 0.75 MG GEL PACKET *(estradiol)*	PA	Prior Authorization required.
DIVIGEL 1 MG GEL PACKET *(estradiol)*	PA	Prior Authorization required.
DIVIGEL 1.25 MG GEL PACKET *(estradiol)*	PA	Prior Authorization required.
DUAVEE 0.45-20 MG TABLET *(estrogens, conjugated/bazedoxifene acetate)*	PA	Prior Authorization required.

Drug List

ESTROGENS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ELESTRIN 0.06% GEL *(estradiol)*	PA	Prior Authorization required.
ESTRACE 0.5 MG TABLET *(use estradiol)*	PA	Prior Authorization required.
ESTRACE 1 MG TABLET *(use estradiol)*	PA	Prior Authorization required.
ESTRACE 2 MG TABLET *(use estradiol)*	PA	Prior Authorization required.
EVAMIST 1.53 MG/SPRAY *(estradiol)*	PA	Prior Authorization required.
FEMHRT 0.5 MG-2.5 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
FYAVOLV 0.5 MG-2.5 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
FYAVOLV 1 MG-5 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
JINTELI 1 MG-5 MCG TABLET *(norethindrone acetate-ethinyl estradiol)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
MENOSTAR 14 MCG/DAY PATCH *(estradiol)*	PA	Prior Authorization required.
MINIVELLE 0.025 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
MINIVELLE 0.0375 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
MINIVELLE 0.05 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
MINIVELLE 0.075 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
MINIVELLE 0.1 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
norethin-eth estrad 1 mg-5 mcg (JEVANTIQUE)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
norethind-eth estrad 0.5-2.5 (FEMHRT)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ORIAHNN 300-1-0.5MG/300MG CAPS *(elagolix sodium/estradiol/norethindrone acetate)*	PA	Prior Authorization required.
PREFEST TABLET *(estradiol/norgestimate)*	PA	Prior Authorization required.
VIVELLE-DOT 0.025 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
VIVELLE-DOT 0.0375 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
VIVELLE-DOT 0.05 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
VIVELLE-DOT 0.075 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
VIVELLE-DOT 0.1 MG PATCH *(use estradiol)*	PA	Prior Authorization required.
GASTROINTESTINAL AGENTS : INFLAMMATORY BOWEL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
balsalazide disodium 750 mg cp (COLAZAL)		
mesalamine 1,000 mg supp (CANASA)	QL	Limited to 30 EA per 30 days.
mesalamine 4 gm/60 ml enema (ROWASA)		
PENTASA 250 MG CAPSULE *(mesalamine)*	QL	Limited to 240 EA per 30 days.
PENTASA 500 MG CAPSULE *(mesalamine)*	QL	Limited to 240 EA per 30 days.

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Drug List

GASTROINTESTINAL AGENTS : INFLAMMATORY BOWEL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
SFROWASA 4 GM/60 ML ENEMA *(mesalamine)*		
sulfasalazine 500 mg tablet (AZULFIDINE)		
sulfasalazine dr 500 mg tab (AZULFIDINE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
APRISO ER 0.375 GRAM CAPSULE *(mesalamine)*	PA	Prior Authorization required.
ASACOL HD DR 800 MG TABLET *(mesalamine)*	PA	Prior Authorization required.
AZULFIDINE 500 MG TABLET *(use sulfasalazine)*	PA	Prior Authorization required.
AZULFIDINE ENTAB 500 MG *(use sulfasalazine)*	PA	Prior Authorization required.
CANASA 1,000 MG SUPPOSITORY *(use mesalamine)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
COLAZAL 750 MG CAPSULE *(use balsalazide disodium)*	PA	Prior Authorization required.
DELZICOL DR 400 MG CAPSULE *(mesalamine)*	PA	Prior Authorization required.
DIPENTUM 250 MG CAPSULE *(olsalazine sodium)*	PA	Prior Authorization required.
LIALDA DR 1.2 GM TABLET *(mesalamine)*	PA	Prior Authorization required.
mesalamine 4 gm/60 ml kit (ROWASA)	PA	Prior Authorization required.
mesalamine 800 mg dr tablet (ASACOL HD)	PA	Prior Authorization required.
mesalamine dr 1.2 gm tablet (LIALDA)	PA	Prior Authorization required.
mesalamine dr 400 mg capsule (DELZICOL)	PA	Prior Authorization required.
mesalamine er 0.375 gram cap (APRISO)	PA	Prior Authorization required.
ROWASA 4 GM/60 ML ENEMA KIT *(mesalamine with cleansing wipes)*	PA	Prior Authorization required.
GASTROINTESTINAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cromolyn 100 mg/5 ml oral conc (GASTROCROM)		
ENULOSE 10 GM/15 ML SOLUTION *(lactulose)*		
GENERLAC 10 GM/15 ML SOLUTION *(lactulose)*		
lactulose 10 gm/15 ml solution (CEPHULAC)		
metoclopramide 10 mg tablet (REGLAN)		
metoclopramide 10 mg/10 ml sol (REGLAN)		
metoclopramide 5 mg tablet (REGLAN)		
metoclopramide 5 mg/5 ml soln (REGLAN)		
ursodiol 300 mg capsule (ACTIGALL)		

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Drug List

GASTROINTESTINAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTIGALL 300 MG CAPSULE *(use ursodiol)*	PA	Prior Authorization required.
alosetron hcl 0.5 mg tablet (LOTRONEX)	PA	Prior Authorization required.
alosetron hcl 1 mg tablet (LOTRONEX)	PA	Prior Authorization required.
alvimopan 12 mg capsule (ENTEREG)	PA	Prior Authorization Required.
AMITIZA 24 MCG CAPSULES *(lubiprostone)*	PA	Prior Authorization required.
AMITIZA 8 MCG CAPSULE *(lubiprostone)*	PA	Prior Authorization required.
CHENODAL 250 MG TABLET *(chenodiol)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CHOLBAM 250 MG CAPSULE *(cholic acid)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CHOLBAM 50 MG CAPSULE *(cholic acid)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENTEREG 12 MG CAPSULE *(alvimopan)*	PA	Prior Authorization required.
GASTROCROM 100 MG/5 ML CONC *(use cromolyn sodium)*	PA	Prior Authorization required.
GATTEX 5 MG 30-VIAL KIT *(teduglutide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GATTEX 5 MG ONE-VIAL KIT *(teduglutide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LINZESS 145 MCG CAPSULE *(linaclotide)*	PA	Prior Authorization required.
LINZESS 290 MCG CAPSULE *(linaclotide)*	PA	Prior Authorization required.
LINZESS 72 MCG CAPSULE *(linaclotide)*	PA	Prior Authorization required.
LOTRONEX 0.5 MG TABLET *(alosetron hcl)*	PA	Prior Authorization required.
LOTRONEX 1 MG TABLET *(alosetron hcl)*	PA	Prior Authorization required.
lubiprostone 24 mcg capsule (AMITIZA)	PA	Prior Authorization required.
lubiprostone 8 mcg capsule (AMITIZA)	PA	Prior Authorization required.
metoclopramide hcl 10 mg odt (METOZOLV ODT)	PA	Prior Authorization required.
metoclopramide hcl 5 mg odt (METOZOLV ODT)	PA	Prior Authorization required.
MOTEGRITY 1 MG TABLET *(prucalopride succinate)*	PA	Prior Authorization required.
MOTEGRITY 2 MG TABLET *(prucalopride succinate)*	PA	Prior Authorization required.
MOVANTIK 12.5 MG TABLET *(naloxegol oxalate)*	PA	Prior Authorization required.
MOVANTIK 25 MG TABLET *(naloxegol oxalate)*	PA	Prior Authorization required.
OCALIVA 10 MG TABLET *(obeticholic acid)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OCALIVA 5 MG TABLET *(obeticholic acid)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REGLAN 10 MG TABLET *(use metoclopramide hcl)*	PA	Prior Authorization required.
REGLAN 5 MG TABLET *(use metoclopramide hcl)*	PA	Prior Authorization required.
RELISTOR 12 MG/0.6 ML SYRINGE *(methylnaltrexone bromide)*	PA	Prior Authorization required.
RELISTOR 12 MG/0.6 ML VIAL *(methylnaltrexone bromide)*	PA	Prior Authorization required.
RELISTOR 150 MG TABLET *(methylnaltrexone bromide)*	PA	Prior Authorization required.
RELISTOR 8 MG/0.4 ML SYRINGE *(methylnaltrexone bromide)*	PA	Prior Authorization required.

Drug List

GASTROINTESTINAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SYMPROIC 0.2 MG TABLET *(naldemedine tosylate)*	PA	Prior Authorization required.
TRULANCE 3 MG TABLET *(plecanatide)*	PA	Prior Authorization required.
URSO 250 MG TABLET *(ursodiol)*	PA	Prior Authorization required.
URSO FORTE 500 MG TABLET *(ursodiol)*	PA	Prior Authorization required.
ursodiol 250 mg tablet (URSO)	PA	Prior Authorization required.
ursodiol 500 mg tablet (URSO FORTE)	PA	Prior Authorization required.
VIBERZI 100 MG TABLET *(eluxadoline)*	PA	Prior Authorization required.
VIBERZI 75 MG TABLET *(eluxadoline)*	PA	Prior Authorization required.
XERMELO 250 MG TABLET *(telotristat etiprate)*	PA	Prior Authorization required.
ZELNORM 6 MG TABLET *(tegaserod hydrogen maleate)*	PA	Prior Authorization required.
GASTROINTESTINAL AGENTS : PHOSPHATE BINDER AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
calcium acetate 667 mg capsule (PHOSLO)		
calcium acetate 667 mg gelcap (PHOSLO)		
calcium acetate 667 mg tablet (ELIPHOS)		
FOSRENOL 1,000 MG POWDER PACK *(lanthanum carbonate)*		
FOSRENOL 750 MG POWDER PACKET *(lanthanum carbonate)*		
lanthanum carb 1,000 mg tb chw (FOSRENOL)		
lanthanum carb 500 mg tab chew (FOSRENOL)		
lanthanum carb 750 mg tab chew (FOSRENOL)		
sevelamer carbonate 800 mg tab (RENVELA)	QL	Limited to 240 EA per 30 days.
sevelamer hcl 400 mg tablet (RENAGEL)		
sevelamer hcl 800 mg tablet (RENAGEL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AURYXIA 210 MG TABLET *(ferric citrate)*	PA	Prior Authorization required.
FOSRENOL 1,000 MG TABLET CHEW *(use lanthanum carbonate)*	PA	Prior Authorization required.
FOSRENOL 500 MG TABLET CHEW *(use lanthanum carbonate)*	PA	Prior Authorization required.
FOSRENOL 750 MG TABLET CHEW *(use lanthanum carbonate)*	PA	Prior Authorization required.
PHOSLYRA 667 MG/5 ML SOLUTION *(calcium acetate)*	PA	Prior Authorization required.
RENAGEL 800 MG TABLET *(use sevelamer hcl)*	PA	Prior Authorization required.

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Drug List

GASTROINTESTINAL AGENTS : PHOSPHATE BINDER AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
RENVELA 0.8 GM POWDER PACKET *(sevelamer carbonate)*	PA	Prior Authorization required.
RENVELA 2.4 GM POWDER PACKET *(sevelamer carbonate)*	PA	Prior Authorization required.
RENVELA 800 MG TABLET *(use sevelamer carbonate)*	PA,QL	Prior Authorization required. Limited to 240 EA per 30 days.
sevelamer 0.8 gm powder packet (RENVELA)	PA	Prior Authorization required.
sevelamer 2.4 gm powder packet (RENVELA)	PA	Prior Authorization required.
VELPHORO 500 MG CHEWABLE TAB *(sucroferric oxyhydroxide)*	PA	Prior Authorization required.
General Injectable Solutions and Diluents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
bd normal saline flush syringe (CLEARSHIELD SODIUM CHLOR FLUSH)		
dextrose 10%-0.45% nacl iv sol		
dextrose 10%-water iv solution		
dextrose 2.5%-0.45% nacl iv		
dextrose 20%-water iv soln		
dextrose 30%-water iv soln		
dextrose 40%-water iv soln		
dextrose 5%-0.2% nacl iv soln		
dextrose 5%-0.225% nacl iv sol		
dextrose 5%-0.3% nacl iv soln		
dextrose 5%-0.33% nacl iv soln		
dextrose 5%-0.45% nacl iv soln		
dextrose 5%-0.9% nacl iv soln		
dextrose 5%-lr iv solution		
dextrose 50%-water iv soln		
normal saline flush syringe (CLEARSHIELD SODIUM CHLOR FLUSH)		
saline 0.45% soln-excel con		
sodium chloride 0.45% soln		
sodium chloride 0.9% carpuject		
sodium chloride 0.9% solution		
sodium chloride 0.9% zr syr (CLEARSHIELD SODIUM CHLOR FLUSH)		
sodium chloride 3% iv soln		
sodium chloride 5% iv soln		
sterile water for injection		
water for injection vial (STERILE WATER FOR KCENTRA)		

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Drug List

GENITOURINARY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CYSTAGON 150 MG CAPSULE *(cysteamine bitartrate)*	SP	Restricted to specialty pharmacies.
CYSTAGON 50 MG CAPSULE *(cysteamine bitartrate)*	SP	Restricted to specialty pharmacies.
ORACIT ORAL SOLUTION *(citric acid/sodium citrate)*		
phenazopyridine 100 mg tab (PYRIDIUM)		
phenazopyridine 200 mg tab (PYRIDIUM)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CYTRA-K CRYSTALS PACKET *(potassium citrate/citric acid)*	PA	Prior Authorization required.
ELMIRON 100 MG CAPSULE *(pentosan polysulfate sodium)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
K-PHOS #2 TABLET *(sodium phosphate,monobasic/potassium phosphate,monobasic)*	PA	Prior Authorization required.
LITHOSTAT 250 MG TABLET *(acetohydroxamic acid)*	PA	Prior Authorization required.
potassium citrate er 10 meq tb (UROCIT-K)	PA	Prior Authorization required.
potassium citrate er 15 meq tb (UROCIT-K)	PA	Prior Authorization required.
potassium citrate er 5 meq tab (UROCIT-K)	PA	Prior Authorization required.
PROCYSBI DR 25 MG CAPSULE *(cysteamine bitartrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCYSBI DR 300 MG GRANULE PKT *(cysteamine bitartrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCYSBI DR 75 MG CAPSULE *(cysteamine bitartrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCYSBI DR 75 MG GRANULE PKT *(cysteamine bitartrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PYRIDIUM 100 MG TABLET *(use phenazopyridine hcl)*	PA	Prior Authorization required.
PYRIDIUM 200 MG TABLET *(use phenazopyridine hcl)*	PA	Prior Authorization required.
THIOLA 100 MG TABLET *(tiopronin)*	PA	Prior Authorization required.
THIOLA EC 100 MG TABLET *(tiopronin)*	PA	Prior Authorization required.
THIOLA EC 300 MG TABLET *(tiopronin)*	PA	Prior Authorization required.
UROCIT-K ER 15 MEQ TABLET *(potassium citrate)*	PA	Prior Authorization required.
UROCIT-K SR 10 MEQ TABLET *(potassium citrate)*	PA	Prior Authorization required.
UROCIT-K SR 5 MEQ TABLET *(potassium citrate)*	PA	Prior Authorization required.
GENITOURINARY AGENTS : PROSTATIC HYPERTROPHY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
alfuzosin hcl er 10 mg tablet (UROXATRAL)		
finasteride 5 mg tablet (PROSCAR)		

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GENITOURINARY AGENTS : PROSTATIC HYPERTROPHY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
tamsulosin hcl 0.4 mg capsule (FLOMAX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AVODART 0.5 MG SOFTGEL *(dutasteride)*	PA	Prior Authorization required.
CARDURA XL 4 MG TABLET *(doxazosin mesylate)*	PA	Prior Authorization required.
CARDURA XL 8 MG TABLET *(doxazosin mesylate)*	PA	Prior Authorization required.
dutasteride 0.5 mg capsule (AVODART)	PA	Prior Authorization required.
dutasteride-tamsulosin 0.5-0.4 (JALYN)	PA	Prior Authorization required.
FLOMAX 0.4 MG CAPSULE *(use tamsulosin hcl)*	PA	Prior Authorization required.
JALYN 0.5-0.4 MG CAPSULE *(dutasteride/tamsulosin hcl)*	PA	Prior Authorization required.
PROSCAR 5 MG TABLET *(use finasteride)*	PA	Prior Authorization required.
RAPAFLO 4 MG CAPSULE *(silodosin)*	PA	Prior Authorization required.
RAPAFLO 8 MG CAPSULE *(silodosin)*	PA	Prior Authorization required.
silodosin 4 mg capsule (RAPAFLO)	PA	Prior Authorization required.
silodosin 8 mg capsule (RAPAFLO)	PA	Prior Authorization required.
GLUCOSE MONITORING SUPPLIES : CGMs		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
DEXCOM G6 RECEIVER *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G6 SENSOR *(blood-glucose sensor)*	PA,QL	Prior Authorization required. Limited to 36 EA per 360 days.
DEXCOM G6 TRANSMITTER *(blood-glucose transmitter)*	PA,QL	Prior Authorization required. Limited to 4 EA per 365 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DEXCOM G4 (PED) RECEIVER KIT *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G4 RECEIVER KIT *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G4 RECEIVER-SHARE (PED) *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G4 RECEIVER-SHARE KIT *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G4 TRANSMITTER KIT *(blood-glucose transmitter)*	PA,QL	Prior Authorization required. Limited to 4 EA per 365 days.
DEXCOM G5 RECEIVER KIT *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
DEXCOM G5 TRANSMITTER KIT *(blood-glucose transmitter)*	PA,QL	Prior Authorization required. Limited to 4 EA per 365 days.
DEXCOM G5-G4 SENSOR KIT *(blood-glucose sensor)*	PA,QL	Prior Authorization required. Limited to 36 EA per 360 days.

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GLUCOSE MONITORING SUPPLIES : CGMs		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
DEXCOM RECEIVER KIT *(blood-glucose meter,continuous)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
ENLITE GLUCOSE SENSOR *(blood-glucose sensor)*	PA	Prior Authorization required.
EVERSENSE SENSOR-HOLDER *(glucose sensor,implantable,continuous/dexamethasone acetate)*	PA	Prior Authorization required.
EVERSENSE SMART TRANSMITTER *(blood-glucose transmitter)*	PA	Prior Authorization required.
FREESTYLE LIBRE 10 DAY READER *(flash glucose scanning reader)*	PA	Prior Authorization required.
FREESTYLE LIBRE 10 DAY SENSOR *(flash glucose sensor)*	PA	Prior Authorization required.
FREESTYLE LIBRE 14 DAY READER *(flash glucose scanning reader)*	PA	Prior Authorization required.
FREESTYLE LIBRE 14 DAY SENSOR *(flash glucose sensor)*	PA	Prior Authorization required.
FREESTYLE LIBRE 2 READER *(flash glucose scanning reader)*	PA	Prior Authorization required.
FREESTYLE LIBRE 2 SENSOR *(flash glucose sensor)*	PA	Prior Authorization required.
GUARDIAN CONNECT TRANSMITTER *(blood-glucose transmitter)*	PA	Prior Authorization required.
GUARDIAN LINK 3 TRANSMITTER *(blood-glucose transmitter)*	PA	Prior Authorization required.
GUARDIAN REAL TIME STARTER KIT *(diabetic supplies,miscell)*	PA	Prior Authorization required.
GUARDIAN REAL-TIME GLU MONITOR *(blood-glucose meter,continuous/blood-glucose transmitter)*	PA	Prior Authorization required.
GUARDIAN RT REPLACE CHARGER *(diabetic supplies,miscell)*	PA	Prior Authorization Required.
GUARDIAN RT REPLACE MONITOR *(diabetic supplies,miscell)*	PA	Prior Authorization required.
GUARDIAN RT REPLACE TEST PLUG *(diabetic supplies,miscell)*	PA	Prior Authorization Required.
GUARDIAN SENSOR 3 *(blood-glucose sensor)*	PA	Prior Authorization required.
GUARDIAN TEST PLUG *(diabetic supplies,miscell)*	PA	Prior Authorization Required.
REPLACEMENT PEDIATRIC MONITOR *(diabetic supplies,miscell)*	PA	Prior Authorization required.
SOF-SENSOR *(blood-glucose sensor)*	PA	Prior Authorization required.
GLUCOSE MONITORING SUPPLIES : INSULIN INFUSION DISPOSABLE PUMP		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
OMNIPOD 5 PACK POD *(insulin pump cartridge)*	PA,QL	Prior Authorization required. Limited to 120 EA per 365 days.
OMNIPOD DASH 5 PACK POD *(insulin pump cartridge)*	PA,QL	Prior Authorization required. Limited to 120 EA per 365 days.
OMNIPOD DASH PDM KIT *(insulin pump controller)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : INSULIN INFUSION DISPOSABLE PUMP		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
OMNIPOD STARTER KIT *(subcutaneous insulin pump)*	PA,QL	Prior Authorization required. Limited to 1 EA per 365 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
V-GO 20 DISPOSABLE DEVICE *(sub-q insulin delivery device, 20 unit,disposable)*	PA	Prior Authorization required.
V-GO 30 DISPOSABLE DEVICE *(sub-q insulin delivery device, 30 unit, disposable)*	PA	Prior Authorization required.
V-GO 40 DISPOSABLE DEVICE *(sub-q insulin delivery device, 40 unit, disposable)*	PA	Prior Authorization required.
GOUT AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
allopurinol 100 mg tablet (ZYLOPRIM)		
allopurinol 300 mg tablet (ZYLOPRIM)		
probenecid 500 mg tablet (BENEMID)		
probenecid-colchicine tablet (COL-PROBENECID)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
colchicine 0.6 mg capsule (MITIGARE)	PA	Prior Authorization required.
colchicine 0.6 mg tablet (COLCRYS)	PA	Prior Authorization required.
COLCRYS 0.6 MG TABLET *(colchicine)*	PA	Prior Authorization required.
febuxostat 40 mg tablet (ULORIC)	PA	Prior Authorization required.
febuxostat 80 mg tablet (ULORIC)	PA	Prior Authorization required.
GLOPERBA 0.6 MG/5 ML SOLUTION *(colchicine)*	PA	Prior Authorization required.
MITIGARE 0.6 MG CAPSULE *(colchicine)*	PA	Prior Authorization required.
ULORIC 40 MG TABLET *(febuxostat)*	PA	Prior Authorization required.
ULORIC 80 MG TABLET *(febuxostat)*	PA	Prior Authorization required.
ZYLOPRIM 300 MG TABLET *(use allopurinol)*	PA	Prior Authorization required.
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ADVATE 1,201-1,800 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADVATE 1,801-2,400 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADVATE 2,401-3,600 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ADVATE 200-400 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADVATE 3,601-4,800 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADVATE 401-800 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADVATE 801-1,200 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 1,251-2,500 UNIT VL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 1,500 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 200-400 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 3,000 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 401-800 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 750 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ADYNOVATE 801-1,250 UNIT VIAL *(antihemophilic factor (fviii) recombinant, full length, peg)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 1,000 UNIT VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 1,500 UNIT RANGE VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 2,000 UNIT VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 2,500 UNIT RANGE VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 250 UNIT VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 3,000 UNIT VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AFSTYLA 500 UNIT VIAL *(antihemophilic factor viii recomb,single-chn,b-dom truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANATE 1,000-400 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ALPHANATE 1,500-600 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANATE 2,000-800 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANATE 250-100 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANATE 500-200 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANINE SD 1,000 UNIT VIAL *(factor ix)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANINE SD 1,500 UNIT VIAL *(factor ix)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPHANINE SD 500 UNIT VIAL *(factor ix)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 1,000 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 2,000 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 250 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 3,000 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 4,000 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ALPROLIX 500 UNIT NOMINAL *(factor ix recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENEFIX 1,000 UNIT RANGE *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENEFIX 2,000 UNIT RANGE *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENEFIX 250 UNIT RANGE *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENEFIX 3,000 UNIT RANGE *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENEFIX 500 UNIT RANGE *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COAGADEX 250 UNIT VIAL *(coagulation factor x)*	PA	Prior Authorization required.
COAGADEX 500 UNIT VIAL *(coagulation factor x)*	PA	Prior Authorization required.
CORIFACT KIT *(factor xiii)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 1,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 1,500 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 2,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 250 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ELOCTATE 3,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 4,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 5,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 500 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 6,000 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ELOCTATE 750 UNIT NOMINAL *(antihemophilic factor (fviii) recombinant, fc fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESPEROCT 1,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-dom truncated peg-exei)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESPEROCT 1,500 UNIT VIAL *(antihemophilic factor (fviii) rec, b-dom truncated peg-exei)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESPEROCT 2,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-dom truncated peg-exei)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESPEROCT 3,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-dom truncated peg-exei)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESPEROCT 500 UNIT VIAL *(antihemophilic factor (fviii) rec, b-dom truncated peg-exei)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FEIBA NF 1,000 UNIT (NOMINAL) *(anti-inhibitor coagulant complex)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FEIBA NF 2,500 UNIT (NOMINAL) *(anti-inhibitor coagulant complex)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FEIBA NF 500 UNIT (NOMINAL) *(anti-inhibitor coagulant complex)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMLIBRA 105 MG/0.7 ML VIAL *(emicizumab-kxwh)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMLIBRA 150 MG/ML VIAL *(emicizumab-kxwh)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMLIBRA 30 MG/ML VIAL *(emicizumab-kxwh)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMLIBRA 60 MG/0.4 ML VIAL *(emicizumab-kxwh)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMOFIL M 1,000 UNIT NOMINAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMOFIL M 1,700 UNIT NOMINAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMOFIL M 250 UNIT NOMINAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HEMOFIL M 500 UNIT NOMINAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
HUMATE-P 1,200 UNIT VWF:RCO *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMATE-P 2,400 UNIT VWF:RCO *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMATE-P 600 UNIT VWF:RCO *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDELVION 1,000 UNIT RANGE VIAL *(factor ix recombinant,albumin fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDELVION 2,000 UNIT RANGE VIAL *(factor ix recombinant,albumin fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDELVION 250 UNIT RANGE VIAL *(factor ix recombinant,albumin fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDELVION 3,500 UNIT RANGE VIAL *(factor ix recombinant,albumin fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IDELVION 500 UNIT RANGE VIAL *(factor ix recombinant,albumin fusion protein)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 1,000 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 1,000 UNIT RANGE-2 VLS *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 1,500 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 1,500 UNIT RANGE-2 VLS *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 2,000 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 250 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 3,000 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
IXINITY 500 UNIT RANGE *(factor ix human recombinant, threonine 148)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
JIVI 1,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-domain deleted peg-aucl)*	PA	Prior Authorization required.
JIVI 2,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-domain deleted peg-aucl)*	PA	Prior Authorization required.
JIVI 3,000 UNIT VIAL *(antihemophilic factor (fviii) rec, b-domain deleted peg-aucl)*	PA	Prior Authorization required.
JIVI 500 UNIT VIAL *(antihemophilic factor (fviii) rec, b-domain deleted peg-aucl)*	PA	Prior Authorization required.
KOATE 1,000 UNIT VIAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOATE 250 UNIT VIAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOATE 500 UNIT VIAL *(antihemophilic factor, human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOGENATE FS 1,000 UNITS VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOGENATE FS 2,000 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
KOGENATE FS 250 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOGENATE FS 3,000 UNITS VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOGENATE FS 500 UNIT VIAL *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOVALTRY 1,000 UNIT KIT *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOVALTRY 2,000 UNIT KIT *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOVALTRY 250 UNIT KIT *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOVALTRY 3,000 UNIT KIT *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KOVALTRY 500 UNIT KIT *(antihemophilic factor (fviii) recombinant,full length)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MONONINE 1,000 UNIT VIAL *(factor ix)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 1,000 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 1,500 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 2,000 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 250 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 3,000 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOEIGHT 500 UNIT VIAL *(antihemophilic factor viii recombinant, b-domain truncated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOSEVEN RT 1 MG VIAL *(coagulation factor viia (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOSEVEN RT 2 MG VIAL *(coagulation factor viia (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOSEVEN RT 5 MG VIAL *(coagulation factor viia (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NOVOSEVEN RT 8 MG VIAL *(coagulation factor viia (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 1,000 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 1,000 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 2,000 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
NUWIQ 2,000 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 2,500 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 2,500 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 250 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 250 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 3,000 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 3,000 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 4,000 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 4,000 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 500 UNIT VIAL *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NUWIQ 500 UNIT VIAL PACK *(antihemophilic factor viii rec hek cell, b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OBIZUR 500 UNIT VIAL *(antihemophilic factor viii, recombinant porcine sequence)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OBIZUR 500 UNIT VIAL - 5 VIALS *(antihemophilic factor viii, recombinant porcine sequence)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROFILNINE 1,000 UNIT VIAL *(factor ix complex, prothrombin cplx conc(pcc) no.4, 3 -factor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROFILNINE 1,500 UNIT VIAL *(factor ix complex, prothrombin cplx conc(pcc) no.4, 3 -factor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROFILNINE 500 UNIT VIAL *(factor ix complex, prothrombin cplx conc(pcc) no.4, 3 -factor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REBINYN 1,000 UNIT VIAL *(factor ix (human) recombinant, pegylated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REBINYN 2,000 UNIT VIAL *(factor ix (human) recombinant, pegylated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REBINYN 500 UNIT VIAL *(factor ix (human) recombinant, pegylated)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RECOMBINATE 1,241-1,800 UNIT V *(antihemophilic factor viii, human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RECOMBINATE 1,801-2,400 UNIT V *(antihemophilic factor viii, human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
RECOMBINATE 220-400 UNIT VIAL *(antihemophilic factor viii, human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RECOMBINATE 401-800 UNIT VIAL *(antihemophilic factor viii, human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RECOMBINATE 801-1,240 UNIT VL *(antihemophilic factor viii, human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIXUBIS 1,000 UNIT NOMINAL *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIXUBIS 2,000 UNIT NOMINAL *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIXUBIS 250 UNIT NOMINAL *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIXUBIS 3,000 UNIT NOMINAL *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RIXUBIS 500 UNIT NOMINAL *(factor ix human recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TRETTEN 2,500 UNIT VIAL *(factor xiii a-subunit, recombinant)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VONVENDI 1,300 UNIT VIAL *(von willebrand factor (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VONVENDI 650 UNIT VIAL *(von willebrand factor (recombinant))*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
WILATE 1,000-1,000 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
WILATE 500-500 UNIT VIAL *(antihemophilic factor, human/von willebrand factor,human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA 1,000 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA 2,000 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA 250 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA 500 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA SOLOFUSE 1,000 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA SOLOFUSE 2,000 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA SOLOFUSE 250 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA SOLOFUSE 3,000 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYNTHA SOLOFUSE 500 UNIT KIT *(antihemophilic factor (factor viii) recomb,b-domain deleted)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

HEMATOLOGICAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
pentoxifylline er 400 mg tab (TRENTAL)	QL	Limited to 90 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FIRAZYR 30 MG/3 ML SYRINGE *(icatibant acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HAEGARDA 2,000 UNIT VIAL *(c1 esterase inhibitor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HAEGARDA 3,000 UNIT VIAL *(c1 esterase inhibitor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
icatibant 30 mg/3 ml syringe (FIRAZYR)	PA	Prior Authorization required.
KALBITOR 10 MG/ML VIAL *(ecallantide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORLADEYO 110 MG CAPSULE *(berotralstat hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORLADEYO 150 MG CAPSULE *(berotralstat hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TAKHZYRO 300 MG/2 ML VIAL *(lanadelumab-flyo)*	PA	Prior Authorization required.
TAVALISSE 100 MG TABLET *(fostamatinib disodium)*	PA	Prior Authorization required.
TAVALISSE 150 MG TABLET *(fostamatinib disodium)*	PA	Prior Authorization required.

HEMATOLOGICAL AGENTS : PLATELET AGGREGATION INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
anagrelide hcl 0.5 mg capsule (AGRYLIN)		
anagrelide hcl 1 mg capsule (AGRYLIN)		
aspirin-dipyridam er 25-200 mg (AGGRENOX)		
BRILINTA 60 MG TABLET *(ticagrelor)*		
BRILINTA 90 MG TABLET *(ticagrelor)*		
clopidogrel 300 mg tablet (PLAVIX)		
clopidogrel 75 mg tablet (PLAVIX)		
dipyridamole 25 mg tablet (PERSANTINE)		
dipyridamole 50 mg tablet (PERSANTINE)		
dipyridamole 75 mg tablet (PERSANTINE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AGGRENOX 25 MG-200 MG CAPSULE *(use aspirin/dipyridamole)*	PA	Prior Authorization required.
AGRYLIN 0.5 MG CAPSULE *(use anagrelide hcl)*	PA	Prior Authorization required.
cilostazol 100 mg tablet (PLETAL)	PA	Prior Authorization required.
cilostazol 50 mg tablet (PLETAL)	PA	Prior Authorization required.
EFFIENT 10 MG TABLET *(prasugrel hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
EFFIENT 5 MG TABLET *(prasugrel hcl)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOLOGICAL AGENTS : PLATELET AGGREGATION INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PLAVIX 75 MG TABLET *(use clopidogrel bisulfate)*	PA	Prior Authorization required.
prasugrel 10 mg tablet (EFFIENT)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
prasugrel 5 mg tablet (EFFIENT)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
YOSPRALA DR 325-40 MG TABLET *(aspirin/omeprazole)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZONTIVITY 2.08 MG TABLET *(vorapaxar sulfate)*	PA	Prior Authorization required.
HEMATOPOIETIC AGENTS : HEMATOPOIETIC GROWTH FACTORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
LEUKINE 250 MCG VIAL *(sargramostim)*	QL,SP	Restricted to specialty pharmacies. Limited to 14 mL per 30 days.
NEUPOGEN 300 MCG/0.5 ML SYR *(filgrastim)*	QL,SP	Restricted to specialty pharmacies. Limited to 7 mL (14 syringes) per 30 days.
NEUPOGEN 300 MCG/ML VIAL *(filgrastim)*	QL,SP	Restricted to specialty pharmacies. Limited to 14 mL per 30 days.
NEUPOGEN 480 MCG/0.8 ML SYR *(filgrastim)*	QL,SP	Restricted to specialty pharmacies. Limited to 11.2 mL (14 syringes) per 30 days.
NEUPOGEN 480 MCG/1.6 ML VIAL *(filgrastim)*	QL,SP	Restricted to specialty pharmacies. Limited to 22.4 mL (14 syringes) per 30 days.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
EPOGEN 10,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPOGEN 2,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPOGEN 20,000 UNITS/2 ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPOGEN 20,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPOGEN 3,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EPOGEN 4,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 10,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 2,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 20,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 3,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 4,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROCRIT 40,000 UNITS/ML VIAL *(epoetin alfa)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARANESP 10 MCG/0.4 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOPOIETIC AGENTS : HEMATOPOIETIC GROWTH FACTORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARANESP 100 MCG/0.5 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 100 MCG/ML VIAL *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 150 MCG/0.3 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 200 MCG/0.4 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 200 MCG/ML VIAL *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 25 MCG/0.42 ML SYRING *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 25 MCG/ML VIAL *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 300 MCG/0.6 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 40 MCG/0.4 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 40 MCG/ML VIAL *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 500 MCG/1 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 60 MCG/0.3 ML SYRINGE *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARANESP 60 MCG/ML VIAL *(darbepoetin alfa in polysorbate 80)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DOPTELET (10 TAB PK) 20 MG TAB *(avatrombopag maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DOPTELET (15 TAB PK) 20 MG TAB *(avatrombopag maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
DOPTELET (30 TAB PK) 20 MG TAB *(avatrombopag maleate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
FULPHILA 6 MG/0.6 ML SYRINGE *(pegfilgrastim-jmdb)*	PA	Prior Authorization required.
GRANIX 300 MCG/0.5 ML SAFE SYR *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GRANIX 300 MCG/0.5 ML SYRINGE *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GRANIX 300 MCG/ML VIAL *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GRANIX 480 MCG/0.8 ML SAFE SYR *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GRANIX 480 MCG/0.8 ML SYRINGE *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GRANIX 480 MCG/1.6 ML VIAL *(tbo-filgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MIRCERA 100 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MIRCERA 150 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MIRCERA 200 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MIRCERA 30 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOPOIETIC AGENTS : HEMATOPOIETIC GROWTH FACTORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
MIRCERA 50 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MIRCERA 75 MCG/0.3 ML SYRINGE *(methoxy polyethylene glycol-epoetin beta)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MULPLETA 3 MG TABLET *(lusutrombopag)*	PA	Prior Authorization required.
NEULASTA 6 MG/0.6 ML SYRINGE *(pegfilgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NEULASTA ONPRO 6 MG/0.6 ML KIT *(pegfilgrastim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NIVESTYM 300 MCG/0.5 ML SYRING *(filgrastim-aafi)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NIVESTYM 300 MCG/ML VIAL *(filgrastim-aafi)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NIVESTYM 480 MCG/0.8 ML SYRING *(filgrastim-aafi)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NIVESTYM 480 MCG/1.6 ML VIAL *(filgrastim-aafi)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NPLATE 125 MCG VIAL *(romiplostim)*	PA	Prior Authorization required.
NPLATE 250 MCG VIAL *(romiplostim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NPLATE 500 MCG VIAL *(romiplostim)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
NYVEPRIA 6 MG/0.6 ML SYRINGE *(pegfilgrastim-apgf)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 12.5 MG SUSPEN PACKET *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 12.5 MG TABLET *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 25 MG SUSPENSION PCKT *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 25 MG TABLET *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 50 MG TABLET *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROMACTA 75 MG TABLET *(eltrombopag olamine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REBLOZYL 25 MG VIAL *(luspatercept-aamt)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REBLOZYL 75 MG VIAL *(luspatercept-aamt)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RETACRIT 10,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 2,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 20,000 UNIT/2 ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 20,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 3,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 4,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
RETACRIT 40,000 UNIT/ML VIAL *(epoetin alfa-epbx)*	PA	Prior Authorization required.
UDENYCA 6 MG/0.6 ML SYRINGE *(pegfilgrastim-cbqv)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HEMATOPOIETIC AGENTS : HEMATOPOIETIC GROWTH FACTORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ZARXIO 300 MCG/0.5 ML SYRINGE *(filgrastim-sndz)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZARXIO 480 MCG/0.8 ML SYRINGE *(filgrastim-sndz)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZIEXTENZO 6 MG/0.6 ML SYRINGE *(pegfilgrastim-bmez)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS : BENZODIAZEPINE HYPNOTICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
estazolam 1 mg tablet (PROSOM)		
estazolam 2 mg tablet (PROSOM)		
temazepam 15 mg capsule (RESTORIL)		
temazepam 22.5 mg capsule (RESTORIL)		
temazepam 30 mg capsule (RESTORIL)		
temazepam 7.5 mg capsule (RESTORIL)		
triazolam 0.125 mg tablet (HALCION)		
triazolam 0.25 mg tablet (HALCION)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
flurazepam 15 mg capsule (DALMANE)	PA	Prior Authorization required.
flurazepam 30 mg capsule (DALMANE)	PA	Prior Authorization required.
HALCION 0.25 MG TABLET *(use triazolam)*	PA	Prior Authorization required.
midazolam hcl 10 mg/5 ml syrup	PA	Prior Authorization required.
midazolam hcl 2 mg/ml syrup (VERSED)	PA	Prior Authorization required.
midazolam hcl 5 mg/2.5 ml syrp	PA	Prior Authorization required.
RESTORIL 15 MG CAPSULE *(use temazepam)*	PA	Prior Authorization required.
RESTORIL 22.5 MG CAPSULE *(use temazepam)*	PA	Prior Authorization required.
RESTORIL 30 MG CAPSULE *(use temazepam)*	PA	Prior Authorization required.
RESTORIL 7.5 MG CAPSULE *(use temazepam)*	PA	Prior Authorization required.

HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
phenobarbital 100 mg tablet		
phenobarbital 15 mg tablet (HEXA-BETALIN)		
phenobarbital 15 mg tablet (LUMINAL)		
phenobarbital 15 mg tablet (SOLFOTON)		
phenobarbital 16.2 mg tablet		
phenobarbital 20 mg/5 ml elix		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
phenobarbital 20 mg/5 ml elix (NEUROVAL)		
phenobarbital 20 mg/5 ml soln (NEUROVAL)		
phenobarbital 30 mg tablet (LUMINAL)		
phenobarbital 32.4 mg tablet		
phenobarbital 60 mg tablet		
phenobarbital 64.8 mg tablet		
phenobarbital 97.2 mg tablet		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BELSOMRA 10 MG TABLET *(suvorexant)*	PA	Prior Authorization required.
BELSOMRA 15 MG TABLET *(suvorexant)*	PA	Prior Authorization required.
BELSOMRA 20 MG TABLET *(suvorexant)*	PA	Prior Authorization required.
BELSOMRA 5 MG TABLET *(suvorexant)*	PA	Prior Authorization required.
DAYVIGO 10 MG TABLET *(lemborexant)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
DAYVIGO 5 MG TABLET *(lemborexant)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
doxepin hcl 3 mg tablet (SILENOR)	PA	Prior Authorization required.
doxepin hcl 6 mg tablet (SILENOR)	PA	Prior Authorization required.
HETLIOZ 20 MG CAPSULE *(tasimelteon)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ramelteon 8 mg tablet (ROZEREM)	PA	Prior Authorization required.
ROZEREM 8 MG TABLET *(ramelteon)*	PA	Prior Authorization required.
SECONAL SODIUM 100 MG CAPSULE *(secobarbital sodium)*	PA	Prior Authorization required.
SILENOR 3 MG TABLET *(doxepin hcl)*	PA	Prior Authorization required.
SILENOR 6 MG TABLET *(doxepin hcl)*	PA	Prior Authorization required.

HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS : NON - BENZODIAZEPINE HYPNOTICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
zolpidem tartrate 10 mg tablet (AMBIEN)	QL	Limited to 30 EA per 30 days.
zolpidem tartrate 10 mg tablet (AMBIEN PAK)	QL	Limited to 30 EA per 30 days.
zolpidem tartrate 5 mg tablet (AMBIEN)	QL	Limited to 30 EA per 30 days.
zolpidem tartrate 5 mg tablet (AMBIEN PAK)	QL	Limited to 30 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AMBIEN 10 MG TABLET *(use zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
AMBIEN 5 MG TABLET *(use zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
AMBIEN CR 12.5 MG TABLET *(zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
AMBIEN CR 6.25 MG TABLET *(zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

HYPNOTICS / SEDATIVES / SLEEP DISORDER AGENTS : NON - BENZODIAZEPINE HYPNOTICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EDLUAR 10 MG SL TABLET *(zolpidem tartrate)*	PA	Prior Authorization required.
EDLUAR 5 MG SL TABLET *(zolpidem tartrate)*	PA	Prior Authorization required.
eszopiclone 1 mg tablet (LUNESTA)	PA	Prior Authorization required.
eszopiclone 2 mg tablet (LUNESTA)	PA	Prior Authorization required.
eszopiclone 3 mg tablet (LUNESTA)	PA	Prior Authorization required.
LUNESTA 1 MG TABLET *(eszopiclone)*	PA	Prior Authorization required.
LUNESTA 2 MG TABLET *(eszopiclone)*	PA	Prior Authorization required.
LUNESTA 3 MG TABLET *(eszopiclone)*	PA	Prior Authorization required.
zaleplon 10 mg capsule (SONATA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
zaleplon 5 mg capsule (SONATA)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
zolpidem tart 1.75 mg tab sl (INTERMEZZO)	PA	Prior Authorization required.
zolpidem tart 3.5 mg tablet sl (INTERMEZZO)	PA	Prior Authorization required.
zolpidem tart er 12.5 mg tab (AMBIEN CR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
zolpidem tart er 6.25 mg tab (AMBIEN CR)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
ZOLPIMIST 5 MG ORAL SPRAY *(zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 4.5 mL per 30 days.
ZOLPIMIST 5 MG ORAL SPRAY *(zolpidem tartrate)*	PA,QL	Prior Authorization required. Limited to 7.7 mL per 30 days.

IMMUNOSUPPRESSIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
azathioprine 50 mg tablet (IMURAN)		
cyclosporine 100 mg capsule (SANDIMMUNE)		
cyclosporine 25 mg capsule (SANDIMMUNE)		
cyclosporine modified 100 mg (NEORAL)		
cyclosporine modified 100mg/ml (NEORAL)		
cyclosporine modified 25 mg (NEORAL)		
cyclosporine modified 50 mg (GENGRAF)		
GENGRAF 100 MG CAPSULE *(cyclosporine, modified)*		
GENGRAF 100 MG/ML SOLUTION *(cyclosporine, modified)*		
GENGRAF 25 MG CAPSULE *(cyclosporine, modified)*		
mycophenolate 200 mg/ml susp (CELLCEPT)		
mycophenolate 250 mg capsule (CELLCEPT)		
mycophenolate 500 mg tablet (CELLCEPT)		
mycophenolic acid dr 180 mg tb (MYFORTIC)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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IMMUNOSUPPRESSIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
mycophenolic acid dr 360 mg tb (MYFORTIC)		
SANDIMMUNE 100 MG/ML SOLN *(cyclosporine)*		
sirolimus 0.5 mg tablet (RAPAMUNE)	SP	Restricted to specialty pharmacies.
sirolimus 1 mg tablet (RAPAMUNE)	SP	Restricted to specialty pharmacies.
sirolimus 1 mg/ml solution (RAPAMUNE)		
sirolimus 2 mg tablet (RAPAMUNE)	SP	Restricted to specialty pharmacies.
tacrolimus 0.5 mg capsule (PROGRAF)		
tacrolimus 1 mg capsule (PROGRAF)		
tacrolimus 5 mg capsule (PROGRAF)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ASTAGRAF XL 0.5 MG CAPSULE *(tacrolimus)*	PA	Prior Authorization required.
ASTAGRAF XL 1 MG CAPSULE *(tacrolimus)*	PA	Prior Authorization required.
ASTAGRAF XL 5 MG CAPSULE *(tacrolimus)*	PA	Prior Authorization required.
AZASAN 100 MG TABLET *(azathioprine)*	PA	Prior Authorization required.
AZASAN 75 MG TABLET *(azathioprine)*	PA	Prior Authorization required.
CELLCEPT 200 MG/ML ORAL SUSP *(use mycophenolate mofetil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CELLCEPT 250 MG CAPSULE *(use mycophenolate mofetil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CELLCEPT 500 MG TABLET *(use mycophenolate mofetil)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENVARSUS XR 0.75 MG TABLET *(tacrolimus)*	PA	Prior Authorization required.
ENVARSUS XR 1 MG TABLET *(tacrolimus)*	PA	Prior Authorization required.
ENVARSUS XR 4 MG TABLET *(tacrolimus)*	PA	Prior Authorization required.
everolimus 0.25 mg tablet (ZORTRESS)	PA	Prior Authorization required.
everolimus 0.5 mg tablet (ZORTRESS)	PA	Prior Authorization required.
everolimus 0.75 mg tablet (ZORTRESS)	PA	Prior Authorization required.
IMURAN 50 MG TABLET *(use azathioprine)*	PA	Prior Authorization required.
MYFORTIC 180 MG TABLET *(use mycophenolate sodium)*	PA	Prior Authorization required.
MYFORTIC 360 MG TABLET *(use mycophenolate sodium)*	PA	Prior Authorization required.
NEORAL 100 MG GELATIN CAPSULE *(use cyclosporine, modified)*	PA	Prior Authorization required.
NEORAL 100 MG/ML SOLUTION *(use cyclosporine, modified)*	PA	Prior Authorization required.
NEORAL 25 MG GELATIN CAPSULE *(use cyclosporine, modified)*	PA	Prior Authorization required.
PROGRAF 0.2 MG GRANULE PACKET *(tacrolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

IMMUNOSUPPRESSIVE AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PROGRAF 0.5 MG CAPSULE *(use tacrolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROGRAF 1 MG CAPSULE *(use tacrolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROGRAF 1 MG GRANULE PACKET *(tacrolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PROGRAF 5 MG CAPSULE *(use tacrolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RAPAMUNE 0.5 MG TABLET *(use sirolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RAPAMUNE 1 MG TABLET *(use sirolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RAPAMUNE 1 MG/ML ORAL SOLN *(use sirolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RAPAMUNE 2 MG TABLET *(use sirolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SANDIMMUNE 100 MG CAPSULE *(use cyclosporine)*	PA	Prior Authorization required.
SANDIMMUNE 25 MG CAPSULE *(use cyclosporine)*	PA	Prior Authorization required.
ZORTRESS 0.25 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZORTRESS 0.5 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZORTRESS 0.75 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZORTRESS 1 MG TABLET *(everolimus)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Irrigation Solutions		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
sodium chloride 0.9% irrig. (AQUA CARE SODIUM CHLORIDE)		
sodium chloride 0.9% prcss sol (AQUA CARE SODIUM CHLORIDE)		
Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
GAVILYTE-N SOLUTION *(sodium chloride/sodium bicarbonate/potassium chloride/peg)*		
NULYTELY WITH FLAVOR PACKS SOL *(sodium chloride/sodium bicarbonate/potassium chloride/peg)*		
peg 3350 electrolyte soln (COLYTE WITH FLAVOR PACKETS)		
peg 3350-electrolyte solution (NULYTELY)		
polyethylene glycol 3350 powd (MIRALAX)		
TRILYTE WITH FLAVOR PACKETS *(sodium chloride/sodium bicarbonate/potassium chloride/peg)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ASSURE ID SYR 0.5 ML 29GX1/2" *(syringe with needle, insulin, safety, 0.5 ml)*		
ASSURE ID SYR 1 ML 29GX1/2" *(syringe with needle, insulin, safety, 1 ml)*		
HUMAPEN LUXURA HD *(insulin admin. supplies)*	QL	Limited to 1 EA over 365 days.
INSULIN SYRIN 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*		
INSULIN SYRIN 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*		
INSULIN SYRINGE 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*		
INSULIN SYRINGE 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*		
MAGELLAN INSULIN SYR 0.3 ML *(syringe with needle, insulin, safety, 0.3 ml)*		
MAGELLAN INSULIN SYR 0.5 ML *(syringe with needle, insulin, safety, 0.5 ml)*		
MAGELLAN INSULIN SYRINGE 1 ML *(syringe with needle, insulin, safety, 1 ml)*		
MONOJECT INSULIN SYR 0.3 ML *(syringe with needle,insulin,0.3 ml)*		
MONOJECT INSULIN SYR 0.5 ML *(syringe with needle,insulin,0.5 ml)*		
MONOJECT INSULIN SYR 1 ML *(syringe with needle,disposable,insulin 1 ml)*		
MONOJECT INSULIN SYR U-100 *(syringe with needle,insulin,0.5 ml)*		
MONOJECT SYRINGE 1 ML *(syringe with needle,disposable,insulin 1 ml)*		
NOVOPEN ECHO INSULIN DEVICE *(insulin admin. supplies)*	QL	Limited to 1 EA over 365 days.
PEN NEEDLE 30G X 5/16" *(pen needle, diabetic)*		
PEN NEEDLE 31G X 3/16" *(pen needle, diabetic)*		
PEN NEEDLE 31G X 5/16" *(pen needle, diabetic)*		
ULTICARE SAFETY 0.5 ML 29GX1/2 *(syringe with needle,insulin,0.5 ml)*		
Medical Supplies and DME - Parenteral Blood Collection Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
MONOJECT BLD COL NEEDLE 20GX1" *(needles, blood collection)*		
MONOJECT BLD COL NEEDLE 21GX1" *(needles, blood collection)*		
MONOJECT BLD COL NEEDLE 22GX1" *(needles, blood collection)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Respiratory Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
EASIVENT HOLDING CHAMBER *(inhaler, assist devices)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
OPTICHAMBER ADULT MASK-LARGE *(inhaler, assist devices, accessories)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
OPTICHAMBER DIAMOND VHC *(inhaler, assist devices)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
OPTICHAMBER DIAMOND W-LRG MASK *(inhaler,assist device with large mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
OPTICHAMBER DIAMOND W-MED MASK *(inhaler,assist device with medium mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
OPTICHAMBER DIAMOND W-SML MASK *(inhaler,assist device with small mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
PROCHAMBER HOLDING CHAMBER *(inhaler, assist devices)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
TRUZONE PEAK FLOW METER *(peak flow meter)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
VORTEX HOLDING CHAMBER *(inhaler, assist devices)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
VORTEX HOLDING CHAMBER-CHILD *(inhaler,assist device with medium mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
VORTEX HOLDING CHAMBER-TODDLER *(inhaler,assist device with small mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
VORTEX VHC FROG CHILD MASK *(inhaler,assist device with medium mask)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.
MIGRAINE PRODUCTS : CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
AIMOVIG 140 MG/ML AUTOINJECTOR *(erenumab-aooe)*	PA	Prior Authorization required.
AIMOVIG 70 MG/ML AUTOINJECTOR *(erenumab-aooe)*	PA	Prior Authorization required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AJOVY 225 MG/1.5 ML AUTOINJECT *(fremanezumab-vfrm)*	PA	Prior Authorization Required.
AJOVY 225 MG/1.5 ML SYRINGE *(fremanezumab-vfrm)*	PA	Prior Authorization required.
EMGALITY 100 MG/ML SYR(1 OF 3) *(galcanezumab-gnlm)*	PA	Prior Authorization required.
EMGALITY 120 MG/ML PEN *(galcanezumab-gnlm)*	PA	Prior Authorization required.
EMGALITY 120 MG/ML SYRINGE *(galcanezumab-gnlm)*	PA	Prior Authorization required.
EMGALITY 300 MG (100 MG X3SYR) *(galcanezumab-gnlm)*	PA	Prior Authorization required.
NURTEC ODT 75 MG TABLET *(rimegepant sulfate)*	PA,QL	Prior Authorization Required. Limited to 8 tablets per 30 days.
UBRELVY 100 MG TABLET *(ubrogepant)*	PA,QL	Prior Authorization Required. Limited to 10 tablets per 30 days.
UBRELVY 50 MG TABLET *(ubrogepant)*	PA,QL	Prior Authorization Required. Limited to 10 tablets per 30 days.
VYEPTI 100 MG/ML VIAL *(eptinezumab-jjmr)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MIGRAINE PRODUCTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
MIGERGOT 2-100 MG SUPPOSITORY *(ergotamine tartrate/caffeine)*	QL	Limited to 20 EA per 28 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CAFERGOT TABLET *(ergotamine tartrate/caffeine)*	PA	Prior Authorization required.
CAMBIA 50 MG POWDER PACKET *(diclofenac potassium)*	PA	Prior Authorization required.
dihydroergotamine 4 mg/ml spry (MIGRANAL)	PA	Prior Authorization required.
ERGOMAR 2 MG TABLET SL *(ergotamine tartrate)*	PA	Prior Authorization required.
MIGRANAL NASAL SPRAY *(dihydroergotamine mesylate)*	PA	Prior Authorization required.
sumatriptan-naproxen 85-500 mg (TREXIMET)	PA	Prior Authorization required.
TREXIMET 85-500 MG TABLET *(sumatriptan succinate/naproxen sodium)*	PA	Prior Authorization required.
MIGRAINE PRODUCTS : SELECTIVE SEROTONIN AGONISTS 5-HT(1F)		
Drug Name	**Drug Status**	**Criteria**
Preferred		
rizatriptan 10 mg odt (MAXALT MLT)		
rizatriptan 10 mg tablet (MAXALT)		
rizatriptan 5 mg odt (MAXALT MLT)		
rizatriptan 5 mg tablet (MAXALT)		
sumatriptan 20 mg nasal spray (IMITREX)		
sumatriptan 4 mg/0.5 ml cart (IMITREX)		
sumatriptan 4 mg/0.5 ml inject (IMITREX)		
sumatriptan 5 mg nasal spray (IMITREX)		
sumatriptan 6 mg/0.5 ml cart (IMITREX)		
sumatriptan 6 mg/0.5 ml inject (IMITREX)		
sumatriptan 6 mg/0.5 ml syrng		
sumatriptan 6 mg/0.5 ml vial (IMITREX)	QL	Limited to 2 mL per 30 days.
sumatriptan succ 100 mg tablet (IMITREX)	QL,FL	Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
sumatriptan succ 25 mg tablet (IMITREX)	QL,FL	Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
sumatriptan succ 50 mg tablet (IMITREX)	QL,FL	Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
almotriptan malate 12.5 mg tab (AXERT)	PA	Prior Authorization required.
almotriptan malate 6.25 mg tab (AXERT)	PA	Prior Authorization required.
AMERGE 1 MG TABLET *(naratriptan hcl)*	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
AMERGE 2.5 MG TABLET *(naratriptan hcl)*	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
eletriptan hbr 20 mg tablet (RELPAX)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MIGRAINE PRODUCTS : SELECTIVE SEROTONIN AGONISTS 5-HT(1F)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
eletriptan hbr 40 mg tablet (RELPAX)	PA	Prior Authorization required.
FROVA 2.5 MG TABLET *(frovatriptan succinate)*	PA	Prior Authorization required.
frovatriptan succ 2.5 mg tab (FROVA)	PA	Prior Authorization required.
IMITREX 100 MG TABLET *(use sumatriptan succinate)*	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
IMITREX 20 MG NASAL SPRAY *(use sumatriptan)*	PA	Prior Authorization required.
IMITREX 25 MG TABLET *(use sumatriptan succinate)*	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
IMITREX 4 MG/0.5 ML CARTRIDGES *(use sumatriptan succinate)*	PA	Prior Authorization required.
IMITREX 4 MG/0.5 ML PEN INJECT *(use sumatriptan succinate)*	PA	Prior Authorization required.
IMITREX 5 MG NASAL SPRAY *(use sumatriptan)*	PA	Prior Authorization required.
IMITREX 50 MG TABLET *(use sumatriptan succinate)*	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
IMITREX 6 MG/0.5 ML CARTRIDGES *(use sumatriptan succinate)*	PA	Prior Authorization required.
IMITREX 6 MG/0.5 ML PEN INJECT *(use sumatriptan succinate)*	PA	Prior Authorization required.
IMITREX 6 MG/0.5 ML VIAL *(use sumatriptan succinate)*	PA,QL	Prior Authorization required. Limited to 2 mL per 30 days.
MAXALT 10 MG TABLET *(use rizatriptan benzoate)*	PA	Prior Authorization required.
MAXALT MLT 10 MG TABLET *(use rizatriptan benzoate)*	PA	Prior Authorization required.
naratriptan hcl 1 mg tablet (AMERGE)	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
naratriptan hcl 2.5 mg tablet (AMERGE)	PA,QL,FL	Prior Authorization required. Limited to 9 EA per 30 days; Limited to 1 fill per 23 days.
ONZETRA XSAIL 11 MG/NOSEPIECE *(sumatriptan succinate)*	PA	Prior Authorization required.
ONZETRA XSAIL 11 MG/NOSEPIECE *(sumatriptan succinate)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
RELPAX 20 MG TABLET *(eletriptan hydrobromide)*	PA	Prior Authorization required.
RELPAX 40 MG TABLET *(eletriptan hydrobromide)*	PA	Prior Authorization required.
REYVOW 100 MG TABLET *(lasmiditan succinate)*	PA,QL	Prior Authorization required. Limited to 4 EA per 30 days.
REYVOW 50 MG TABLET *(lasmiditan succinate)*	PA,QL	Prior Authorization required. Limited to 4 EA per 30 days.
TOSYMRA 10 MG NASAL SPRAY *(sumatriptan)*	PA	Prior Authorization required.
ZEMBRACE SYMTOUCH 3 MG/0.5 ML *(sumatriptan succinate)*	PA	Prior Authorization required.
zolmitriptan 2.5 mg nasal spry (ZOMIG)	PA	Prior Authorization Required.
zolmitriptan 2.5 mg odt (ZOMIG ZMT)	PA	Prior Authorization required.
zolmitriptan 2.5 mg tablet (ZOMIG)	PA	Prior Authorization required.
zolmitriptan 5 mg nasal spray (ZOMIG)	PA	Prior Authorization Required.
zolmitriptan 5 mg odt (ZOMIG ZMT)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MIGRAINE PRODUCTS : SELECTIVE SEROTONIN AGONISTS 5-HT(1F)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
zolmitriptan 5 mg tablet (ZOMIG)	PA	Prior Authorization required.
ZOMIG 2.5 MG NASAL SPRAY *(zolmitriptan)*	PA	Prior Authorization required.
ZOMIG 2.5 MG TABLET *(zolmitriptan)*	PA	Prior Authorization required.
ZOMIG 5 MG NASAL SPRAY *(zolmitriptan)*	PA	Prior Authorization required.
ZOMIG 5 MG TABLET *(zolmitriptan)*	PA	Prior Authorization required.
ZOMIG ZMT 2.5 MG TABLET *(zolmitriptan)*	PA	Prior Authorization required.
ZOMIG ZMT 5 MG TABLET *(zolmitriptan)*	PA	Prior Authorization required.
Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
calcium gluc 1,000 mg/10 ml vl	PA	Prior Authorization required.
calcium gluc 10,000 mg/100 ml	PA	Prior Authorization required.
calcium gluc 5,000 mg/50 ml vl	PA	Prior Authorization required.
calcium gluconate 10% vial	PA	Prior Authorization required.
dextrose 5%-electrolyte 48		
dextrose 5%-ringers iv soln (DEXTROSE W/ACETATED RINGERS)		
K-TAB ER 10 MEQ TABLET *(potassium chloride)*		
KLOR-CON 10 MEQ TABLET *(potassium chloride)*		
KLOR-CON M20 TABLET *(potassium chloride)*		
magnesium sulfate 50% vial		
MULTITRACE-5 CONC VIAL *(zinc sulfate/copper sulfate/manganese/chromium/selenium)*		
potassium acet 100 meq/50 ml		
potassium acet 40 meq/20 ml vl		
potassium cl 10 meq/5 ml conc		
potassium cl 10 meq/5 ml conc	PA	Prior Authorization required.
potassium cl 10% (20 meq/15ml) (KLORVESS)		
potassium cl 10% (40 meq/30ml) (KLORVESS)		
potassium cl 2 meq/ml conc		
potassium cl 20 meq/10 ml conc		
potassium cl 20 meq/10 ml conc	PA	Prior Authorization required.
potassium cl 40 meq/20 ml conc		
potassium cl 40 meq/20 ml conc	PA	Prior Authorization required.
potassium cl 60 meq/30 ml conc		
potassium cl 60 meq/30 ml conc	PA	Prior Authorization required.
potassium cl er 10 meq tablet (KAON-CL 10)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
potassium cl er 10 meq tablet (KLOR-CON M10)		
potassium cl er 20 meq tablet (KLOR-CON M20)		
potassium cl er 8 meq tablet (KLOR-CON 8)		
potassium phosp 150 mmol/50 ml		
potassium phosp 45 mmol/15 ml		
potassium phosph 15 mmol/5 ml		
sodium acetate 100 meq/50 ml		
sodium acetate 200 meq/100 ml		
sodium acetate 4 meq/ml vial		
sodium acetate 40 meq/20 ml vl		
sodium acetate 400 meq/100 ml		
sodium phosphate 45 mmol/15 ml	PA	Prior Authorization required.
zinc sulfate 10 mg/10 ml vial (ZINCA-PAK)	PA	Prior Authorization required.
MISCELLANEOUS THERAPEUTIC CLASSES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
KIONEX 15 GM/60 ML SUSPENSION *(sodium polystyrene sulfonate/sorbitol solution)*		
sod polystyren sulf 15 g/60 ml	QL,FL	Limited to 240 mL per 7 days; Limited to 1 fill per 180 days.
sodium polystyrene sulf powder (KAYEXALATE)		
sodium polystyrene sulf powder (KIONEX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BENLYSTA 200 MG/ML AUTOINJECT *(belimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
BENLYSTA 200 MG/ML SYRINGE *(belimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LOKELMA 10 GRAM POWDER PACKET *(sodium zirconium cyclosilicate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LOKELMA 5 GRAM POWDER PACKET *(sodium zirconium cyclosilicate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 10 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 15 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 2.5 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 20 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 25 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REVLIMID 5 MG CAPSULE *(lenalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SPS 15 GM/60 ML SUSPENSION *(sodium polystyrene sulfonate/sorbitol solution)*	PA	Prior Authorization Required.
SPS 30 GM/120 ML ENEMA SUSP *(sodium polystyrene sulfonate/sorbitol solution)*	PA	Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MISCELLANEOUS THERAPEUTIC CLASSES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
THALOMID 100 MG CAPSULE *(thalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
THALOMID 150 MG CAPSULE *(thalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
THALOMID 200 MG CAPSULE *(thalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
THALOMID 50 MG CAPSULE *(thalidomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VELTASSA 16.8 GM POWDER PACKET *(patiromer calcium sorbitex)*	PA	Prior Authorization required.
VELTASSA 25.2 GM POWDER PACKET *(patiromer calcium sorbitex)*	PA	Prior Authorization required.
VELTASSA 8.4 GM POWDER PACKET *(patiromer calcium sorbitex)*	PA	Prior Authorization required.
MOUTH / THROAT / DENTAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
chlorhexidine 0.12% rinse (PAROEX)		
chlorhexidine 0.12% rinse (PERIDEX)		
clotrimazole 10 mg troche (MYCELEX)		
lidocaine 2% viscous soln (XYLOCAINE VISCOUS)	QL	Limited to 200 mL per 30 days.
lidocaine hcl 4% solution (PRE-ATTACHED LTA KIT)	QL	Limited to 50 mL per 30 days.
nystatin 100,000 unit/ml susp (MYCOSTATIN)		
nystatin 500,000 unit/5 ml sus (MYCOSTATIN)		
ORALONE 0.1% PASTE *(triamcinolone acetonide)*	QL	Limited to 5 g per 30 days.
PAROEX 0.12% ORAL RINSE *(chlorhexidine gluconate)*		
pilocarpine hcl 5 mg tablet (SALAGEN)		
pilocarpine hcl 7.5 mg tablet (SALAGEN)		
triamcinolone 0.1% paste (ORALONE)	QL	Limited to 5 g per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AQUORAL SPRAY *(saliva substitute combo no.3)*	PA	Prior Authorization required.
cevimeline hcl 30 mg capsule (EVOXAC)	PA	Prior Authorization required.
DENTA 5000 PLUS CREAM *(fluoride (sodium))*	PA	Prior Authorization required.
DENTAGEL 1.1% GEL *(fluoride (sodium))*	PA	Prior Authorization required.
EVOXAC 30 MG CAPSULE *(cevimeline hcl)*	PA	Prior Authorization required.
GELX ORAL GEL *(povidone/taurine/zinc gluconate/peg-40 castor oil)*	PA	Prior Authorization Required.
ORAVIG 50 MG BUCCAL TABLET *(miconazole)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MOUTH / THROAT / DENTAL AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SALAGEN 5 MG TABLET *(use pilocarpine hcl)*	PA	Prior Authorization required.
SALAGEN 7.5 MG TABLET *(use pilocarpine hcl)*	PA	Prior Authorization required.
SF 1.1% GEL *(fluoride (sodium))*	PA	Prior Authorization required.
SF 5000 PLUS CREAM *(fluoride (sodium))*	PA	Prior Authorization required.
sod fluoride enam prot 5000ppm (PREVIDENT 5000 ENAMEL PROTECT)	PA	Prior Authorization required.
sodium fluoride 1.1% gel (DENTAGEL)	PA	Prior Authorization required.
sodium fluoride 1.1% gel (PREVIDENT)	PA	Prior Authorization required.
SODIUM FLUORIDE 5000 PLUS CRM *(fluoride (sodium))*	PA	Prior Authorization required.
sodium fluoride 5000 ppm cream (DENTA 5000 PLUS)	PA	Prior Authorization required.
sodium fluoride 5000 ppm paste (PREVIDENT)	PA	Prior Authorization required.
sodium fluoride senstv 5000ppm (PREVIDENT 5000 ENAMEL PROTECT)	PA	Prior Authorization required.

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CITRANATAL 90 DHA COMBO PACK *(prenatal vit no.72/iron carbony,gluc/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL ASSURE COMBO PACK *(prenatal vit no.73/iron carbony,gluc/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL BLOOM TABLET *(iron carbonyl,gluc/folic acid/vit b12/vit c/docusate sodium)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL DHA PACK *(prenatal vit no.76/iron carbony,gluc/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL HARMONY CAPSULE *(prenatal vitamin no.59/iron carb,fum/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL RX TABLET *(prenatal vits no.81/iron carbonyl,gluc/folic acid/docusate)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PNV OB+DHA COMBO PACK *(prenatal vit no.22/iron cbn,glucon/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PNV-DHA + DOCUSATE SOFTGEL *(prenatal vits,calcium no.66/iron fum/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENAISSANCE CAPSULE *(prenatal vits with calcium no.80/iron fum/folic acid/dss/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENAISSANCE PLUS SOFTGEL *(prenatal vit with calcium no.69/iron/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
TARON-PREX PRENATAL DHA CAP *(multivitamin no.53/ferrous fum/folic acid/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VITAFOL FE+ DOCUSATE COMBO PCK *(prenatal vits no.102/iron polysacch/folate no.1/docusate/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VP-CH-PNV PRENATAL SOFTGEL *(prenatal vits no.34/iron,carb/folic acid/docusate sodium/dha)*	PA,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
MUSCULOSKELETAL THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
baclofen 10 mg tablet (BACLOFEN)		
baclofen 10 mg tablet (LIORESAL)		
baclofen 20 mg tablet (BACLOFEN)		
baclofen 20 mg tablet (LIORESAL)		
baclofen 5 mg tablet		
chlorzoxazone 250 mg tablet (PARAFLEX)		
chlorzoxazone 375 mg tablet (LORZONE)		
chlorzoxazone 500 mg tablet (PARAFON FORTE DSC)		
chlorzoxazone 750 mg tablet (LORZONE)		
cyclobenzaprine 10 mg tablet (FLEXERIL)		
cyclobenzaprine 5 mg tablet (FLEXERIL)		
cyclobenzaprine 7.5 mg tablet (FEXMID)		
dantrolene sodium 100 mg cap (DANTRIUM)		
dantrolene sodium 25 mg cap (DANTRIUM)		
dantrolene sodium 50 mg cap (DANTRIUM)		
LORZONE 375 MG TABLET *(chlorzoxazone)*		
LORZONE 750 MG TABLET *(chlorzoxazone)*		
methocarbamol 500 mg tablet (ROBAXIN)		
methocarbamol 750 mg tablet (ROBAXIN-750)		
orphenadrine er 100 mg tablet (NORFLEX)		
tizanidine hcl 2 mg tablet (ZANAFLEX)		
tizanidine hcl 4 mg tablet (ZANAFLEX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AMRIX ER 15 MG CAPSULE *(cyclobenzaprine hcl)*	PA	Prior Authorization required.
AMRIX ER 30 MG CAPSULE *(cyclobenzaprine hcl)*	PA	Prior Authorization required.
carisoprodol 250 mg tablet (SOMA)	PA	Prior Authorization required.
carisoprodol 350 mg tablet (SOMA)	PA	Prior Authorization required.
carisoprodol-aspirin-codein tb (SOMA COMPOUND WITH CODEINE)	PA,AL	Prior Authorization required. Limited to members age 18 and older.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

MUSCULOSKELETAL THERAPY AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
cyclobenzaprine er 15 mg cap (AMRIX)	PA	Prior Authorization required.
cyclobenzaprine er 30 mg cap (AMRIX)	PA	Prior Authorization required.
DANTRIUM 25 MG CAPSULE *(use dantrolene sodium)*	PA	Prior Authorization required.
DANTRIUM 50 MG CAPSULE *(use dantrolene sodium)*	PA	Prior Authorization required.
FEXMID 7.5 MG TABLET *(use cyclobenzaprine hcl)*	PA	Prior Authorization required.
METAXALL 800 MG TABLET *(metaxalone)*	PA	Prior Authorization required.
metaxalone 400 mg tablet (SKELAXIN)	PA	Prior Authorization required.
metaxalone 800 mg tablet (SKELAXIN)	PA	Prior Authorization required.
NORGESIC FORTE 50-770-60 MG TB *(orphenadrine citrate/aspirin/caffeine)*	PA	Prior Authorization required.
ROBAXIN-750 TABLET *(use methocarbamol)*	PA	Prior Authorization required.
SKELAXIN 800 MG TABLET *(metaxalone)*	PA	Prior Authorization required.
SOMA 250 MG TABLET *(carisoprodol)*	PA	Prior Authorization required.
SOMA 350 MG TABLET *(carisoprodol)*	PA	Prior Authorization required.
tizanidine hcl 2 mg capsule (ZANAFLEX)	PA	Prior Authorization required.
tizanidine hcl 4 mg capsule (ZANAFLEX)	PA	Prior Authorization required.
tizanidine hcl 6 mg capsule (ZANAFLEX)	PA	Prior Authorization required.
ZANAFLEX 2 MG CAPSULE *(tizanidine hcl)*	PA	Prior Authorization required.
ZANAFLEX 4 MG CAPSULE *(tizanidine hcl)*	PA	Prior Authorization required.
ZANAFLEX 4 MG TABLET *(use tizanidine hcl)*	PA	Prior Authorization required.
ZANAFLEX 6 MG CAPSULE *(tizanidine hcl)*	PA	Prior Authorization required.

NASAL AGENTS - SYSTEMIC AND TOPICAL : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
azelastine 0.1% (137 mcg) spry (ASTELIN)		
azelastine 0.1% (137 mcg) spry (ASTEPRO)		
azelastine 0.15% nasal spray (ASTEPRO)		
flunisolide 0.025% spray (NASALIDE)	QL	Limited to 25.2 mL per 30 days.
fluticasone prop 50 mcg spray (CHILDREN'S FLONASE ALLERGY RLF)	QL	Limited to 16.2 g per 30 days.
olopatadine 665 mcg nasal spry (PATANASE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
azelastin-flutic 137-50mcg spr (DYMISTA)	PA	Prior Authorization required.
BECONASE AQ 0.042% SPRAY *(beclomethasone dipropionate)*	PA	Prior Authorization required.
DYMISTA NASAL SPRAY *(azelastine hcl/fluticasone propionate)*	PA	Prior Authorization required.
ipratropium 0.03% spray (ATROVENT)	PA,QL	Prior Authorization required. Limited to 30 mL per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

NASAL AGENTS - SYSTEMIC AND TOPICAL : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ipratropium 0.06% spray (ATROVENT)	PA,QL	Prior Authorization required. Limited to 15 mL per 30 days.
mometasone furoate 50 mcg spry (NASONEX)	PA	Prior Authorization required.
NASONEX 50 MCG NASAL SPRAY *(mometasone furoate)*	PA	Prior Authorization required.
OMNARIS 50 MCG NASAL SPRAY *(ciclesonide)*	PA	Prior Authorization required.
PATANASE 665 MCG NASAL SPRAY *(use olopatadine hcl)*	PA	Prior Authorization required.
QNASL 80 MCG NASAL SPRAY *(beclomethasone dipropionate)*	PA	Prior Authorization required.
QNASL CHILDREN'S 40 MCG SPRAY *(beclomethasone dipropionate)*	PA	Prior Authorization required.
SINUVA 1,350 MCG SINUS IMPLANT *(mometasone furoate)*	PA	Prior Authorization required.
XHANCE 93 MCG NASAL SPRAY *(fluticasone propionate)*	PA	Prior Authorization required.
ZETONNA 37 MCG NASAL SPRAY *(ciclesonide)*	PA	Prior Authorization required.
NEUROMUSCULAR AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
riluzole 50 mg tablet (RILUTEK)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
RILUTEK 50 MG TABLET *(use riluzole)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TIGLUTIK 50 MG/10 ML SUSP *(riluzole)*	PA	Prior Authorization required.
OPHTHALMIC AGENTS : BETA-BLOCKERS - OPHTHALMIC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
betaxolol hcl 0.5% eye drop (BETOPTIC)		
carteolol hcl 1% eye drops (OCUPRESS)		
dorzolamide-timolol eye drops (COSOPT)		
levobunolol 0.5% eye drops (BETAGAN)		
timolol 0.25% gel-solution (TIMOPTIC-XE)		
timolol 0.25% gfs gel-solution (TIMOPTIC-XE)		
timolol 0.5% eye drop (ISTALOL)		
timolol 0.5% gel-solution (TIMOPTIC-XE)		
timolol 0.5% gfs gel-solution (TIMOPTIC-XE)		
timolol maleate 0.25% eye drop (TIMOPTIC)		
timolol maleate 0.5% eye drops (TIMOPTIC)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : BETA-BLOCKERS - OPHTHALMIC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BETOPTIC S 0.25% EYE DROPS *(betaxolol hcl)*	PA	Prior Authorization required.
COMBIGAN 0.2%-0.5% EYE DROPS *(brimonidine tartrate/timolol maleate)*	PA	Prior Authorization required.
COSOPT EYE DROPS *(use dorzolamide hcl/timolol maleate)*	PA	Prior Authorization required.
COSOPT PF EYE DROPS *(dorzolamide hcl/timolol maleate/pf)*	PA	Prior Authorization required.
dorzolamide-timolol 2%-0.5% (COSOPT PF)	PA	Prior Authorization required.
ISTALOL 0.5% EYE DROPS *(use timolol maleate)*	PA	Prior Authorization required.
timolol maleate 0.5% eye drop (TIMOPTIC OCUDOSE)	PA	Prior Authorization required.
TIMOPTIC 0.25% EYE DROP *(use timolol maleate)*	PA	Prior Authorization required.
TIMOPTIC 0.25% OCUDOSE DROP *(timolol maleate/pf)*	PA	Prior Authorization required.
TIMOPTIC 0.5% EYE DROP *(use timolol maleate)*	PA	Prior Authorization required.
TIMOPTIC 0.5% OCUDOSE DROP *(timolol maleate/pf)*	PA	Prior Authorization required.
TIMOPTIC-XE 0.25% EYE GEL-SOLN *(use timolol maleate)*	PA	Prior Authorization required.
TIMOPTIC-XE 0.5% GEL-SOLUTION *(use timolol maleate)*	PA	Prior Authorization required.

OPHTHALMIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ALPHAGAN P 0.1% DROPS *(brimonidine tartrate)*		
ALPHAGAN P 0.15% EYE DROPS *(brimonidine tartrate)*		
atropine 1% eye drops (ISOPTO ATROPINE)		
atropine 1% eye ointment (SPECTRO-ATROPINE)		
brimonidine 0.2% eye drop (ALPHAGAN)		
brimonidine tartrate 0.15% drp (ALPHAGAN P)		
CYCLOMYDRIL EYE DROPS *(cyclopentolate hcl/phenylephrine hcl)*		
cyclopentolate 0.5% eye drops (CYCLOGYL)		
cyclopentolate 1% eye drop (CYCLOGYL)		
cyclopentolate 1% eye drops (CYCLOGYL)		
cyclopentolate hcl 2% drops (CYCLOGYL)		
diclofenac 0.1% eye drops (VOLTAREN)		
dorzolamide hcl 2% eye drops (TRUSOPT)		
flurbiprofen 0.03% eye drop (OCUFEN)		
ketorolac 0.4% ophth solution (ACULAR LS)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ketorolac 0.5% ophth solution (ACULAR)		
LACRISERT 5 MG EYE INSERT *(hydroxypropyl cellulose)*		
latanoprost 0.005% eye drops (XALATAN)		
PHOSPHOLINE IODIDE 0.125% *(echothiophate iodide)*		
pilocarpine 1% eye drops (ISOPTO CARPINE)		
pilocarpine 2% eye drops (ISOPTO CARPINE)		
pilocarpine 4% eye drops (ISOPTO CARPINE)		
tropicamide 0.5% eye drop (MYDRAL)		
tropicamide 0.5% eye drops (MYDRAL)		
tropicamide 1% eye drop (MYDRIACYL)		
tropicamide 1% eye drops (MYDRIACYL)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACULAR 0.5% EYE DROPS *(use ketorolac tromethamine)*	PA	Prior Authorization required.
ACULAR LS 0.4% OPHTH SOL *(use ketorolac tromethamine)*	PA	Prior Authorization required.
ACUVAIL 0.45% OPHTH SOLUTION *(ketorolac tromethamine/pf)*	PA	Prior Authorization required.
AKTEN 3.5% GEL DROPS *(lidocaine hcl/pf)*	PA	Prior Authorization required.
ALCAINE 0.5% EYE DROPS *(proparacaine hcl)*	PA	Prior Authorization required.
apraclonidine hcl 0.5% drops (IOPIDINE)	PA	Prior Authorization required.
AZOPT 1% EYE DROPS *(brinzolamide)*	PA	Prior Authorization required.
bimatoprost 0.03% eye drops (LUMIGAN)	PA	Prior Authorization required.
bimatoprost 0.03% eyelash soln (LATISSE)	PA	Prior Authorization Required.
bromfenac sodium 0.09% eye drp (BROMDAY)	PA	Prior Authorization required.
bromfenac sodium 0.09% eye drp (XIBROM)	PA	Prior Authorization required.
BROMSITE 0.075% EYE DROPS *(bromfenac sodium)*	PA	Prior Authorization required.
CEQUA 0.09% SOLUTION *(cyclosporine)*	PA	Prior Authorization required.
CYCLOGYL 0.5% EYE DROPS *(use cyclopentolate hcl)*	PA	Prior Authorization required.
CYCLOGYL 1% EYE DROPS *(use cyclopentolate hcl)*	PA	Prior Authorization required.
CYCLOGYL 2% EYE DROPS *(use cyclopentolate hcl)*	PA	Prior Authorization required.
CYSTADROPS 0.37% EYE DROPS *(cysteamine hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CYSTARAN 0.44% EYE DROPS *(cysteamine hcl)*	PA	Prior Authorization required.
GLOSTRIPS 1 MG OPHTH STRIP *(fluorescein sodium)*	PA	Prior Authorization required.

Drug List

OPHTHALMIC AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ILEVRO 0.3% OPHTH DROPS *(nepafenac)*	PA	Prior Authorization required.
IOPIDINE 1% EYE DROPS *(apraclonidine hcl)*	PA	Prior Authorization required.
ISOPTO ATROPINE 1% EYE DROP *(use atropine sulfate)*	PA	Prior Authorization required.
ISOPTO CARPINE 1% EYE DROPS *(use pilocarpine hcl)*	PA	Prior Authorization required.
ISOPTO CARPINE 2% EYE DROPS *(use pilocarpine hcl)*	PA	Prior Authorization required.
ISOPTO CARPINE 4% EYE DROPS *(use pilocarpine hcl)*	PA	Prior Authorization required.
LUMIGAN 0.01% EYE DROPS *(bimatoprost)*	PA	Prior Authorization required.
MYDRIACYL 1% EYE DROPS *(use tropicamide)*	PA	Prior Authorization required.
NEVANAC 0.1% DROPTAINER *(nepafenac)*	PA	Prior Authorization required.
OXERVATE 0.002% EYE DROP *(cenegermin-bkbj)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
phenylephrine 10% eye drops (NEO-SYNEPHRINE)	PA	Prior Authorization required.
phenylephrine 2.5% eye drop (NEO-SYNEPHRINE)	PA	Prior Authorization required.
PROLENSA 0.07% EYE DROPS *(bromfenac sodium)*	PA	Prior Authorization required.
proparacaine 0.5% eye drops (ALCAINE)	PA	Prior Authorization required.
RESTASIS 0.05% EYE EMULSION *(cyclosporine)*	PA	Prior Authorization required.
RESTASIS MULTIDOSE 0.05% EYE *(cyclosporine)*	PA	Prior Authorization required.
RHOPRESSA 0.02% OPHTH SOLUTION *(netarsudil mesylate)*	PA	Prior Authorization required.
ROCKLATAN 0.02%-0.005% EYE DRP *(netarsudil mesylate/latanoprost)*	PA	Prior Authorization required.
SIMBRINZA 1%-0.2% EYE DROPS *(brinzolamide/brimonidine tartrate)*	PA	Prior Authorization required.
tetracaine 0.5% eye drop (ALTACAINE)	PA	Prior Authorization required.
tetracaine 0.5% eye drop (PONTOCAINE)	PA	Prior Authorization required.
tetracaine 0.5% steri-unit sol	PA	Prior Authorization required.
TRAVATAN Z 0.004% EYE DROP *(travoprost)*	PA	Prior Authorization required.
travoprost 0.004% eye drop (TRAVATAN Z)	PA	Prior Authorization required.
TRUSOPT 2% EYE DROPS *(use dorzolamide hcl)*	PA	Prior Authorization required.
VYZULTA 0.024% OPHTH SOLUTION *(latanoprostene bunod)*	PA	Prior Authorization required.
XALATAN 0.005% EYE DROPS *(use latanoprost)*	PA	Prior Authorization required.
XELPROS 0.005% EYE DROP *(latanoprost)*	PA	Prior Authorization required.
XIIDRA 5% EYE DROPS *(lifitegrast)*	PA	Prior Authorization required.
ZIOPTAN 0.0015% EYE DROPS *(tafluprost/pf)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : OPHTHALMIC ANTIALLERGIC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
azelastine hcl 0.05% drops (OPTIVAR)	QL	Limited to 6 mL per 30 days.
cromolyn 4% eye drops (OPTICROM)		
PAZEO 0.7% EYE DROPS *(olopatadine hcl)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ALOCRIL 2% EYE DROPS *(nedocromil sodium)*	PA	Prior Authorization required.
ALOMIDE 0.1% EYE DROPS *(lodoxamide tromethamine)*	PA	Prior Authorization required.
BEPREVE 1.5% EYE DROPS *(bepotastine besilate)*	PA	Prior Authorization required.
epinastine hcl 0.05% eye drops (ELESTAT)	PA	Prior Authorization required.
LASTACAFT 0.25% EYE DROPS *(alcaftadine)*	PA	Prior Authorization required.
olopatadine hcl 0.1% eye drops (PATADAY TWICE DAILY RELIEF)	PA	Prior Authorization required.
olopatadine hcl 0.2% eye drop (PATADAY ONCE DAILY RELIEF)	PA	Prior Authorization required.
PATADAY 0.2% EYE DROPS *(olopatadine hcl)*	PA	Prior Authorization required.
PATANOL 0.1% EYE DROPS *(olopatadine hcl)*	PA	Prior Authorization required.
ZERVIATE 0.24% EYE DROP *(cetirizine hcl)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
OPHTHALMIC AGENTS : OPHTHALMIC ANTI-INFECTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AK-POLY-BAC EYE OINTMENT *(bacitracin/polymyxin b sulfate)*		
bacitracin 500 unit/gm ophth (BACIGUENT)		
bacitracin-polymyxin eye oint (AK-POLY-BAC)		
CILOXAN 0.3% OINTMENT *(ciprofloxacin hcl)*		
ciprofloxacin 0.3% eye drop (CILOXAN)		
erythromycin 0.5% eye ointment (ILOTYCIN)		
GENTAK 0.3 % EYE OINTMENT *(gentamicin sulfate)*		
gentamicin 0.3% eye drop (GARAMYCIN)		
gentamicin 3 mg/ml eye drop (GARAMYCIN)		
levofloxacin 0.5% eye drops (QUIXIN)		
NATACYN EYE DROPS *(natamycin)*		
NEO-POLYCIN EYE OINTMENT *(neomycin sulfate/bacitracin/polymyxin b)*		
neomyc-bacit-polymix eye oint (NEOSPORIN)		
neomyc-polym-gramicid eye drop (NEOCIDIN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : OPHTHALMIC ANTI-INFECTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ofloxacin 0.3% eye drops (OCUFLOX)		
POLYCIN EYE OINTMENT *(bacitracin/polymyxin b sulfate)*		
polymyxin b-tmp eye drops (POLYTRIM)		
sulfacetamide 10% eye drops (BLEPH-10)		
sulfacetamide 10% eye ointment (AK-SULF)		
tobramycin 0.3% eye drop (TOBREX)		
TOBREX 0.3% EYE OINTMENT *(tobramycin)*		
trifluridine 1% eye drops (VIROPTIC)		
ZIRGAN 0.15% OPHTHALMIC GEL *(ganciclovir)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AZASITE 1% EYE DROPS *(azithromycin)*	PA	Prior Authorization required.
BESIVANCE 0.6% SUSP *(besifloxacin hcl)*	PA	Prior Authorization required.
BETADINE 5% EYE SOLUTION *(povidone-iodine)*	PA	Prior Authorization required.
BLEPH-10 10% EYE DROPS *(use sulfacetamide sodium)*	PA	Prior Authorization required.
CILOXAN 0.3% EYE DROPS *(use ciprofloxacin hcl)*	PA	Prior Authorization required.
gatifloxacin 0.5% eye drops (ZYMAXID)	PA	Prior Authorization required.
MOXEZA 0.5% EYE DROPS *(moxifloxacin hcl)*	PA	Prior Authorization required.
moxifloxacin 0.5% eye drops (MOXEZA)	PA	Prior Authorization required.
moxifloxacin 0.5% eye drops (VIGAMOX)	PA	Prior Authorization required.
OCUFLOX 0.3% EYE DROPS *(use ofloxacin)*	PA	Prior Authorization required.
POLYTRIM EYE DROPS *(use polymyxin b sulfate/trimethoprim)*	PA	Prior Authorization required.
TOBREX 0.3% EYE DROP *(use tobramycin)*	PA	Prior Authorization required.
VIGAMOX 0.5% EYE DROPS *(moxifloxacin hcl)*	PA	Prior Authorization required.
ZYMAXID 0.5% EYE DROPS *(gatifloxacin)*	PA	Prior Authorization required.
OPHTHALMIC AGENTS : OPHTHALMIC STEROIDS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ALREX 0.2% EYE DROPS *(loteprednol etabonate)*		
dexamethasone 0.1% eye drop (DECADRON)		
FLAREX 0.1% EYE DROPS *(fluorometholone acetate)*		
fluorometholone 0.1% drops (FML)		
FML FORTE 0.25% EYE DROPS *(fluorometholone)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : OPHTHALMIC STEROIDS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
FML S.O.P. 0.1% OINTMENT *(fluorometholone)*	QL	Limited to 3.5 g per 30 days.
loteprednol etabonate 0.5% drp (LOTEMAX)		
MAXIDEX 0.1% EYE DROPS *(dexamethasone)*	QL	Limited to 5 mL per 30 days.
neo-bacit-poly-hc eye ointment (NEO-POLYCIN HC)		
NEO-POLYCIN HC EYE OINTMENT *(neomycin sulfate/bacitracin zinc/polymyxin b/hydrocortisone)*		
neomyc-polym-dexamet eye ointm (MAXITROL)		
neomyc-polym-dexameth eye drop (MAXITROL)		
neomycin-poly-hc eye drops (CORTISPORIN)		
PRED MILD 0.12% EYE DROPS *(prednisolone acetate)*		
prednisolone ac 1% eye drop (OMNIPRED)		
prednisolone sod 1% eye drop (PREDNISOL)		
tobramycin-dexameth ophth susp (TOBRADEX)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BLEPHAMIDE EYE DROPS *(sulfacetamide sodium/prednisolone acetate)*	PA	Prior Authorization required.
BLEPHAMIDE EYE OINTMENT *(sulfacetamide sodium/prednisolone acetate)*	PA	Prior Authorization required.
DEXTENZA 0.4 MG INSERT *(dexamethasone)*	PA	Prior Authorization required.
DUREZOL 0.05% EYE DROPS *(difluprednate)*	PA	Prior Authorization required.
EYSUVIS 0.25% EYE DROPS *(loteprednol etabonate)*	PA	Prior Authorization required.
FML LIQUIFILM 0.1% EYE DROP *(use fluorometholone)*	PA	Prior Authorization required.
INVELTYS 1% EYE DROP *(loteprednol etabonate)*	PA	Prior Authorization required.
LOTEMAX 0.5% EYE DROPS *(use loteprednol etabonate)*	PA	Prior Authorization required.
LOTEMAX 0.5% EYE OINTMENT *(loteprednol etabonate)*	PA	Prior Authorization required.
LOTEMAX 0.5% OPHTHALMIC GEL *(loteprednol etabonate)*	PA	Prior Authorization required.
LOTEMAX SM 0.38% OPHTH GEL *(loteprednol etabonate)*	PA	Prior Authorization required.
MAXITROL EYE DROPS *(use neomycin/polymyxin b sulfate/dexamethasone)*	PA	Prior Authorization required.
MAXITROL EYE OINTMENT *(use neomycin/polymyxin b sulfate/dexamethasone)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OPHTHALMIC AGENTS : OPHTHALMIC STEROIDS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
OMNIPRED 1% EYE DROPS *(use prednisolone acetate)*	PA	Prior Authorization required.
PRED FORTE 1% EYE DROPS *(use prednisolone acetate)*	PA	Prior Authorization required.
PRED-G 1% EYE DROPS *(gentamicin sulfate/prednisolone acetate)*	PA	Prior Authorization required.
PRED-G S.O.P. EYE OINTMENT *(gentamicin sulfate/prednisolone acetate)*	PA	Prior Authorization required.
sulf-pred 10-0.23% eye drops (VASOCIDIN)	PA	Prior Authorization required.
TOBRADEX EYE DROPS *(use tobramycin/dexamethasone)*	PA	Prior Authorization required.
TOBRADEX EYE OINTMENT *(tobramycin/dexamethasone)*	PA	Prior Authorization required.
TOBRADEX ST EYE DROPS *(tobramycin/dexamethasone)*	PA	Prior Authorization required.
ZYLET EYE DROPS *(tobramycin/loteprednol etabonate)*	PA	Prior Authorization required.
OTIC AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acetic acid 2% ear solution (ACETASOL)		
acetic acid 2% ear solution (VOSOL)		
ofloxacin 0.3% ear drops (FLOXIN)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ciprofloxacin 0.2% otic soln (CETRAXAL)	PA	Prior Authorization required.
DERMOTIC OIL 0.01% EAR DROPS *(fluocinolone acetonide oil)*	PA	Prior Authorization required.
FLAC OTIC OIL 0.01% EAR DROP *(fluocinolone acetonide oil)*	PA	Prior Authorization required.
fluocinolone oil 0.01% ear drp (DERMOTIC)	PA	Prior Authorization required.
hydrocortison-acetic acid soln (VOSOL HC)	PA	Prior Authorization required.
OTIC AGENTS : OTIC COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CIPRODEX OTIC SUSPENSION *(ciprofloxacin hcl/dexamethasone)*		
ciproflox-dexameth otic susp (CIPRODEX)		
neomycin-polymyxin-hc ear soln (CORTISPORIN)		
neomycin-polymyxin-hc ear susp (ANTIBIOTIC EAR SUSPENSION)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CIPRO HC OTIC SUSPENSION *(ciprofloxacin hcl/hydrocortisone)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

OTIC AGENTS : OTIC COMBINATIONS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ciprofloxfluocinln 0.3-0.025% (OTOVEL)	PA	Prior Authorization required.
CORTISPORIN-TC EAR SUSPENSION *(neomycin sulf/colistin sul/hydrocortisone ac/thonzonium brom)*	PA	Prior Authorization required.
OTOVEL 0.3%-0.025% EAR DROPS *(ciprofloxacin hcl/fluocinolone acetonide)*	PA	Prior Authorization required.
Parenteral Nutrition Solutions		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
INTRALIPID 20% IV FAT EMUL *(fat emulsions)*	PA	Prior Authorization required.
NUTRILIPID 20% IV FAT EMULSION *(fat emulsions)*	PA	Prior Authorization required.
Passive Immunizing Agents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
HYPERRHO S-D 1,500 UNIT SYRING *(rho (d) immune globulin)*	QL,AL	Limited to members age 16 and older. Limited to 2 EA per 270 days
HYPERRHO S-D 250 UNIT SYRINGE *(rho (d) immune globulin)*	QL	Limited to 2 EA per 270 days
MICRHOGAM ULTRA-FILTD PLUS SYR *(rho(d) immune globulin)*	QL	Limited to 2 EA per 270 days
RHOGAM ULTRA-FILTERED PLUS SYR *(rho(d) immune globulin)*	QL	Limited to 2 EA per 270 days
RHOPHYLAC 300 MCG/2 ML SYRINGE *(rho(d) immune globulin)*	QL	Limited to 4 mL per 270 days
WINRHO SDF 1,500 UNIT VIAL *(rho(d) immune globulin/maltose)*	QL,SP	Restricted to specialty pharmacies. Limited to 2.6 mL per 270 days.
WINRHO SDF 15,000 UNIT VIAL *(rho(d) immune globulin/maltose)*	QL,SP	Restricted to specialty pharmacies. Limited to 26 mL per 270 days.
WINRHO SDF 2,500 UNIT VIAL *(rho(d) immune globulin/maltose)*	QL,SP	Restricted to specialty pharmacies. Limited to 4 mL per 270 days.
WINRHO SDF 5,000 UNIT VIAL *(rho(d) immune globulin/maltose)*	QL,SP	Restricted to specialty pharmacies. Limited to 8.8 mL per 270 days.
PROGESTINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
medroxyprogesterone 10 mg tab (PROVERA)		
medroxyprogesterone 2.5 mg tab (PROVERA)		
medroxyprogesterone 2.5 mg tab (PROVERA CP)		
medroxyprogesterone 5 mg tab (PROVERA)		
progesterone 100 mg capsule (PROMETRIUM)	QL	Limited to 60 EA per 30 days.
progesterone 200 mg capsule (PROMETRIUM)	QL	Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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PROGESTINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
progesterone 500 mg/10 ml vial (PROGESTERONE IN OIL)	QL	Limited to 20 mL per 30 days.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
MAKENA 250 MG/ML VIAL *(hydroxyprogesterone caproate/pf)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAKENA 275 MG/1.1 ML AUTOINJCT *(hydroxyprogesterone caproate/pf)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AYGESTIN 5 MG TABLET *(norethindrone acetate)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
hydroxyprogest 1,250 mg/5 ml (MAKENA)	PA	Prior Authorization required.
hydroxyprogest 250 mg/ml vial (MAKENA)	PA	Prior Authorization required.
megestrol 625 mg/5 ml susp (MEGACE ES)	PA	Prior Authorization required.
norethindrone 5 mg tablet (AYGESTIN)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
PROMETRIUM 100 MG CAPSULE *(use progesterone, micronized)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
PROMETRIUM 200 MG CAPSULE *(use progesterone, micronized)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
PROVERA 10 MG TABLET *(use medroxyprogesterone acetate)*	PA	Prior Authorization required.
PROVERA 2.5 MG TABLET *(use medroxyprogesterone acetate)*	PA	Prior Authorization required.
PROVERA 5 MG TABLET *(use medroxyprogesterone acetate)*	PA	Prior Authorization required.
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : ANTIDEMENTIA AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
donepezil hcl 10 mg tablet (ARICEPT)	QL	Limited to 60 EA per 30 days.
donepezil hcl 23 mg tablet (ARICEPT)		
donepezil hcl 5 mg tablet (ARICEPT)	QL	Limited to 60 EA per 30 days.
donepezil hcl odt 10 mg tablet (ARICEPT ODT)		
donepezil hcl odt 5 mg tablet (ARICEPT ODT)		
memantine hcl 10 mg tablet (NAMENDA)	QL	Limited to 60 EA per 30 days.
memantine hcl 10 mg tablet (NAMENDA)	QL	Quantity Limit of 60 each per 30 days
memantine hcl 5 mg tablet (NAMENDA)	QL	Limited to 60 EA per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ARICEPT 10 MG TABLET *(use donepezil hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
ARICEPT 23 MG TABLET *(use donepezil hcl)*	PA	Prior Authorization required.
ARICEPT 5 MG TABLET *(use donepezil hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : ANTIDEMENTIA AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EXELON 13.3 MG/24HR PATCH *(rivastigmine)*	PA	Prior Authorization required.
EXELON 4.6 MG/24HR PATCH *(rivastigmine)*	PA	Prior Authorization required.
EXELON 9.5 MG/24HR PATCH *(rivastigmine)*	PA	Prior Authorization required.
galantamine 4 mg/ml oral soln (RAZADYNE)	PA,QL	Prior Authorization required. Limited to 60 mL per 30 days.
galantamine er 16 mg capsule (RAZADYNE ER)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
galantamine er 24 mg capsule (RAZADYNE ER)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
galantamine er 8 mg capsule (RAZADYNE ER)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
galantamine hbr 12 mg tablet (RAZADYNE)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
galantamine hbr 4 mg tablet (RAZADYNE)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
galantamine hbr 8 mg tablet (RAZADYNE)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
memantine 5-10 mg titration pk (NAMENDA)	PA	Prior Authorization required.
memantine hcl 10 mg/5 ml soln (NAMENDA)	PA	Prior Authorization required.
memantine hcl 2 mg/ml solution (NAMENDA)	PA	Prior Authorization required.
memantine hcl er 14 mg capsule (NAMENDA XR)	PA	Prior Authorization required.
memantine hcl er 21 mg capsule (NAMENDA XR)	PA	Prior Authorization required.
memantine hcl er 28 mg capsule (NAMENDA XR)	PA	Prior Authorization required.
memantine hcl er 7 mg capsule (NAMENDA XR)	PA	Prior Authorization required.
NAMENDA 10 MG TABLET *(use memantine hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
NAMENDA 5 MG TABLET *(use memantine hcl)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
NAMENDA 5-10 MG TITRATION PK *(memantine hcl)*	PA	Prior Authorization required.
NAMENDA XR 14 MG CAPSULE *(memantine hcl)*	PA	Prior Authorization required.
NAMENDA XR 21 MG CAPSULE *(memantine hcl)*	PA	Prior Authorization required.
NAMENDA XR 28 MG CAPSULE *(memantine hcl)*	PA	Prior Authorization required.
NAMENDA XR 7 MG CAPSULE *(memantine hcl)*	PA	Prior Authorization required.
NAMENDA XR TITRATION PACK *(memantine hcl)*	PA	Prior Authorization required.
NAMZARIC 14 MG-10 MG CAPSULE *(memantine hcl/donepezil hcl)*	PA	Prior Authorization required.
NAMZARIC 21 MG-10 MG CAPSULE *(memantine hcl/donepezil hcl)*	PA	Prior Authorization required.
NAMZARIC 28 MG-10 MG CAPSULE *(memantine hcl/donepezil hcl)*	PA	Prior Authorization required.
NAMZARIC 7 MG-10 MG CAPSULE *(memantine hcl/donepezil hcl)*	PA	Prior Authorization required.

Drug List

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : ANTIDEMENTIA AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NAMZARIC TITRATION PACK *(memantine hcl/donepezil hcl)*	PA	Prior Authorization required.
RAZADYNE ER 16 MG CAPSULE *(galantamine hbr)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RAZADYNE ER 24 MG CAPSULE *(galantamine hbr)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
RAZADYNE ER 8 MG CAPSULE *(galantamine hbr)*	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
rivastigmine 1.5 mg capsule (EXELON)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
rivastigmine 13.3 mg/24hr ptch (EXELON)	PA	Prior Authorization required.
rivastigmine 3 mg capsule (EXELON)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
rivastigmine 4.5 mg capsule (EXELON)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
rivastigmine 4.6 mg/24hr patch (EXELON)	PA	Prior Authorization required.
rivastigmine 6 mg capsule (EXELON)	PA,QL	Prior Authorization required. Limited to 60 EA per 30 days.
rivastigmine 9.5 mg/24hr patch (EXELON)	PA	Prior Authorization required.

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
chlordiazepo-amitriptyl 5-12.5 (LIMBITROL)		
chlordiazepox-amitriptyl 10-25 (LIMBITROL DS)		
ergoloid mesylates 1 mg tab (HYDERGINE)		
perphen-amitrip 2 mg-10 mg tab (TRIAVIL 10-2)		
perphen-amitrip 2 mg-25 mg tab (TRIAVIL 25-2)		
perphen-amitrip 4 mg-10 mg tab (TRIAVIL 4-10)		
perphen-amitrip 4 mg-25 mg tab (TRIAVIL 25-4)		
perphen-amitrip 4 mg-50 mg tab (TRIAVIL 4-50)		
pimozide 1 mg tablet (ORAP)		
pimozide 2 mg tablet (ORAP)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AUSTEDO 12 MG TABLET *(deutetrabenazine)*	PA	Prior Authorization required.
AUSTEDO 6 MG TABLET *(deutetrabenazine)*	PA	Prior Authorization required.
AUSTEDO 9 MG TABLET *(deutetrabenazine)*	PA	Prior Authorization required.
BRISDELLE 7.5 MG CAPSULE *(paroxetine mesylate)*	PA	Prior Authorization required.
fluoxetine hcl 10 mg tablet (SARAFEM)	PA	Prior Authorization required.
fluoxetine hcl 20 mg tablet (SARAFEM)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
GABAPAL KIT *(gabapentin/lidocaine hcl/gauze bandage/silicone adhesive)*	PA	Prior Authorization required.
GRALISE ER 300 MG TABLET *(gabapentin)*	PA	Prior Authorization required.
GRALISE ER 600 MG TABLET *(gabapentin)*	PA	Prior Authorization required.
HORIZANT ER 300 MG TABLET *(gabapentin enacarbil)*	PA	Prior Authorization required.
HORIZANT ER 600 MG TABLET *(gabapentin enacarbil)*	PA	Prior Authorization required.
INGREZZA 40 MG CAPSULE *(valbenazine tosylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INGREZZA 80 MG CAPSULE *(valbenazine tosylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INGREZZA INITIATION PACK *(valbenazine tosylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LIDOTIN KIT *(gabapentin/lidocaine hcl/silicone adhesive)*	PA	Prior Authorization required.
LIPRITIN II KIT *(gabapentin/lidocaine/prilocaine/transparent dressing)*	PA	Prior Authorization required.
LIPRITIN KIT *(gabapentin/lidocaine/prilocaine/transparent dressing)*	PA	Prior Authorization required.
LYRICA CR 165 MG TABLET *(pregabalin)*	PA	Prior Authorization required.
LYRICA CR 330 MG TABLET *(pregabalin)*	PA	Prior Authorization required.
LYRICA CR 82.5 MG TABLET *(pregabalin)*	PA	Prior Authorization required.
NUEDEXTA 20-10 MG CAPSULE *(dextromethorphan hbr/quinidine sulfate)*	PA	Prior Authorization required.
olanzapine-fluoxetine 12-25 mg (SYMBYAX)	PA	Prior Authorization required.
olanzapine-fluoxetine 12-50 mg (SYMBYAX)	PA	Prior Authorization required.
olanzapine-fluoxetine 3-25 mg (SYMBYAX)	PA	Prior Authorization required.
olanzapine-fluoxetine 6-25 mg (SYMBYAX)	PA	Prior Authorization required.
olanzapine-fluoxetine 6-50 mg (SYMBYAX)	PA	Prior Authorization required.
paroxetine mesylate 7.5 mg cap (BRISDELLE)	PA	Prior Authorization required.
PENTICAN KIT *(gabapentin/lidocaine)*	PA	Prior Authorization required.
SARAFEM 10 MG TABLET *(use fluoxetine hcl)*	PA	Prior Authorization required.
SAVELLA 100 MG TABLET *(milnacipran hcl)*	PA	Prior Authorization required.
SAVELLA 12.5 MG TABLET *(milnacipran hcl)*	PA	Prior Authorization required.
SAVELLA 25 MG TABLET *(milnacipran hcl)*	PA	Prior Authorization required.
SAVELLA 50 MG TABLET *(milnacipran hcl)*	PA	Prior Authorization required.
SAVELLA TITRATION PACK *(milnacipran hcl)*	PA	Prior Authorization required.
SYMBYAX 12-50 MG CAPSULE *(olanzapine/fluoxetine hcl)*	PA	Prior Authorization required.
SYMBYAX 3-25 MG CAPSULE *(olanzapine/fluoxetine hcl)*	PA	Prior Authorization required.
SYMBYAX 6-25 MG CAPSULE *(olanzapine/fluoxetine hcl)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
SYMBYAX 6-50 MG CAPSULE *(olanzapine/fluoxetine hcl)*	PA	Prior Authorization required.
TEGSEDI 284 MG/1.5 ML SYRINGE *(inotersen sodium)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tetrabenazine 12.5 mg tablet (XENAZINE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
tetrabenazine 25 mg tablet (XENAZINE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XENAZINE 12.5 MG TABLET *(tetrabenazine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XENAZINE 25 MG TABLET *(tetrabenazine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XYREM 500 MG/ML ORAL SOLUTION *(sodium oxybate)*	PA	Prior Authorization required.
XYWAV 0.5 GM/ML ORAL SOLUTION *(sodium oxybate/calcium oxybate/magnesium oxybate/pot oxybate)*	PA	Prior Authorization required.
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MULTIPLE SCLEROSIS AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
BETASERON 0.3 MG KIT *(interferon beta-1b)*	SP	Restricted to specialty pharmacies.
COPAXONE 20 MG/ML SYRINGE *(glatiramer acetate)*	SP	Restricted to specialty pharmacies.
REBIF 22 MCG/0.5 ML SYRINGE *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
REBIF 44 MCG/0.5 ML SYRINGE *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
REBIF REBIDOSE 22 MCG/0.5 ML *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
REBIF REBIDOSE 44 MCG/0.5 ML *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
REBIF REBIDOSE TITRATION PACK *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
REBIF TITRATION PACK *(interferon beta-1a/albumin human)*	SP	Restricted to specialty pharmacies.
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
TECFIDERA DR 120 MG CAPSULE *(dimethyl fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TECFIDERA DR 240 MG CAPSULE *(dimethyl fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TECFIDERA STARTER PACK *(dimethyl fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AMPYRA ER 10 MG TABLET *(dalfampridine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AUBAGIO 14 MG TABLET *(teriflunomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AUBAGIO 7 MG TABLET *(teriflunomide)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AVONEX 30 MCG VIAL KIT *(interferon beta-1a/albumin human)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

Drug List

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MULTIPLE SCLEROSIS AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
AVONEX PEN 30 MCG/0.5 ML KIT *(interferon beta-1a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AVONEX PREFILLED SYR 30 MCG KT *(interferon beta-1a)*	PA,QL,SP	Restricted to specialty pharmacies. Prior Authorization required. Limited to 1 EA per 30 days.
BAFIERTAM DR 95 MG CAPSULE *(monomethyl fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
COPAXONE 40 MG/ML SYRINGE *(glatiramer acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
dalfampridine er 10 mg tablet (AMPYRA)	PA	Prior Authorization required.
dimethyl fumarate 30d start pk (TECFIDERA)	PA	Prior Authorization required.
dimethyl fumarate dr 120 mg cp (TECFIDERA)	PA	Prior Authorization required.
dimethyl fumarate dr 240 mg cp (TECFIDERA)	PA	Prior Authorization required.
EXTAVIA 0.3 MG KIT *(interferon beta-1b)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
EXTAVIA 0.3 MG VIAL *(interferon beta-1b)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GILENYA 0.25 MG CAPSULE *(fingolimod hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GILENYA 0.5 MG CAPSULE *(fingolimod hcl)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
glatiramer 20 mg/ml syringe (COPAXONE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
glatiramer 40 mg/ml syringe (COPAXONE)	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GLATOPA 20 MG/ML SYRINGE *(glatiramer acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
GLATOPA 40 MG/ML SYRINGE *(glatiramer acetate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KESIMPTA 20 MG/0.4 ML PEN *(ofatumumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
LEMTRADA 12 MG/1.2 ML VIAL *(alemtuzumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 10 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 4 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 5 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 6 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 7 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 8 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAVENCLAD 10 MG X 9 TABLET PK *(cladribine)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAYZENT 0.25 MG STARTER PACK *(siponimod)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAYZENT 0.25 MG TABLET *(siponimod)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
MAYZENT 2 MG TABLET *(siponimod)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OCREVUS 300 MG/10 ML VIAL *(ocrelizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PLEGRIDY 125 MCG/0.5 ML PEN *(peginterferon beta-1a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : MULTIPLE SCLEROSIS AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PLEGRIDY 125 MCG/0.5 ML SYRING *(peginterferon beta-1a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PLEGRIDY PEN INJ STARTER PACK *(peginterferon beta-1a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PLEGRIDY SYRINGE STARTER PACK *(peginterferon beta-1a)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TYSABRI 300 MG/15 ML VIAL *(natalizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
VUMERITY DR 231 MG CAPSULE *(diroximel fumarate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZEPOSIA 0.23-0.46 MG START PCK *(ozanimod hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZEPOSIA 0.23-0.46-0.92 MG KIT *(ozanimod hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ZEPOSIA 0.92 MG CAPSULE *(ozanimod hydrochloride)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : SMOKING DETERRENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
bupropion hcl sr 150 mg tablet (ZYBAN)	QL	Limited to 60 EA per 30 days.
CHANTIX 0.5 MG TABLET *(varenicline tartrate)*	FL	Limited to 6 fills per 365 days.
CHANTIX 1 MG CONT MONTH BOX *(varenicline tartrate)*	FL	Limited to 6 fills per 365 days.
CHANTIX 1 MG TABLET *(varenicline tartrate)*	FL	Limited to 6 fills per 365 days.
CHANTIX STARTING MONTH BOX *(varenicline tartrate)*	FL	Limited to 6 fills per 365 days.
NICOTROL CARTRIDGE INHALER *(nicotine)*	FL	Limited to 6 fills per 365 days.
NICOTROL NS 10 MG/ML SPRAY *(nicotine)*	FL	Limited to 6 fills per 365 days.
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
PULMOZYME 1 MG/ML AMPUL *(dornase alfa)*	QL,SP	Restricted to specialty pharmacies. Limited to 75 mL per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
BRONCHITOL 40 MG INHALE CAP *(mannitol)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KALYDECO 150 MG TABLET *(ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KALYDECO 25 MG GRANULES PACKET *(ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KALYDECO 50 MG GRANULES PACKET *(ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KALYDECO 75 MG GRANULES PACKET *(ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORKAMBI 100 MG-125 MG TABLET *(lumacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ORKAMBI 100-125 MG GRANULE PKT *(lumacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORKAMBI 150-188 MG GRANULE PKT *(lumacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORKAMBI 200 MG-125 MG TABLET *(lumacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SYMDEKO 100/150 MG-150 MG TABS *(tezacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SYMDEKO 50/75 MG-75 MG TABLETS *(tezacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
TRIKAFTA 100/50/75 MG-150 MG *(elexacaftor/tezacaftor/ivacaftor)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RESPIRATORY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ESBRIET 267 MG CAPSULE *(pirfenidone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESBRIET 267 MG TABLET *(pirfenidone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ESBRIET 801 MG TABLET *(pirfenidone)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OFEV 100 MG CAPSULE *(nintedanib esylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OFEV 150 MG CAPSULE *(nintedanib esylate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Respiratory Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
promethazine vc-codeine syrup (PHENERGAN VC WITH CODEINE)		
promethazine-dm 6.25-15 mg/5ml (PROMETHAZINE-DM)		
promethazine-pe-codeine syrup (PHENERGAN VC WITH CODEINE)		
SUBSTANCE USE DISORDER AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
acamprosate calc dr 333 mg tab (CAMPRAL)		
ANTABUSE 250 MG TABLET *(disulfiram)*		
ANTABUSE 500 MG TABLET *(disulfiram)*		
BUNAVAIL 2.1-0.3 MG FILM *(buprenorphine hcl/naloxone hcl)*		
BUNAVAIL 4.2-0.7 MG FILM *(buprenorphine hcl/naloxone hcl)*		
BUNAVAIL 6.3-1 MG FILM *(buprenorphine hcl/naloxone hcl)*		
bupreno-nalox 2-0.5 mg sl film (SUBOXONE)		
buprenor-nalox 12-3 mg sl film (SUBOXONE)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

SUBSTANCE USE DISORDER AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
buprenorp-nalox 4-1 mg sl film (SUBOXONE)		
buprenorp-nalox 8-2 mg sl film (SUBOXONE)		
buprenorphin-naloxon 8-2 mg sl (SUBOXONE)		
buprenorphine 2 mg tablet sl (SUBUTEX)		
buprenorphine 8 mg tablet sl (SUBUTEX)		
buprenorphn-naloxn 2-0.5 mg sl (SUBOXONE)		
disulfiram 250 mg tablet (ANTABUSE)		
disulfiram 500 mg tablet (ANTABUSE)		
LUCEMYRA 0.18 MG TABLET *(lofexidine hcl)*		
naloxone 0.4 mg/ml carpuject (NARCAN PREFILLED)		
naloxone 0.4 mg/ml vial (NARCAN MULTIPLE DOSE)		
naloxone 2 mg/2 ml syringe (NARCAN)		
naloxone 4 mg/10 ml vial (NARCAN MULTIPLE DOSE)		
naltrexone 50 mg tablet (REVIA)		
naltrexone 50 mg tablet (TREXAN)		
NARCAN 4 MG NASAL SPRAY *(naloxone hcl)*		
PROBUPHINE 74.2 MG IMPLANT *(buprenorphine hcl)*		
SUBLOCADE 100 MG/0.5 ML SYRING *(buprenorphine)*	QL	Limited to 0.5 mL per 30 days.
SUBLOCADE 300 MG/1.5 ML SYRING *(buprenorphine)*	QL	Limited to 1.5 mL per 30 days.
SUBOXONE 12 MG-3 MG SL FILM *(buprenorphine hcl/naloxone hcl)*		
SUBOXONE 2 MG-0.5 MG SL FILM *(buprenorphine hcl/naloxone hcl)*		
SUBOXONE 4 MG-1 MG SL FILM *(buprenorphine hcl/naloxone hcl)*		
SUBOXONE 8 MG-2 MG SL FILM *(buprenorphine hcl/naloxone hcl)*		
VIVITROL 380 MG VIAL + DILUENT *(naltrexone microspheres)*		
ZUBSOLV 0.7-0.18 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		
ZUBSOLV 1.4-0.36 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		
ZUBSOLV 11.4-2.9 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		
ZUBSOLV 2.9-0.71 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		
ZUBSOLV 5.7-1.4 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

SUBSTANCE USE DISORDER AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ZUBSOLV 8.6-2.1 MG TABLET SL *(buprenorphine hcl/naloxone hcl)*		

THYROID AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ARMOUR THYROID 120 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 15 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 180 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 240 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 30 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 300 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 60 MG TABLET *(thyroid,pork)*		
ARMOUR THYROID 90 MG TABLET *(thyroid,pork)*		
EUTHYROX 100 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 112 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 125 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 137 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 150 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 175 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 200 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 25 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 50 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 75 MCG TABLET *(levothyroxine sodium)*		
EUTHYROX 88 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 100 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 112 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 125 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 137 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 150 MCG TABLET *(levothyroxine sodium)*		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

THYROID AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
LEVO-T 175 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 200 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 25 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 300 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 50 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 75 MCG TABLET *(levothyroxine sodium)*		
LEVO-T 88 MCG TABLET *(levothyroxine sodium)*		
levothyroxine 100 mcg tablet (EUTHYROX)		
levothyroxine 112 mcg tablet (EUTHYROX)		
levothyroxine 125 mcg tablet (EUTHYROX)		
levothyroxine 137 mcg tablet (EUTHYROX)		
levothyroxine 150 mcg tablet (EUTHYROX)		
levothyroxine 175 mcg tablet (EUTHYROX)		
levothyroxine 200 mcg tablet (EUTHYROX)		
levothyroxine 25 mcg tablet (EUTHYROX)		
levothyroxine 300 mcg tablet (LEVO-T)		
levothyroxine 50 mcg tablet (EUTHYROX)		
levothyroxine 75 mcg tablet (EUTHYROX)		
levothyroxine 88 mcg tablet (EUTHYROX)		
LEVOXYL 100 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 112 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 125 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 137 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 150 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 175 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 200 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 25 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 50 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 75 MCG TABLET *(levothyroxine sodium)*		
LEVOXYL 88 MCG TABLET *(levothyroxine sodium)*		
liothyronine sod 25 mcg tab (CYTOMEL)		
liothyronine sod 5 mcg tab (CYTOMEL)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

THYROID AGENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
liothyronine sod 50 mcg tab (CYTOMEL)		
methimazole 10 mg tablet (TAPAZOLE)		
methimazole 5 mg tablet (TAPAZOLE)		
NP THYROID 120 MG TABLET *(thyroid,pork)*		
NP THYROID 15 MG TABLET *(thyroid,pork)*		
NP THYROID 30 MG TABLET *(thyroid,pork)*		
NP THYROID 60 MG TABLET *(thyroid,pork)*		
NP THYROID 90 MG TABLET *(thyroid,pork)*		
propylthiouracil 50 mg tablet (PROPACIL)		
thyroid 120 mg tablet (ARMOUR THYROID)		
thyroid 15 mg tablet (ARMOUR THYROID)		
THYROID 30 MG TABLET *(thyroid,pork)*		
THYROID 60 MG TABLET *(thyroid,pork)*		
THYROID 90 MG TABLET *(thyroid,pork)*		
UNITHROID 100 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 112 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 125 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 137 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 150 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 175 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 200 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 25 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 300 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 50 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 75 MCG TABLET *(levothyroxine sodium)*		
UNITHROID 88 MCG TABLET *(levothyroxine sodium)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CYTOMEL 25 MCG TABLET *(use liothyronine sodium)*	PA	Prior Authorization required.
CYTOMEL 5 MCG TABLET *(use liothyronine sodium)*	PA	Prior Authorization required.
CYTOMEL 50 MCG TABLET *(use liothyronine sodium)*	PA	Prior Authorization required.
levothyroxine 100 mcg capsule (TIROSINT)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

THYROID AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
levothyroxine 112 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 125 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 13 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 137 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 150 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 175 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 200 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 25 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 50 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 75 mcg capsule (TIROSINT)	PA	Prior Authorization required.
levothyroxine 88 mcg capsule (TIROSINT)	PA	Prior Authorization required.
SYNTHROID 100 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 112 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 125 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 137 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 150 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 175 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 200 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 25 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 300 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 50 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 75 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
SYNTHROID 88 MCG TABLET *(use levothyroxine sodium)*	PA	Prior Authorization required.
TAPAZOLE 10 MG TABLET *(use methimazole)*	PA	Prior Authorization required.
TAPAZOLE 5 MG TABLET *(use methimazole)*	PA	Prior Authorization required.
THYQUIDITY 100 MCG/5 ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization Required.
TIROSINT 100 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 112 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 125 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 13 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 137 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

THYROID AGENTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
TIROSINT 150 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 175 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 200 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 25 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 50 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 75 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT 88 MCG CAPSULE *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 100 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 112 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 125 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 13 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 137 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 150 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 175 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 200 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 25 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 50 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 75 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TIROSINT-SOL 88 MCG/ML SOLN *(levothyroxine sodium)*	PA	Prior Authorization required.
TUMOR NECROSIS FACTOR ALPHA INHIBITORS AND MISC IMMUNOSUPPRESSIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
CIMZIA 2X200 MG/ML SYRINGE KIT *(certolizumab pegol)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
CIMZIA 2X200 MG/ML(X3)START KT *(certolizumab pegol)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENBREL 25 MG KIT *(etanercept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENBREL 25 MG/0.5 ML SYRINGE *(etanercept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENBREL 25 MG/0.5 ML VIAL *(etanercept)*	PA	Prior Authorization required.
ENBREL 50 MG/ML MINI CARTRIDGE *(etanercept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

TUMOR NECROSIS FACTOR ALPHA INHIBITORS AND MISC IMMUNOSUPPRESSIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred with Prior Authorization		
ENBREL 50 MG/ML SURECLICK *(etanercept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENBREL 50 MG/ML SYRINGE *(etanercept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA 40 MG/0.8 ML SYRINGE *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA PEN 40 MG/0.8 ML *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA PEN CROHN-UC-HS 40 MG *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA PEN PS-UV-ADOL HS 40 MG *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) 10 MG/0.1 ML SYRING *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) 20 MG/0.2 ML SYRING *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) 40 MG/0.4 ML SYRING *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEDI CROHN 80-40 MG *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEDI CROHN 80MG/0.8 *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEN 40 MG/0.4 ML *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEN 80 MG/0.8 ML *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEN CRHN-UC-HS 80MG *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
HUMIRA(CF) PEN PS-UV-AHS 80-40 *(adalimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XELJANZ 10 MG TABLET *(tofacitinib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XELJANZ 5 MG TABLET *(tofacitinib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XELJANZ XR 11 MG TABLET *(tofacitinib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
XELJANZ XR 22 MG TABLET *(tofacitinib citrate)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACTEMRA 162 MG/0.9 ML SYRINGE *(tocilizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ACTEMRA 200 MG/10 ML VIAL *(tocilizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ACTEMRA 400 MG/20 ML VIAL *(tocilizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ACTEMRA 80 MG/4 ML VIAL *(tocilizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ACTEMRA ACTPEN 162 MG/0.9 ML *(tocilizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ARCALYST 220 MG INJECTION *(rilonacept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
AVSOLA 100 MG VIAL *(infliximab-axxq)*	PA	Prior Authorization required.
CIMZIA 200 MG VIAL KIT *(certolizumab pegol)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ENTYVIO 300 MG VIAL *(vedolizumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

TUMOR NECROSIS FACTOR ALPHA INHIBITORS AND MISC IMMUNOSUPPRESSIVES		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ILARIS 150 MG/ML VIAL *(canakinumab/pf)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
INFLECTRA 100 MG VIAL *(infliximab-dyyb)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KEVZARA 150 MG/1.14 ML PEN INJ *(sarilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KEVZARA 150 MG/1.14 ML SYRINGE *(sarilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KEVZARA 200 MG/1.14 ML PEN INJ *(sarilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KEVZARA 200 MG/1.14 ML SYRINGE *(sarilumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
KINERET 100 MG/0.67 ML SYRINGE *(anakinra)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OLUMIANT 1 MG TABLET *(baricitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OLUMIANT 2 MG TABLET *(baricitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENCIA 125 MG/ML SYRINGE *(abatacept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENCIA 250 MG VIAL *(abatacept/maltose)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENCIA 50 MG/0.4 ML SYRINGE *(abatacept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENCIA 87.5 MG/0.7 ML SYRINGE *(abatacept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ORENCIA CLICKJECT 125 MG/ML *(abatacept)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OTEZLA 28 DAY STARTER PACK *(apremilast)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
OTEZLA 30 MG TABLET *(apremilast)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
REMICADE 100 MG VIAL *(infliximab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RENFLEXIS 100 MG VIAL *(infliximab-abda)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
RINVOQ ER 15 MG TABLET *(upadacitinib)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIMPONI 100 MG/ML PEN INJECTOR *(golimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIMPONI 100 MG/ML SYRINGE *(golimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIMPONI 50 MG/0.5 ML PEN INJEC *(golimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIMPONI 50 MG/0.5 ML SYRINGE *(golimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
SIMPONI ARIA 50 MG/4 ML VIAL *(golimumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
STELARA 130 MG/26 ML VIAL *(ustekinumab)*	PA,SP	Restricted to specialty pharmacies. Prior Authorization Required.
ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : H-2 ANTAGONISTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cimetidine 200 mg tablet (TAGAMET HB)		
cimetidine 300 mg tablet (TAGAMET)		
cimetidine 300 mg/5 ml soln (TAGAMET)		
cimetidine 400 mg tablet (TAGAMET)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : H-2 ANTAGONISTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
cimetidine 800 mg tablet (TAGAMET)		
famotidine 20 mg tablet (ACID-PEP)		
famotidine 20 mg tablet (PEPCID AC)		
famotidine 40 mg tablet (PEPCID)		
famotidine 40 mg/5 ml susp (PEPCID)		
nizatidine 15 mg/ml solution (AXID)		
nizatidine 150 mg capsule (AXID)		
nizatidine 300 mg capsule (AXID)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PEPCID 20 MG TABLET *(use famotidine)*	PA	Prior Authorization required.
PEPCID 40 MG TABLET *(use famotidine)*	PA	Prior Authorization required.
ranitidine 15 mg/ml syrup (ZANTAC)	PA	Prior Authorization required.
ranitidine 150 mg capsule (ZANTAC)	PA	Prior Authorization required.
ranitidine 150 mg tablet (ZANTAC)	PA	Prior Authorization required.
ranitidine 150 mg/10 ml syrup (ZANTAC)	PA	Prior Authorization required.
ranitidine 300 mg capsule (ZANTAC)	PA	Prior Authorization required.
ranitidine 300 mg tablet (ZANTAC)	PA	Prior Authorization required.

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
belladonna-opium 16.2-30 supp (B & O SUPPRETTES NO.15-A)		
belladonna-opium 16.2-60 supp (B & O SUPPRETTES NO.16-A)		
CARAFATE 1 GM/10 ML SUSP *(sucralfate)*		
dicyclomine 10 mg capsule (BENTYL)		
dicyclomine 10 mg/5 ml soln		
dicyclomine 20 mg tablet (BENTYL)		
ED-SPAZ 0.125 MG ODT *(hyoscyamine sulfate)*		
glycopyrrolate 1 mg tablet (ROBINUL)		
glycopyrrolate 2 mg tablet (ROBINUL FORTE)		
hyoscyamine 0.125 mg odt (ANASPAZ)		
hyoscyamine 0.125 mg tab sl (LEVSIN-SL)		
hyoscyamine 0.125 mg/5 ml elix (LEVSIN)		
hyoscyamine 0.125 mg/ml drop (HYOSYNE)		
hyoscyamine 0.125 mg/ml drop (LEVSIN)		
hyoscyamine sulf 0.125 mg tab (LEVSIN)		
misoprostol 100 mcg tablet (CYTOTEC)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
misoprostol 200 mcg tablet (CYTOTEC)		
NULEV 0.125 MG CHEWABLE MELT *(hyoscyamine sulfate)*		
OSCIMIN 0.125 MG ODT *(hyoscyamine sulfate)*		
OSCIMIN 0.125 MG TABLET *(hyoscyamine sulfate)*		
OSCIMIN SL 0.125 MG TABLET *(hyoscyamine sulfate)*		
OSCIMIN SR 0.375 MG TABLET *(hyoscyamine sulfate)*		
propantheline 15 mg tablet (PRO-BANTHINE)		
sucralfate 1 gm tablet (CARAFATE)		
sucralfate 1 gm/10 ml susp (CARAFATE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ANASPAZ 0.125 MG TABLET ODT *(use hyoscyamine sulfate)*	PA	Prior Authorization required.
CARAFATE 1 GM TABLET *(use sucralfate)*	PA	Prior Authorization required.
chlordiazepoxide-clidinium cap (LIBRAX)	PA	Prior Authorization required.
CUVPOSA 1 MG/5 ML SOLUTION *(glycopyrrolate)*	PA	Prior Authorization required.
CYTOTEC 100 MCG TABLET *(use misoprostol)*	PA	Prior Authorization required.
CYTOTEC 200 MCG TABLET *(use misoprostol)*	PA	Prior Authorization required.
GLYCATE 1.5 MG TABLET *(glycopyrrolate)*	PA	Prior Authorization required.
HELIDAC THERAPY PACK *(bismuth subsalicylate/metronidazole/tetracycline hcl)*	PA	Prior Authorization required.
lansoprazol-amoxicil-clarithro (PREVPAC)	PA	Prior Authorization required.
LEVSIN 0.125 MG TABLET *(use hyoscyamine sulfate)*	PA	Prior Authorization required.
LEVSIN-SL 0.125 MG TABLET SL *(use hyoscyamine sulfate)*	PA	Prior Authorization required.
LIBRAX CAPSULE *(chlordiazepoxide/clidinium bromide)*	PA	Prior Authorization required.
methscopolamine brom 2.5 mg tb (PAMINE)	PA	Prior Authorization required.
methscopolamine brom 5 mg tab (PAMINE FORTE)	PA	Prior Authorization required.
OMECLAMOX-PAK COMBO PACK *(omeprazole/clarithromycin/amoxicillin trihydrate)*	PA	Prior Authorization required.
OMECLAMOX-PAK DAILY CARD *(omeprazole/clarithromycin/amoxicillin trihydrate)*	PA	Prior Authorization required.
omeprazole-bicarb 20-1,100 cap (ZEGERID)	PA	Prior Authorization required.
omeprazole-bicarb 20-1,680 pkt (ZEGERID)	PA	Prior Authorization required.
omeprazole-bicarb 40-1,100 cap (ZEGERID)	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
omeprazole-bicarb 40-1,680 pkt (ZEGERID)	PA	Prior Authorization required.
PYLERA CAPSULE *(colloidal bismuth subcitrate/metronidazole/tetracycline hcl)*	PA	Prior Authorization required.
TALICIA DR 10-250-12.5 MG CAP *(omeprazole magnesium/amoxicillin trihydrate/rifabutin)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
ZEGERID 20 MG CAPSULE *(omeprazole/sodium bicarbonate)*	PA	Prior Authorization required.
ZEGERID 20 MG PACKET *(omeprazole/sodium bicarbonate)*	PA	Prior Authorization required.
ZEGERID 40 MG CAPSULE *(omeprazole/sodium bicarbonate)*	PA	Prior Authorization required.
ZEGERID 40 MG PACKET *(omeprazole/sodium bicarbonate)*	PA	Prior Authorization required.

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : PROTON PUMP INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
lansoprazole odt 15 mg tablet (PREVACID)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
lansoprazole odt 30 mg tablet (PREVACID)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
omeprazole dr 10 mg capsule (PRILOSEC)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
omeprazole dr 20 mg capsule (PRILOSEC)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
omeprazole dr 40 mg capsule (PRILOSEC)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
pantoprazole sod dr 20 mg tab (PROTONIX)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
pantoprazole sod dr 40 mg tab (PROTONIX)	QL,FL	Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACIPHEX DR 20 MG TABLET *(rabeprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
ACIPHEX SPRINKLE DR 10 MG CAP *(rabeprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
ACIPHEX SPRINKLE DR 5 MG CAP *(rabeprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
DEXILANT DR 30 MG CAPSULE *(dexlansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
DEXILANT DR 60 MG CAPSULE *(dexlansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
DEXILANT DR 60 MG CAPSULE *(dexlansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
esomeprazole dr 10 mg packet (NEXIUM)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
esomeprazole dr 20 mg packet (NEXIUM)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
esomeprazole dr 40 mg packet (NEXIUM)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
esomeprazole mag dr 20 mg cap (NEXIUM)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
esomeprazole mag dr 40 mg cap (NEXIUM)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS : PROTON PUMP INHIBITORS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
lansoprazole dr 15 mg capsule (PREVACID)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
lansoprazole dr 15 mg capsule (PREVACID 24HR)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
lansoprazole dr 30 mg capsule (PREVACID)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 10 MG PACKET *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 2.5 MG PACKET *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 20 MG CAPSULE *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 20 MG PACKET *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 40 MG CAPSULE *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 40 MG PACKET *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
NEXIUM DR 5 MG PACKET *(esomeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
pantoprazole 40 mg suspension (PROTONIX)	PA,QL,FL	Prior Authorization required. Limited to 120 EA per 30 days. Limited to 6 fills per year.
PREVACID 15 MG SOLUTAB *(use lansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
PREVACID 30 MG SOLUTAB *(use lansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
PREVACID DR 15 MG CAPSULE *(lansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
PREVACID DR 30 MG CAPSULE *(lansoprazole)*	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
PRILOSEC DR 10 MG SUSPENSION *(omeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 120 EA per 30 days. Limited to 6 fills per 365 days.
PRILOSEC DR 2.5 MG SUSPENSION *(omeprazole magnesium)*	PA,QL,FL	Prior Authorization required. Limited to 120 EA per 30 days. Limited to 6 fills per 365 days.
PROTONIX 40 MG SUSPENSION *(pantoprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
PROTONIX DR 20 MG TABLET *(use pantoprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
PROTONIX DR 40 MG TABLET *(use pantoprazole sodium)*	PA,QL,FL	Prior Authorization required. Limited to 60 EA per 30 days; Limited to 6 fills per 365 days.
rabeprazole sod dr 20 mg tab (ACIPHEX)	PA,QL,FL	Prior Authorization required. Limited to 30 EA per 30 days. Limited to 6 fills per 365 days.
URINARY ANTISPASMODICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
bethanechol 10 mg tablet (URECHOLINE)		
bethanechol 25 mg tablet (URECHOLINE)		
bethanechol 5 mg tablet (URECHOLINE)		
bethanechol 50 mg tablet (URECHOLINE)		
oxybutynin 5 mg tablet (DITROPAN)		
oxybutynin 5 mg/5 ml syrup (DITROPAN)		

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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URINARY ANTISPASMODICS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
oxybutynin cl er 10 mg tablet (DITROPAN XL)		
oxybutynin cl er 15 mg tablet (DITROPAN XL)		
oxybutynin cl er 5 mg tablet (DITROPAN XL)		
solifenacin 10 mg tablet (VESICARE)		
solifenacin 5 mg tablet (VESICARE)		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
darifenacin er 15 mg tablet (ENABLEX)	PA	Prior Authorization required.
darifenacin er 7.5 mg tablet (ENABLEX)	PA	Prior Authorization required.
DETROL 1 MG TABLET *(tolterodine tartrate)*	PA	Prior Authorization required.
DETROL 2 MG TABLET *(tolterodine tartrate)*	PA	Prior Authorization required.
DETROL LA 2 MG CAPSULE *(tolterodine tartrate)*	PA	Prior Authorization required.
DETROL LA 4 MG CAPSULE *(tolterodine tartrate)*	PA	Prior Authorization required.
DITROPAN XL 10 MG TABLET *(use oxybutynin chloride)*	PA	Prior Authorization required.
DITROPAN XL 5 MG TABLET *(use oxybutynin chloride)*	PA	Prior Authorization required.
ENABLEX 7.5 MG TABLET *(darifenacin hydrobromide)*	PA	Prior Authorization required.
flavoxate hcl 100 mg tablet (URISPAS)	PA	Prior Authorization required.
GELNIQUE 10% GEL SACHET *(oxybutynin chloride)*	PA	Prior Authorization required.
MYRBETRIQ ER 25 MG TABLET *(mirabegron)*	PA	Prior Authorization required.
MYRBETRIQ ER 50 MG TABLET *(mirabegron)*	PA	Prior Authorization required.
OXYTROL 3.9 MG/24HR PATCH *(oxybutynin)*	PA	Prior Authorization required.
tolterodine tart er 2 mg cap (DETROL LA)	PA	Prior Authorization required.
tolterodine tart er 4 mg cap (DETROL LA)	PA	Prior Authorization required.
tolterodine tartrate 1 mg tab (DETROL)	PA	Prior Authorization required.
tolterodine tartrate 2 mg tab (DETROL)	PA	Prior Authorization required.
TOVIAZ ER 4 MG TABLET *(fesoterodine fumarate)*	PA	Prior Authorization required.
TOVIAZ ER 8 MG TABLET *(fesoterodine fumarate)*	PA	Prior Authorization required.
trospium chloride 20 mg tablet (SANCTURA)	PA	Prior Authorization required.
trospium chloride er 60 mg cap (SANCTURA XR)	PA	Prior Authorization required.
URECHOLINE 50 MG TABLET *(use bethanechol chloride)*	PA	Prior Authorization required.
VESICARE 10 MG TABLET *(use solifenacin succinate)*	PA	Prior Authorization required.
VESICARE 5 MG TABLET *(use solifenacin succinate)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

URINARY ANTISPASMODICS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VESICARE LS 5 MG/5 ML SUSP *(solifenacin succinate)*	PA	Prior Authorization Required.
Vaccines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
AFLURIA QUAD 2019-20 (3YR UP) *(influenza virus vaccine quadrivalent 2019-20 (36 mos up)/pf)*	QL,FL	Limited to 1 vaccination per flu season.
AFLURIA QUAD 2019-20 (6-35MO) *(influenza virus vaccine quadrival 2019-20 (6 mos-35 mos)/pf)*	QL,FL,AL	Limited to 1 vaccination per flu season; Limited to members 3 years and younger.
AFLURIA QUAD 2019-2020 VIAL *(influenza virus vaccine quadrivalent 2019-20 (6 mos and up))*	QL,FL	Limited to 1 vaccination per flu season.
AFLURIA QUAD 2020-2021 VIAL *(influenza virus vaccine quadrivalent 2020-21 (6 mos and up))*	QL,FL	Covered for up to 1 vaccination per flu season
AFLURIA QUAD 2020-21 (3YR UP) *(influenza virus vaccine quadrivalent 2020-21 (36 mos up)/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 3 and older
AFLURIA QUAD 2020-21 (6-35MO) *(influenza virus vaccine quadrival 2020-21 (6 mos-35 mos)/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 3 and younger
ASTRAZENECA COVID19 VAC(UNAPP) *(covid-19 vaccine, azd-1222 (astrazeneca)/pf)*		
FLUAD 2019-2020 SYRINGE *(influenza vaccine tvs 2019-20 (65 yr up)/adjuvant mf59c.1/pf)*	QL,FL,AL	Limited to 1 vaccination per flu season; Limited to members age 65 years and older.
FLUAD 2020-2021 SYRINGE *(influenza vaccine tvs 2020-21 (65 yr up)/adjuvant mf59c.1/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 65 and older
FLUAD QUAD 2020-2021 SYRINGE *(influenza vaccine quadrivalent 2020-21 (65 yr up)/mf59c.1/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 65 and older
FLUARIX QUAD 2019-2020 SYRINGE *(influenza virus vaccine quadrival 2019-2020 (6 mos and up)/pf)*	QL,FL	Limited to 1 vaccination per flu season.
FLUARIX QUAD 2020-2021 SYRINGE *(influenza virus vaccine quadrival 2020-2021 (6 mos and up)/pf)*	QL,FL	Covered for up to 1 vaccination per flu season
FLUCELVAX QUAD 2019-2020 SYR *(flu vaccine quad 2019-2020(4 years and older)cell derived/pf)*	QL,FL	Limited to 1 vaccination per flu season.
FLUCELVAX QUAD 2019-2020 VIAL *(flu vaccine quadriv 2019-2020(4 years and older)cell derived)*	QL,FL	Limited to 1 vaccination per flu season.
FLUCELVAX QUAD 2020-2021 SYR *(flu vaccine quad 2020-2021(4 years and older)cell derived/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 4 and older
FLUCELVAX QUAD 2020-2021 VIAL *(flu vaccine quadriv 2020-2021(4 years and older)cell derived)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 4 and older

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Vaccines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
FLULAVAL QUAD 2019-2020 SYR *(influenza virus vaccine quadrival 2019-2020 (6 mos and up)/pf)*	QL,FL	Limited to 1 vaccination per flu season.
FLULAVAL QUAD 2019-2020 VIAL *(influenza virus vaccine quadrivalent 2019-20 (6 mos and up))*	QL,FL	Limited to 1 vaccination per flu season.
FLULAVAL QUAD 2020-2021 SYR *(influenza virus vaccine quadrival 2020-2021 (6 mos and up)/pf)*	QL,FL	Covered for up to 1 vaccination per flu season
FLUMIST QUAD NASAL 2019-20 VAC *(influenza vaccine quadrivalent live 2019-2020 (2 yrs-49 yrs))*	QL,FL	Limited to 1 vaccination per flu season.
FLUMIST QUAD NASAL 2020-21 VAC *(influenza vaccine quadrivalent live 2020-2021 (2 yrs-49 yrs))*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members between the ages of 2 and 49
FLUZONE HIGH-DOSE 2019-20 SYR *(influenza virus vaccine trival split 2019-2020 (65 yr up)/pf)*	QL,FL,AL	Limited to 1 vaccination per flu season; Limited to members age 65 years and older.
FLUZONE HIGH-DOSE QUAD 2020-21 *(influenza virus vaccine quadrival split 2020-21(65 yr up)/pf)*	QL,FL,AL	Covered for up to 1 vaccination per flu season; Limited to members age 65 and older
FLUZONE QUAD 2019-2020 SYRINGE *(influenza virus vaccine quadrival 2019-2020 (6 mos and up)/pf)*	QL,FL	Limited to 1 vaccination per flu season.
FLUZONE QUAD 2019-2020 VIAL *(influenza virus vaccine quadrival 2019-2020(6 mos and up)/pf)*	QL,FL	Limited to 1 vaccination per flu season.
FLUZONE QUAD 2019-2020 VIAL *(influenza virus vaccine quadrivalent 2019-20 (6 mos and up))*	QL,FL	Limited to 1 vaccination per flu season.
FLUZONE QUAD 2020-2021 SYRINGE *(influenza virus vaccine quadrival 2020-2021 (6 mos and up)/pf)*	QL,FL	Covered for up to 1 vaccination per flu season
FLUZONE QUAD 2020-2021 VIAL *(influenza virus vaccine quadrival 2020-2021(6 mos and up)/pf)*	QL,FL	Covered for up to 1 vaccination per flu season
FLUZONE QUAD 2020-2021 VIAL *(influenza virus vaccine quadrivalent 2020-21 (6 mos and up))*	QL,FL	Covered for up to 1 vaccination per flu season
FLUZONE QUAD PEDI 2019-20 SYR *(influenza virus vaccine quadrival 2019-20 (6 mos-35 mos)/pf)*	QL,FL,AL	Limited to 1 vaccination per flu season; Limited to members 3 years and younger.
GARDASIL 9 SYRINGE *(human papillomavirus vaccine, 9-valent/pf)*	AL	Limited to members between the ages of 19 and 45.
GARDASIL 9 VIAL *(human papillomavirus vaccine, 9-valent/pf)*	AL	Limited to members between the ages of 19 and 45.
JANSSEN COVID19 VACC(UNAPPROV) *(covid-19 vac, ad26.cov2.s (janssen)/pf)*		
MODERNA COVID-19 VACCINE (EUA) *(covid-19 vaccine, mrna-1273, lnp-s (moderna)/pf)*		
PFIZER COVID-19 VACCINE (EUA) *(covid-19 vaccine, mrna, bnt162b2, lnp-s (pfizer)/pf)*		

Drug List

VAGINAL PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
CLEOCIN 100 MG VAGINAL OVULE *(clindamycin phosphate)*		
clindamycin 2% vaginal cream (CLEOCIN)	GR	Limited to females only.
ENDOMETRIN 100 MG VAG INSERT *(progesterone, micronized)*		
estradiol 0.01% cream (ESTRACE)		
metronidazole vaginal 0.75% gl (METROGEL-VAGINAL)	GR	Limited to females only.
miconazole 3 200 mg vag supp (MONISTAT 3)		
PHEXXI 1.8-1-0.4% VAGINAL GEL *(lactic acid/citric acid/potassium bitartrate)*		
PREMARIN VAGINAL CREAM-APPL *(estrogens, conjugated)*		
terconazole 0.4% cream (TERAZOL 7)	GR	Limited to females only.
terconazole 0.8% cream (TERAZOL 3)	GR	Limited to females only.
terconazole 80 mg suppository (TERAZOL 3)	GR	Limited to females only.
VANDAZOLE VAGINAL 0.75% GEL *(metronidazole)*		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CLEOCIN 2% VAGINAL CREAM *(use clindamycin phosphate)*	PA	Prior Authorization required.
CLINDESSE 2% VAGINAL CREAM *(clindamycin phosphate)*	PA	Prior Authorization required.
CRINONE 4% GEL *(progesterone, micronized)*	PA,QL	Prior Authorization required. Limited to 33.75 g per 30 days.
CRINONE 8% GEL *(progesterone, micronized)*	PA,QL	Prior Authorization required. Limited to 33.75 g per 30 days.
ESTRACE 0.01% CREAM *(use estradiol)*	PA	Prior Authorization required.
estradiol 10 mcg vaginal insrt (VAGIFEM)	PA	Prior Authorization required.
ESTRING 2 MG VAGINAL RING *(estradiol)*	PA	Prior Authorization required.
FEMRING 0.05 MG/DAY VAG RING *(estradiol acetate)*	PA	Prior Authorization required.
FEMRING 0.10 MG/DAY VAG RING *(estradiol acetate)*	PA	Prior Authorization required.
GYNAZOLE 1 2% CREAM *(butoconazole nitrate)*	PA	Prior Authorization required.
IMVEXXY 10 MCG MAINTENANCE PAK *(estradiol)*	PA	Prior Authorization required.
IMVEXXY 10 MCG STARTER PACK *(estradiol)*	PA	Prior Authorization required.
IMVEXXY 4 MCG MAINTENANCE PACK *(estradiol)*	PA	Prior Authorization required.
IMVEXXY 4 MCG STARTER PACK *(estradiol)*	PA	Prior Authorization required.
INTRAROSA 6.5 MG VAG INSERT *(prasterone (dhea))*	PA	Prior Authorization required.
METROGEL-VAGINAL 0.75% GEL *(use metronidazole)*	PA	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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VAGINAL PRODUCTS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NUVESSA VAGINAL 1.3% GEL *(metronidazole)*	PA	Prior Authorization required.
TRIMO-SAN JELLY *(oxyquinoline sulfate/sodium lauryl sulfate)*	PA	Prior Authorization required.
VAGIFEM 10 MCG VAGINAL TAB *(estradiol)*	PA	Prior Authorization required.
YUVAFEM 10 MCG VAGINAL INSERT *(estradiol)*	PA	Prior Authorization required.
YUVAFEM 10 MCG VAGINAL TABLET *(estradiol)*	PA	Prior Authorization required.
Vitamins		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cyanocobalamin 1,000 mcg/ml (RUBRAMIN PC)		
folic acid 1 mg tablet (FOLACIN-K)		
vitamin d2 1.25mg(50,000 unit) (DRISDOL)	QL	Limited to 4 EA per 28 days.

Covered Non-Prescription Drugs

Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
THEREMS-M TABLET *(multivitamin,therapeutic with iron and minerals)*	QL	
Acne Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ACNE MEDICATION 10% GEL *(benzoyl peroxide)*	QL,AL	Limited to members age 10 and older.
ACNE MEDICATION 5% GEL *(benzoyl peroxide)*	QL,AL	Limited to members age 10 and older.
benzoyl peroxide 10% gel (PERSA-GEL)	QL,AL	Limited to members age 10 and older.
benzoyl peroxide 10% wash (DESQUAM-X)	QL,AL	Limited to members age 10 and older.
benzoyl peroxide 5% gel (BENZAC AC)	QL,AL	Limited to members age 10 and older.
Alternative Therapy - Antioxidant		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
PROSIGHT TABLET *(vit a/c/e acetate/zinc oxide/sodium selenate/cupric oxide)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Analgesic, Anti-inflammatory or Antipyretic - Non-Opioid		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
acetaminophen 120 mg suppos (FEVERALL)	QL	Limited to 990 EA per 30 days.
acetaminophen 160 mg/5 ml liq (TEMPRA)	QL	Limited to 3,750 mL per 30 days.
acetaminophen 160 mg/5 ml susp (CHILDREN'S TYLENOL)	QL	Limited to 3,750 mL per 30 days.
acetaminophen 325 mg gelcap (TYLENOL)	QL	Limited to 390 EA per 30 days.
acetaminophen 325 mg tablet (TYLENOL)	QL	Limited to 390 EA per 30 days.
acetaminophen 500 mg caplet (PAIN & FEVER)	QL	Limited to 240 EA per 30 days.
acetaminophen 500 mg gelcap (PAIN & FEVER)	QL	Limited to 240 EA per 30 days.
acetaminophen 500 mg tablet (PAIN & FEVER)	QL	Limited to 240 EA per 30 days.
aspirin 300 mg suppository	QL	
aspirin 325 mg tablet (ASPIRIN)	QL	
aspirin 600 mg suppository	QL	
aspirin ec 325 mg tablet (ECOTRIN)	QL	
aspirin ec 500 mg tablet (ECOTRIN)	QL	
BAYER ASPIRIN 325 MG TABLET *(aspirin)*	QL	
bayer aspirin 325 mg tablet (ASPIRIN)	QL	
buffered aspirin 325 mg tb (BUFFERIN)	QL	
child aurophen pain 160 mg/5ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
child fever reducer 120 mg sup (FEVERALL)	QL	Limited to 990 EA per 30 days.
child pain rel-fever 120mg sup (FEVERALL)	QL	Limited to 990 EA per 30 days.
child pain rlf 160 mg/5 ml sus (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
CHILD PAIN-FEVER 160 MG/5 ML *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
child pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
child tactinal 80 mg tab chw (CHILDREN'S MAPAP)	QL	Limited to 1,500 EA per 30 days.
child's pain reliever susp (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
children ibuprofen 100 mg/5 ml (CHILDREN'S ADVIL)	QL	Limited to 4,800 mL per 30 days.
CHILDREN'S MAPAP 80 MG TAB CHW *(acetaminophen)*	QL	Limited to 1,500 EA per 30 days.
CHILDREN'S TYLENOL 160 MG/5 ML *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
chld acetaminophen 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
chld acetaminophen 160 mg/5 ml (ED-APAP)	QL	Limited to 3,750 mL per 30 days.
cvs acetaminophen 500 mg gelcp (PAIN & FEVER)	QL	Limited to 240 EA per 30 days.
cvs aspirin 325 mg tablet (ASPIRIN)	QL	
cvs aspirin ec 325 mg tablet (ECOTRIN)	QL	
cvs child pain rlf 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Analgesic, Anti-inflammatory or Antipyretic - Non-Opioid		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs child pain-fever 160 mg/5 (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
cvs pain relief 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
cvs pain relief 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
cvs pain relief 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
cvs pain relief 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
ECOTRIN EC 325 MG TABLET *(aspirin)*	QL	
ecpirin ec 325 mg tablet (ASPIR-TRIN)	QL	
ED-APAP 160 MG/5 ML LIQUID *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
eq acetaminophen 500 mg tablet (PAIN & FEVER)	QL	Limited to 240 EA per 30 days.
eq aspirin 325 mg tablet (ASPIRIN)	QL	
eq chld pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
eq pain reliever 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
eql chld acetaminophn 160 mg/5 (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
EXCEDRIN EXTRA STRENGTH CAPLET *(aspirin/acetaminophen/caffeine)*	QL	
EXCEDRIN MIGRAINE CAPLET *(aspirin/acetaminophen/caffeine)*	QL	
FEVERALL 120 MG SUPPOSITORY *(acetaminophen)*	QL	Limited to 990 EA per 30 days.
FEVERALL 325 MG SUPPOSITORY *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
gnp pain reliever 325 mg tab (APHEN)	QL	Limited to 390 EA per 30 days.
gs aspirin 325 mg tablet (ASPIRIN)	QL	
gs child ibuprofen 100 mg/5 ml (CHILDREN'S ADVIL)	QL	Limited to 4,800 mL per 30 days.
gs chld pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
gs infant pain-fever 160 mg/5 (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
gs pain relief 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
gs pain relief 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
headache relief caplet (BAYER MIGRAINE)	QL	
hm aspirin 325 mg tablet (ASPIRIN)	QL	
hm aspirin ec 325 mg tablet (ECOTRIN)	QL	
hm child ibuprofen 100 mg/5 ml (CHILDREN'S ADVIL)	QL	Limited to 4,800 mL per 30 days.
hm chld pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
hm infant pain-fever 160 mg/5 (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
hm pain relief 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
hm pain relief 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
hm pain reliever 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Analgesic, Anti-inflammatory or Antipyretic - Non-Opioid		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
hm pain reliever 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
inf acetaminophen 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
infant ibuprofen 50 mg/1.25 ml (INFANT'S MOTRIN)	QL	Limited to2,400 mL per 30 days.
infant pain relief 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
infant pain relief susp (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
INFANT PAIN RLF 80 MG/0.8 ML *(acetaminophen)*	QL	Limited to 1,200 mL per 30 days.
infant pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
INFANT'S PAIN RLF 80 MG/0.8 ML *(acetaminophen)*	QL	Limited to 1,200 mL per 30 days.
infants pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
INFANTS' TYLENOL 160 MG/5 ML *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
lite coat aspirin 325 mg tab (ASPIRIN)	QL	
MAPAP 160 MG/5 ML LIQUID *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
MAPAP 325 MG TABLET *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
MAPAP 500 MG CAPLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
MAPAP 500 MG GELCAP *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
MAPAP 500 MG TABLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
migraine formula caplet (BAYER MIGRAINE)	QL	
migraine relief caplet (BAYER MIGRAINE)	QL	
NON-ASPIRIN 160 MG/5 ML ELIX *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
PAIN & FEVER 325 MG TABLET *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
PAIN & FEVER 500 MG CAPLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
PAIN & FEVER 500 MG TABLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
PAIN RELIEF 160 MG/5 ML LIQUID *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
pain relief 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
pain relief 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
pain relief 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
PAIN RELIEF 500 MG TABLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
pain relief 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
pain reliever 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
pain reliever 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
pain reliever 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
pain reliever 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
PAIN RELIEVER PLUS TABLET *(aspirin/acetaminophen/caffeine)*	QL	

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Drug List

Analgesic, Anti-inflammatory or Antipyretic - Non-Opioid		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
PHARBETOL 325 MG TABLET *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
PHARBETOL 500 MG CAPLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
PHARBETOL 500 MG TABLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
qc aspirin 325 mg tablet (ASPIRIN)	QL	
qc aspirin ec 325 mg tablet (ECOTRIN)	QL	
qc child pain rlf 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
qc headache relief tablet (BAYER MIGRAINE)	QL	
qc infant pain rlf 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
qc non-aspirin 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
qc non-aspirin 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
qc non-aspirin 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
qc non-aspirin pain relief tb (MASOPHEN)	QL	Limited to 240 EA per 30 days.
qc pain relief 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
qc pain relief 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sb aspirin 325 mg tablet (ASPIRIN)	QL	
sb ex-strength non-aspirin tab (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sb non-aspirin 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
sb non-aspirin 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sb pain relief e-s tablet (BAYER MIGRAINE)	QL	
sb pain reliever 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
SILAPAP 160 MG/5 ML LIQUID *(acetaminophen)*	QL	Limited to 3,750 mL per 30 days.
sm aspirin 325 mg tablet (ASPIRIN)	QL	
sm aspirin ec 325 mg tablet (ECOTRIN)	QL	
sm child's pain reliever susp (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
sm chld pain-fever 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
sm ibuprofen 100 mg/5 ml susp (CHILDREN'S ADVIL)	QL	Limited to 4,800 mL per 30 days.
sm infant pain rlf 160 mg/5 ml (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
sm infant pain-fever 160 mg/5 (BETATEMP)	QL	Limited to 3,750 mL per 30 days.
sm migraine relief caplet (BAYER MIGRAINE)	QL	
sm pain relief 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sm pain reliever 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
sm pain reliever 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sm pain reliever 500 mg gelcap (MASOPHEN)	QL	Limited to 240 EA per 30 days.
sm pain reliever 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.

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Drug List

Analgesic, Anti-inflammatory or Antipyretic - Non-Opioid		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
tactinal 325 mg tablet (APHEN)	QL	Limited to 390 EA per 30 days.
tactinal 500 mg caplet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
tactinal 500 mg tablet (MASOPHEN)	QL	Limited to 240 EA per 30 days.
TRI-BUFFERED ASPIRIN 325 MG *(aspirin/calcium carbonate/magnesium)*	QL	
TYLENOL 325 MG CAPLET *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
TYLENOL 325 MG TABLET *(acetaminophen)*	QL	Limited to 390 EA per 30 days.
TYLENOL EX-STR 500 MG CAPLET *(acetaminophen)*	QL	Limited to 240 EA per 30 days.
Anorectal - Hemorrhoidal Single Agents Other		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ANU-MED SUPPOSITORY *(phenylephrine hcl)*	QL	
cvs medicated 50% pads (HEMORRHOIDAL HYGIENE)	QL	
hemorrhoidal medicated 50% pad (HEMORRHOIDAL HYGIENE)	QL	
HEMORRHOIDAL SUPPOSITORY *(phenylephrine hcl)*	QL	
medicated 50% pads (HEMORRHOIDAL HYGIENE)	QL	
medicated 50% wipes (HEMORRHOIDAL HYGIENE)	QL	
SM HEMORRHOIDAL SUPPOSITORY *(phenylephrine hcl)*	QL	
Antacids and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ACID GONE ANTACID LIQUID *(magnesium carbonate/aluminum hydroxide/alginic acid)*	QL	
ALMACONE SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
ALMACONE-2 LIQUID *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
aluminum hydroxide gel (AMPHOJEL)	QL	
ANTACID 500 MG CHEW TABLET *(calcium carbonate)*	QL	
antacid 500 mg chewable tablet (ANTACID)	QL	
ANTACID 500 MG CHEWABLE TABLET *(calcium carbonate)*	QL	
antacid 750 mg chewable tablet (ANTACID EXTRA STRENGTH)	QL	
ANTACID 750 MG CHEWABLE TABLET *(calcium carbonate)*	QL	
antacid anti-gas liquid (ALMACONE-2)	QL	

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Drug List

Antacids and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
antacid ex-str 750 mg tab chew (ANTACID EXTRA STRENGTH)	QL	
ANTACID EX-STR 750 MG TAB CHEW *(calcium carbonate)*	QL	
antacid ex-str tablet chew (ANTACID EXTRA STRENGTH)	QL	
antacid liquid (ANTACID-ANTIGAS)	QL	
antacid maximum strength liq (ALMACONE-2)	QL	
antacid plus anti-gas relf liq (ANTACID-ANTIGAS)	QL	
antacid plus anti-gas susp (ALMACONE-2)	QL	
antacid suspension (ANTACID-ANTIGAS)	QL	
antacid ultra str 1,000 mg chw (TUMS ULTRA)	QL	
antacid ultra tablet chew (TUMS ULTRA)	QL	
antacid xtra strength chew tab (ANTACID EXTRA STRENGTH)	QL	
antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
antacid-antigas suspension (ANTACID-ANTIGAS)	QL	
antacid-simethicone liquid (ALMACONE-2)	QL	
CAL-GEST 500 MG TABLET CHEW *(calcium carbonate)*	QL	
calcium antacid 1,000 mg tab (TUMS ULTRA)	QL	
calcium antacid 500 mg chw tab (ANTACID)	QL	
CALCIUM ANTACID 500 MG CHW TAB *(calcium carbonate)*	QL	
CALCIUM ANTACID 750 MG TB CHEW *(calcium carbonate)*	QL	
calcium antacid ex-str tablet (ANTACID EXTRA STRENGTH)	QL	
calcium carb 500 mg tab chew (TUMS)	QL	
calcium carbonate 648 mg tab	QL	
comfort gel suspension (ANTACID-ANTIGAS)	QL	
cvs antacid plus anti-gas liq (ALMACONE-2)	QL	
cvs antacid ultra tab chew (TUMS ULTRA)	QL	
cvs antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
cvs calcium antacid 1,000 mg (TUMS ULTRA)	QL	
cvs flavor chew antacid 750 mg (ANTACID EXTRA STRENGTH)	QL	
cvs smooth antacid 750 mg chew (ANTACID EXTRA STRENGTH)	QL	
GAVISCON 80-14.2 MG TAB CHEW *(magnesium trisilicate/aluminum hydrox/sod bicarb/alginic ac)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Antacids and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
GAVISCON LIQUID *(magnesium carbonate/aluminum hydroxide/alginic acid)*	QL	
GERI-LANTA LIQUID *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
gs adv antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
GS ANTACID 500 MG CHEWABLE TAB *(calcium carbonate)*	QL	
gs antacid plus anti-gas liq (ANTACID-ANTIGAS)	QL	
gs cal antacid 500 mg chew tab (ANTACID)	QL	
GS CAL ANTACID 750 MG CHEW TAB *(calcium carbonate)*	QL	
hm adv antacid-antigas susp (ALMACONE-2)	QL	
hm antacid anti-gas suspension (ALMACONE-2)	QL	
hm antacid-antigas suspension (ANTACID-ANTIGAS)	QL	
hm cal antacid 750 mg chew tab (ANTACID)	QL	
hm cal antacid 750 mg chew tab (ANTACID EXTRA STRENGTH)	QL	
HM CAL ANTACID 750 MG CHEW TAB *(calcium carbonate)*	QL	
liquid antacid suspension (ANTACID-ANTIGAS)	QL	
MAALOX ADVANCED SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MAALOX MAXIMUM STRENGTH SUSP *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MAG-AL PLUS SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MAG-AL PLUS XS SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
magnesium oxide 400 mg tablet (MAGOX 400)	QL	
masanti liquid (ALMACONE-2)	QL	
MI ACID SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MI-ACID 400-400-40 MG/10 ML LQ *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MI-ACID DS TABLET *(calcium carbonate/magnesium hydroxide)*	QL	
MI-ACID MAX STRENGTH LIQUID *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MINTOX MAXIMUM STRENGTH SUSP *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Antacids and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
MINTOX PLUS TABLET CHEWABLE *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MINTOX SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
MYLANTA MAXIMUM STRENGTH LIQ *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
qc antacid 500 mg chew tablet (ANTACID)	QL	
qc antacid suspension (ANTACID-ANTIGAS)	QL	
qc antacid xtra str chew tab (ANTACID EXTRA STRENGTH)	QL	
qc antacid-antigas max str (ALMACONE-2)	QL	
qc antacid-antigas suspension (ANTACID-ANTIGAS)	QL	
RULOX SUSPENSION *(magnesium hydroxide/aluminum hydroxide/simethicone)*	QL	
sb antacid 500 mg chew tablet (ANTACID)	QL	
sb antacid anti-gas d-s liq (ALMACONE-2)	QL	
sb antacid suspension (ANTACID-ANTIGAS)	QL	
sb antacid xtra str chew tab (ANTACID EXTRA STRENGTH)	QL	
sb antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
sm adv antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
sm adv antacid-antigas susp (ALMACONE-2)	QL	
sm antacid 500 mg chew tablet (ANTACID)	QL	
sm antacid 750 mg chew tablet (ANTACID EXTRA STRENGTH)	QL	
sm antacid anti-gas liquid (ALMACONE-2)	QL	
sm antacid max strength susp (ALMACONE-2)	QL	
sm antacid suspension (ALMACONE-2)	QL	
sm antacid suspension (ANTACID-ANTIGAS)	QL	
sm antacid xtra str chew tab (ANTACID EXTRA STRENGTH)	QL	
sm antacid-antigas liquid (ANTACID-ANTIGAS)	QL	
sm cal antacid 750 mg chew tab (ANTACID EXTRA STRENGTH)	QL	
SM CAL ANTACID 750 MG CHEW TAB *(calcium carbonate)*	QL	
sm calcium antacid tab chew (TUMS ULTRA)	QL	
sm smooth antacid tab chew (ANTACID EXTRA STRENGTH)	QL	
sodium bicarb 10 grain tablet (ANTACID)	QL	
sodium bicarb 325 mg tablet (ANTACID)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Antacids and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
sodium bicarb 650 mg tablet (ANTACID)	QL	
TUMS 750 MG CHEWY BITES *(calcium carbonate)*	QL	
TUMS E-X TABLET CHEWABLE *(calcium carbonate)*	QL	
TUMS FRESHERS ANTACID CHEW TAB *(calcium carbonate)*	QL	
TUMS KIDS 300 MG (750) CHEWTAB *(calcium carbonate)*	QL	
TUMS SMOOTHIES CHEW TABLET *(calcium carbonate)*	QL	
TUMS TABLET CHEWABLE *(calcium carbonate)*	QL	
TUMS ULTRA TABLET CHEWABLE *(calcium carbonate)*	QL	
TUMS X-STR 750 TABLET CHEWABLE *(calcium carbonate)*	QL	
ANTIDIABETICS : INSULIN		
Drug Name	**Drug Status**	**Criteria**
Preferred		
HUMULIN 70-30 VIAL *(insulin nph human isophane/insulin regular, human)*	QL	Limited to 30 mL per 30 days.
HUMULIN 70/30 KWIKPEN *(insulin nph human isophane/insulin regular, human)*	QL	
HUMULIN N 100 UNIT/ML KWIKPEN *(insulin nph human isophane)*	QL	
HUMULIN N 100 UNIT/ML VIAL *(insulin nph human isophane)*	QL	Limited to 30 mL per 30 days.
HUMULIN R 100 UNIT/ML VIAL *(insulin regular, human)*	QL	Limited to 30 mL per 30 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NOVOLIN 70-30 100 UNIT/ML VIAL *(insulin nph human isophane/insulin regular, human)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NOVOLIN 70-30 FLEXPEN *(insulin nph human isophane/insulin regular, human)*	PA,QL	Prior Authorization required.
NOVOLIN N 100 UNIT/ML FLEXPEN *(insulin nph human isophane)*	PA,QL	Prior Authorization required.
NOVOLIN N 100 UNIT/ML VIAL *(insulin nph human isophane)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
NOVOLIN R 100 UNIT/ML FLEXPEN *(insulin regular, human)*	PA,QL	Prior Authorization required.
NOVOLIN R 100 UNIT/ML VIAL *(insulin regular, human)*	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
relion novolin 70-30 flexpen (HUMULIN 70/30 KWIKPEN)	PA,QL	Prior Authorization required.
relion novolin 70-30 vial (HUMULIN 70-30)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
relion novolin n 100 unit/ml (HUMULIN N)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
relion novolin n u-100 flexpen (HUMULIN N KWIKPEN)	PA,QL	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

ANTIDIABETICS : INSULIN		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
relion novolin r 100 unit/ml (HUMULIN R)	PA,QL	Prior Authorization required. Limited to 30 EA per 30 days.
relion novolin r u-100 flexpen (NOVOLIN R FLEXPEN)	PA,QL	Prior Authorization required.

Antidiarrheals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
ANTI-DIARRHEAL 2 MG CAPLET *(loperamide hcl)*	QL	
anti-diarrheal 2 mg softgel (IMODIUM A-D)	QL	
anti-diarrheal 2 mg tablet (ANTI-DIARRHEAL)	QL	
BISMATROL 525 MG/15 ML SUSP *(bismuth subsalicylate)*	QL	
BISMATROL 525 MG/30 ML SUSP *(bismuth subsalicylate)*	QL	
BISMATROL TABLET CHEW *(bismuth subsalicylate)*	QL	
cvs anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
cvs bismuth 262 mg caplet (KAOPECTATE)	QL	
cvs bismuth chewable tablet (BISMATROL)	QL	
cvs stomach relf 525 mg/30 ml (BISMATROL)	QL	
eq stomach rlf 262 mg chew tab (BISMATROL)	QL	
gs anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
gs stomach relief 525 mg/30 ml (BISMATROL)	QL	
gs stomach rlf 262 mg chew tab (BISMATROL)	QL	
hm anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
hm loperamide 2 mg softgel (IMODIUM A-D)	QL	
hm stomach relief 262 mg/15 ml (BISMATROL)	QL	
hm stomach relief 525 mg/15 ml (BISMATROL)	QL	
hm stomach relief 525 mg/30 ml (BISMATROL)	QL	
hm stomach rlf 262 mg chew tab (BISMATROL)	QL	
IMODIUM A-D 2 MG CAPLET *(loperamide hcl)*	QL	
k-pec suspension (BISMATROL)	QL	
KAO-TIN SUSPENSION *(bismuth subsalicylate)*	QL	
KAOPECTATE 262 MG/15 ML SUSP *(bismuth subsalicylate)*	QL	

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Drug List

Antidiarrheals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
loperamide 1 mg/5 ml liquid (IMODIUM A-D)	QL	
loperamide 1 mg/5 ml solution (IMODIUM A-D)	QL	
PEPTIC RELIEF 262 MG CHEW TAB *(bismuth subsalicylate)*	QL	
PEPTIC RELIEF 262 MG/15 ML *(bismuth subsalicylate)*	QL	
PEPTO-BISMOL 525 MG/30 ML SUSP *(bismuth subsalicylate)*	QL	
PEPTO-BISMOL CAPLET *(bismuth subsalicylate)*	QL	
PEPTO-BISMOL TABLET CHEW *(bismuth subsalicylate)*	QL	
pink bismuth 262 mg/15 ml susp (BISMATROL)	QL	
pink bismuth caplet (KAOPECTATE)	QL	
pink bismuth max-str susp (BISMATROL)	QL	
pink bismuth tablet chew (BISMATROL)	QL	
qc anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
qc anti-diarrheal 2 mg softgel (IMODIUM A-D)	QL	
qc diarrhea rlf 262 mg/15 ml (BISMATROL)	QL	
qc pink bismuth tablet chew (BISMATROL)	QL	
sb anti-diarrhea 2 mg caplet (ANTI-DIARRHEAL)	QL	
sb bismuth chewable tablet (BISMATROL)	QL	
sb bismuth regular liquid (BISMATROL)	QL	
SM ANTI-DIARRHEAL 1 MG/5 ML *(loperamide hcl)*	QL	
sm anti-diarrheal 2 mg caplet (ANTI-DIARRHEAL)	QL	
sm anti-diarrheal 2 mg softgel (IMODIUM A-D)	QL	
sm stomach relief 262 mg/15 ml (BISMATROL)	QL	
sm stomach relief 525 mg/30 ml (BISMATROL)	QL	
sm stomach relief caplet (KAOPECTATE)	QL	
sm stomach relief liquid (BISMATROL)	QL	
sm stomach relief max str liq (BISMATROL)	QL	
sm stomach rlf 262 mg chew tab (BISMATROL)	QL	
soothe 262 mg caplet (KAOPECTATE)	QL	
soothe 262 mg chewable tablet (BISMATROL)	QL	
soothe 262 mg/15 ml suspension (BISMATROL)	QL	
soothe regular strength susp (BISMATROL)	QL	
stomach relief 262 mg/15 ml (BISMATROL)	QL	

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Drug List

Antidiarrheals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
stomach relief 525 mg/15 ml (BISMATROL)	QL	
stomach relief max str liquid (BISMATROL)	QL	
stomach rlf 262 mg/15 ml susp (BISMATROL)	QL	

Antiemetics		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
anti-nausea liquid (EMETROL)	QL	
DRIMINATE 50 MG TABLET *(dimenhydrinate)*	QL	
FORMULA EM SOLUTION *(phosphorated carbohydrate (dextrose and fructose))*	QL	
gs nausea relief liquid (EMETROL)	QL	
hm anti-nausea liquid (EMETROL)	QL	
hm motion sickness 50 mg tab (DRAMAMINE)	QL	
motion sickness 50 mg tablet (DRAMAMINE)	QL	
nausea control liquid (EMETROL)	QL	
nausea relief liquid (EMETROL)	QL	
sb motion sickness 50 mg tab (DRAMAMINE)	QL	
sm anti-nausea liquid (EMETROL)	QL	
sm motion sickness 50 mg tab (DRAMAMINE)	QL	
travel sickness 50 mg tablet (DRAMAMINE)	QL	
wal-dram 50 mg tablet (DRAMAMINE)	QL	

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ALAVERT 10 MG ODT *(loratadine)*	QL	
all day allergy 10 mg tablet (ALLERGY RELIEF)	QL	
ALL DAY ALLERGY 10 MG TABLET *(cetirizine hcl)*	QL	
ALLEGRA ALLERGY 180 MG TABLET *(fexofenadine hcl)*	QL	Limited to 30 EA per 30 days.
ALLEGRA ALLERGY 60 MG TABLET *(fexofenadine hcl)*	QL	Limited to 60 EA per 30 days.
aller-ease 180 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
aller-ease 60 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 60 EA per 30 days.
ALLERGY (LORATADINE) 10 MG TAB *(loratadine)*	QL	
allergy 25 mg capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
allergy 25 mg softgel (ALER-CAPS)	QL,AL	Limited to members age 65 and under.

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Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
allergy 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
allergy 4 mg tablet (ALLER-CHLOR)	QL	
allergy relief 10 mg odt (ALAVERT)	QL	
allergy relief 10 mg tablet (ALLERGY RELIEF)	QL	
ALLERGY RELIEF 10 MG TABLET *(loratadine)*	QL	
allergy relief 180 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
ALLERGY RELIEF 180 MG TABLET *(fexofenadine hcl)*	QL	Limited to 30 EA per 30 days.
allergy relief 25 mg capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
ALLERGY RELIEF 25 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
allergy relief 25 mg softgel (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
allergy relief 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
allergy relief 4 mg tablet (ALLER-CHLOR)	QL	
allergy relief 5 mg/5 ml soln (CHILDREN'S CLARITIN)	QL	
ALLERGY RLF (CETRZN) 10 MG TAB *(cetirizine hcl)*	QL	
allerhist 1.34 mg tablet (TAVIST-1)	QL	
BANOPHEN 12.5 MG/5 ML SOLUTION *(diphenhydramine hcl)*	QL	
BANOPHEN 25 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
BANOPHEN 50 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
BANOPHEN ALLERGY 12.5 MG/5 ML *(diphenhydramine hcl)*	QL	
BENADRYL 25 MG LIQUI-GELS *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
cetirizine hcl 1 mg/ml soln (CHILDREN'S ZYRTEC)	QL	
cetirizine hcl 1 mg/ml syrup (CHILDREN'S ZYRTEC)	QL	
cetirizine hcl 10 mg tablet (ZYRTEC)	QL	
cetirizine hcl 5 mg chew tab (ALL DAY ALLERGY)	QL	
cetirizine hcl 5 mg tablet (ZYRTEC)	QL	
CHILD ALL DAY ALLERGY 1 MG/ML *(cetirizine hcl)*	QL	
child all day allergy 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
child allergy 5 mg/5 ml soln (CHILDREN'S CLARITIN)	QL	
CHILD ALLERGY RELIEF 1 MG/ML *(cetirizine hcl)*	QL	
child allergy rlf 12.5 mg/5 ml (ALLERGY RELIEF)	QL	

Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
child aurodryl 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
child cetirizine 5 mg chew tab (ALL DAY ALLERGY)	QL	
child cetirizine hcl 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
CHILD CLARITIN 5 MG/5 ML SOLN *(loratadine)*	QL	
child diphenhydramin 12.5 mg/5 (ALLERGY RELIEF)	QL	
child diphenhydramin 25mg/10ml (ALLERGY RELIEF)	QL	
child loratadine 5 mg tab chew (CHILDREN'S CLARITIN)	QL	
child loratadine 5 mg/5 ml sol (CHILDREN'S CLARITIN)	QL	
child loratadine 5 mg/5 ml syr (CHILDREN'S CLARITIN)	QL	
child wal-itin 5 mg/5 ml soln (CHILDREN'S CLARITIN)	QL	
child wal-zyr 1 mg/ml solution (CHILDREN'S ALL DAY ALLERGY)	QL	
CHILD ZYRTEC 1 MG/ML SOLUTION *(cetirizine hcl)*	QL	
child's allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
CHILD'S BENADRYL 12.5 MG/5 ML *(diphenhydramine hcl)*	QL	
CHILD'S CLARITIN 5 MG TAB CHEW *(loratadine)*	QL	
child's wal-dryl 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
CLARITIN 10 MG REDITABS *(loratadine)*	QL	
CLARITIN 10 MG TABLET *(loratadine)*	QL	
cvs allergy (cetrzn) 10 mg tab (ALLERGY RELIEF)	QL	
cvs allergy (lorat) 10 mg tab (ALLERGY RELIEF)	QL	
cvs allergy 25 mg capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
cvs allergy 25 mg softgel (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
cvs allergy 50 mg/20 ml liq (ALLERGY RELIEF)	QL	
cvs allergy relief 180 mg tab (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
cvs allergy relief 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
cvs allergy relief 25 mg tab (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
cvs allergy relief 5 mg/5 ml (CHILDREN'S CLARITIN)	QL	
cvs child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
cvs child allergy relf 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	

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Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
dayhist allergy 1.34 mg tablet (TAVIST-1)	QL	
diphedryl 12.5 mg/5 ml elixir (ALLERGY RELIEF)	QL	
diphedryl allergy capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
DIPHENHIST 12.5 MG/5 ML SOLN *(diphenhydramine hcl)*	QL	
DIPHENHIST 25 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
diphenhydramine 12.5 mg/5 ml (CHILDREN'S BENADRYL ALLERGY)	QL	
diphenhydramine 25 mg caplet (SLEEP TABS)	QL,AL	Limited to members age 65 and under.
diphenhydramine 25 mg capsule (BENADRYL)	QL,AL	Limited to members age 65 and under.
diphenhydramine 25 mg tablet (SLEEP TABS)	QL,AL	Limited to members age 65 and under.
diphenhydramine 25 mg/10 ml (CHILDREN'S BENADRYL ALLERGY)	QL	
diphenhydramine 50 mg capsule (BANOPHEN)	QL,AL	Limited to members age 65 and under.
eq allergy (lorat) 10 mg tab (ALLERGY RELIEF)	QL	
eq allergy relief 10 mg tablet (ALLERGY RELIEF)	QL	
eq allergy relief 10 mg tablet (ALLERGY RELIEF)	QL	
eq allergy relief 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
eq allergy relief 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
eq child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
eq child allergy 5 mg/5 ml sol (CHILDREN'S CLARITIN)	QL	
eq child allergy relf 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
eql child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
fexofenadine hcl 180 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
fexofenadine hcl 60 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 60 EA per 30 days.
gs all day allergy 10 mg tab (ALLERGY RELIEF)	QL	
gs aller-ease 180 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
gs allergy relief 10 mg tablet (ALLERGY RELIEF)	QL	
gs allergy relief 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
gs allergy relief 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
gs allergy relief 4 mg tablet (ALLER-CHLOR)	QL	
GS CHILD ALL DAY ALLER 1 MG/ML *(cetirizine hcl)*	QL	

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Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gs child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
hm all day allergy 10 mg tab (ALLERGY RELIEF)	QL	
hm allergy 25 mg capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
hm allergy 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
hm allergy relief 10 mg tablet (ALLERGY RELIEF)	QL	
hm allergy relief 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
hm allergy relief 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
hm allergy relief 4 mg tablet (ALLER-CHLOR)	QL	
hm child all day aller 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
hm child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
hm child cetirizine 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
hm child loratadine 5 mg/5 ml (CHILDREN'S CLARITIN)	QL	
hm fexofenadine hcl 180 mg tab (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
hm fexofenadine hcl 60 mg tab (ALLEGRA ALLERGY)	QL	Limited to 60 EA per 30 days.
hm loratadine 10 mg tablet (ALLERGY RELIEF)	QL	
loratadine 10 mg tablet (ALLERGY RELIEF)	QL	
loratadine 5 mg/5 ml soln (CHILDREN'S CLARITIN)	QL	
loratadine 5 mg/5 ml syrup (CHILDREN'S CLARITIN)	QL	
loratadine allergy 5 mg/5 ml (CHILDREN'S CLARITIN)	QL	
loratadine hives 5 mg/5 ml (CHILDREN'S CLARITIN)	QL	
M-DRYL 12.5 MG/5 ML SOLUTION *(diphenhydramine hcl)*	QL	
NON-DROWSY ALLERGY 10 MG TAB *(loratadine)*	QL	
PHARBEDRYL 25 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
PHARBEDRYL 50 MG CAPSULE *(diphenhydramine hcl)*	QL,AL	Limited to members age 65 and under.
qc all day allergy 10 mg tab (ALLERGY RELIEF)	QL	
qc child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
qc children's allergy 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
qc chlorpheniramine 4 mg tab (CHLOR-TRIMETON)	QL	

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Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
qc complete allergy 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
qc complete allergy 25 mg cplt (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
qc fexofenadine hcl 180 mg tab (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
qc loratadine 10 mg tablet (ALLERGY RELIEF)	QL	
sb allergy 10 mg tablet (ALLERGY RELIEF)	QL	
sb allergy 12.5 mg/5 ml elixir (ALLERGY RELIEF)	QL	
sb allergy med 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
sb allergy medicine 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
sb chlorpheniramine 4 mg tab (CHLOR-TRIMETON)	QL	
sb loratadine 10 mg tablet (ALLERGY RELIEF)	QL	
SILADRYL 12.5 MG/5 ML LIQUID *(diphenhydramine hcl)*	QL	
sm all day allergy 10 mg tab (ALLERGY RELIEF)	QL	
sm allergy 4 mg tablet (ALLER-CHLOR)	QL	
sm allergy 4-hr 4 mg tablet (ALLER-CHLOR)	QL	
sm allergy relief 1.34 mg tab (TAVIST-1)	QL	
sm allergy relief 10 mg odt (ALAVERT)	QL	
sm allergy relief 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
sm allergy relief 25 mg cap (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
sm allergy relief 25 mg tablet (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
sm child all day aller 1 mg/ml (CHILDREN'S ALL DAY ALLERGY)	QL	
sm child allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	
sm child allergy 5 mg/5 ml sol (CHILDREN'S CLARITIN)	QL	
sm child loratadine 5 mg/5 ml (CHILDREN'S CLARITIN)	QL	
sm fexofenadine hcl 180 mg tab (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
sm fexofenadine hcl 60 mg tab (ALLEGRA ALLERGY)	QL	Limited to 60 EA per 30 days.
sm loratadine 10 mg odt (ALAVERT)	QL	
sm loratadine 10 mg tablet (ALLERGY RELIEF)	QL	
sm loratadine 5 mg/5 ml syrup (CHILDREN'S CLARITIN)	QL	
wal-dryl allergy 12.5 mg/5 ml (ALLERGY RELIEF)	QL	

Drug List

Antihistamines		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
wal-dryl allergy 25 mg capsule (ALER-CAPS)	QL,AL	Limited to members age 65 and under.
wal-dryl allergy 25 mg minitab (ALLER-G-TIME)	QL,AL	Limited to members age 65 and under.
wal-fex allergy 180 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 30 EA per 30 days.
wal-fex allergy 60 mg tablet (ALLEGRA ALLERGY)	QL	Limited to 60 EA per 30 days.
wal-finate 4 mg tablet (ALLER-CHLOR)	QL	
wal-itin 10 mg tablet (ALLERGY RELIEF)	QL	
wal-itin 5 mg/5 ml syrup (CHILDREN'S CLARITIN)	QL	
wal-zyr 10 mg tablet (ALLERGY RELIEF)	QL	
ZYRTEC 10 MG TABLET *(cetirizine hcl)*	QL	

Antiparasitics		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs pinworm treatment 50 mg/ml (PINAWAY)	QL	
REESE'S PINWORM 144 MG/ML SUSP *(pyrantel pamoate)*	QL	

Antiseptic - Alcohols		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ALCOHOL 70% PREP PADS *(alcohol antiseptic pads)*	QL	
alcohol 70% prep pads (ALCOHOL PADS)	QL	
ALCOHOL 70% SWABS *(alcohol antiseptic pads)*	QL	
alcohol 70% swabs (ALCOHOL PADS)	QL	
ALCOHOL PREP PADS *(alcohol antiseptic pads)*	QL	
alcohol swab (ALCOHOL PADS)	QL	
alcohol swabs (ALCOHOL PADS)	QL	
BD SINGLE USE SWAB *(alcohol antiseptic pads)*	QL	
CARETOUCH ALCOHOL 70% PREP PAD *(alcohol antiseptic pads)*	QL	
CURITY ALCOHOL PREPS *(alcohol antiseptic pads)*	QL	
cvs alcohol 70% prep pads (ALCOHOL PADS)	QL	
cvs isopropyl alcohol 70% wipe (ALCOHOL PADS)	QL	
EASY COMFORT ALCOHOL 70% PAD *(alcohol antiseptic pads)*	QL	
EASY TOUCH ALCOHOL 70% PADS *(alcohol antiseptic pads)*	QL	

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Antiseptic - Alcohols		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
FIFTY50 ALCOHOL PREP PADS *(alcohol antiseptic pads)*	QL	
gnp alcohol swab (ALCOHOL PADS)	QL	
gnp isopropyl alcohol 70% wipe (ALCOHOL PADS)	QL	
heb incontrol alcohol 70% pads (ALCOHOL PADS)	QL	
hm alcohol 70% prep pads (ALCOHOL PADS)	QL	
isopropyl alcohol 70% wipes (ALCOHOL PADS)	QL	
iv antiseptic wipes (ALCOHOL PADS)	QL	
KENDALL ALCOHOL 70% PREP PAD *(alcohol antiseptic pads)*	QL	
kro alcohol 70% prep pads (ALCOHOL PADS)	QL	
kro alcohol 70% swabs (ALCOHOL PADS)	QL	
PHARM CHOICE ALCOHOL PREP PADS *(alcohol antiseptic pads)*	QL	
PREP EASE ALCOHOL PADS *(alcohol antiseptic pads)*	QL	
qc alcohol 70% swabs (ALCOHOL PADS)	QL	
ra alcohol swabs (ALCOHOL PADS)	QL	
ra isopropyl alcohol 70% wipes (ALCOHOL PADS)	QL	
relion alcohol 70% swabs (ALCOHOL PADS)	QL	
SAPS ALCOHOL 70% PREP PADS *(alcohol antiseptic pads)*	QL	
sm alcohol 70% prep pads (ALCOHOL PADS)	QL	
sm alcohol prep pads (ALCOHOL PADS)	QL	
SURE COMFORT ALCOHOL PREP PADS *(alcohol antiseptic pads)*	QL	
SURE-PREP ALCOHOL PREP PADS *(alcohol antiseptic pads)*	QL	
ULTILET ALCOHOL STERL SWAB *(alcohol antiseptic pads)*	QL	
v-r alcohol prep pads (ALCOHOL PADS)	QL	
WEBCOL ALCOHOL PREPS *(alcohol antiseptic pads)*	QL	

Antitussives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
COUGH RELIEF LIQUID *(dextromethorphan hbr)*	QL	
CVS TUSSIN LONG-ACTING LIQUID *(dextromethorphan hbr)*	QL	
QC COUGH RELIEF LIQUID *(dextromethorphan hbr)*	QL	

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Drug List

Antitussives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
SM COUGH RELIEF LIQUID *(dextromethorphan hbr)*	QL	
TUSSIN COUGH LIQUID *(dextromethorphan hbr)*	QL	
TUSSIN COUGH SYRUP *(dextromethorphan hbr)*	QL	
WAL-TUSSIN MAX STR COUGH SYRUP *(dextromethorphan hbr)*	QL	
Artificial Tears and Lubricants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ARTIFICIAL TEARS 1.4% DROPS *(polyvinyl alcohol)*	QL	
artificial tears drops (ARTIFICIAL TEARS)	QL	
artificial tears eye drops (GENTEAL TEARS)	QL	
ARTIFICIAL TEARS EYE OINTMENT *(mineral oil/petrolatum,white)*	QL	
CLEAR EYES NATURAL TEARS DROP *(polyvinyl alcohol/povidone)*	QL	
GENTEAL TEARS 0.1%-0.3% DROP *(dextran 70/hypromellose)*	QL	
LIQUITEARS 1.4% DROPS *(polyvinyl alcohol)*	QL	
LUBRIFRESH PM EYE OINTMENT *(mineral oil/petrolatum,white)*	QL	
NATURAL BALANCE TEARS EYE DROP *(dextran 70/hypromellose)*	QL	
NATURE'S TEARS EYE DROPS *(dextran 70/hypromellose)*	QL	
polyvinyl alcohl 1.4% eyedrop (AQUA-FILM TEARS)	QL	
qc artificial tears drops (ARTIFICIAL TEARS)	QL	
REFRESH LACRI-LUBE OINTMENT *(mineral oil/petrolatum,white)*	QL	
sm artificial tears (ARTIFICIAL TEARS)	QL	
Bulk Chemicals		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
METHYLCELLULOSE 400 CP POWDER *(methylcellulose 400cps)*	QL	
CONTRACEPTIVES : EMERGENCY CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
AFTERA 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
ECONTRA EZ 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
ECONTRA ONE-STEP 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.

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CONTRACEPTIVES : EMERGENCY CONTRACEPTIVES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
levonorgestrel 1.5 mg tablet (AFTERA)	QL	Limited to 3 EA per fill.
MY CHOICE 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
MY WAY 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
NEW DAY 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
OPCICON ONE-STEP 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
option 2 1.5 mg tablet (AFTERA)	QL	Limited to 3 EA per fill.
PLAN B ONE-STEP 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
TAKE ACTION 1.5 MG TABLET *(levonorgestrel)*	QL	Limited to 3 EA per fill.
Contraceptives Intravaginal		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
VCF CONTRACEPTIVE FOAM *(nonoxynol 9)*	QL,GR,AL	Limited to females only; Limited to members between the ages of 10 and 76.
Dental-Periodontal Products		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
fluoride 0.25 mg tablet chew (LURIDE)	QL,AL	Limited to members age 11 and under.
fluoride 0.5 mg tablet chew (LUDENT FLUORIDE)	QL,AL	Limited to members age 11 and under.
fluoride 1 mg tablet chewable (FLUORITAB)	QL,AL	Limited to members age 11 and under.
Dermatological - Anti-infectives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ANTIFUNGAL 1% CREAM *(tolnaftate)*	QL	
antifungal 1% spray powder (LAMISIL AF)	QL	
ANTIFUNGAL 2% TOPICAL CREAM *(miconazole nitrate)*	QL	
athlete's foot 1% powder spray (LAMISIL AF)	QL	
athlete's foot af 1% cream (LAMISIL AT)	QL	
bacitracin 500 unit/gm ointmnt	QL	
bacitracin 500 unit/gm ointmnt (BACIGUENT)	QL	
bacitracin zn 500 unit/gm oint	QL	
bacitracin zn 500 unit/gm oint (BACITRACIN ZINC)	QL	
BACITRAYCIN PLUS 500 UNIT/GM *(bacitracin)*	QL	
BAZA ANTIFUNGAL 2% CREAM *(miconazole nitrate)*	QL	
cvs af 1% spray powder (LAMISIL AF)	QL	

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Dermatological - Anti-infectives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
cvs antifungal 1% cream (ANTIFUNGAL CREAM)	QL	
cvs bacitracin zn 500 unit/gm (BACITRACIN ZINC)	QL	
cvs povidone-iodine 10% soln (BETADINE)	QL	
eq bacitracin zn 500 unit/gm (BACITRACIN ZINC)	QL	
FUNGOID-D 1% CREAM *(tolnaftate)*	QL	
hm bacitracin zn 500 unit/gm (BACITRACIN ZINC)	QL	
hm povidone-iodine 10% soln (BETADINE)	QL	
hm triple antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
jock itch 1% powder spray (LAMISIL AF)	QL	
miconazole 2% topical cream (REMEDY ANTIFUNGAL)	QL	
NEOSPORIN OINTMENT *(neomycin sulfate/bacitracin zinc/polymyxin b)*	QL	
POLYSPORIN OINTMENT *(bacitracin zinc/polymyxin b sulfate)*	QL	
povidone-iodine 10% ointment (BETADINE)	QL	
povidone-iodine 10% solution (BETADINE)	QL	
qc bacitracin 500 unit/gm oint (BACIGUENT)	QL	
qc povidone-iodine 10% soln (BETADINE)	QL	
qc tolnaftate 1% cream (TINACTIN)	QL	
qc triple antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
sb povidone-iodine 10% soln (BETADINE)	QL	
sb triple antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
sm antibiotic 500 unit/gm oint (BACITRACIN ZINC)	QL	
sm antifungal 1% cream (ANTIFUNGAL CREAM)	QL	
sm athlete's 1% foot cream (LAMISIL AT)	QL	
sm double antibiotic oint (DOUBLE ANTIBIOTIC)	QL	
sm miconazole 2% topical cream (REMEDY ANTIFUNGAL)	QL	
sm povidone-iodine 10% soln (BETADINE)	QL	
sm triple antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
terbinafine 1% cream (LAMISIL AT)	QL	
TINACTIN 1% CREAM *(tolnaftate)*	QL	
TINACTIN JOCK ITCH 1% CREAM *(tolnaftate)*	QL	
tolnaftate 1% cream (TINACTIN)	QL	

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Dermatological - Anti-infectives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
tolnaftate 1% spray powder (TINACTIN)	QL	
tolnaftate af 1% cream (TINACTIN)	QL	
triple antibiotic ointment (FIRST AID ANTIBIOTIC)	QL	
TRIPLE ANTIBIOTIC OINTMENT *(neomycin sulfate/bacitracin zinc/polymyxin b)*	QL	
Dermatological - Emollients and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
DERMACERIN CREAM *(mineral oil/petrolatum,white)*	QL	
MINERIN CREME *(lanolin alcohols/mineral oil/petrolatum,white/ceresin)*	QL	
Dermatological - Irritants-Counter-Irritants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ARTHRITIS PAIN RLF 0.075% CRM *(capsaicin)*	QL	
capsaicin 0.025% cream (ZOSTRIX)	QL	Limited to 60 g per 30 days.
ZOSTRIX 0.033% CREAM *(capsaicin)*	QL	
ZOSTRIX HP 0.1% CREAM *(capsaicin)*	QL	
Dermatological - Keratoplastics		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
DHS TAR 0.5% SHAMPOO *(coal tar)*	QL	
DHS TAR GEL 0.5% SHAMPOO *(coal tar)*	QL	
sm anti-dandruff 0.5% shampoo (DHS TAR)	QL	
T-GEL 0.5% THERAPEUTIC SHAMPOO *(coal tar)*	QL	
THERA-GEL 0.5% SHAMPOO *(coal tar)*	QL	
Dermatological - Protectants and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
BAZA PROTECT CREAM *(dimethicone/zinc oxide)*	QL	
THERASEAL 1% CREAM *(dimethicone)*	QL	
Dermatological - Topical Local Anesthetics and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
dibucaine 1% ointment (DERMASAN)	QL	

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Drug List

DERMATOLOGICALS : MISC		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
XERAC AC 6.25% SOLUTION *(aluminum chloride)*	PA,QL	Prior Authorization required.

DERMATOLOGICALS : SCABICIDES & PEDICULICIDES		
Drug Name	**Drug Status**	**Criteria**
Preferred		
gs lice killing shampoo (LICE KILLING)	QL	
hm lice killing shampoo (LICE KILLING)	QL	
hm lice treatment 1% crm rinse (NIX)	QL	
lice killing shampoo (LICE KILLING)	QL	
LICE KILLING SHAMPOO *(piperonyl butoxide/pyrethrins)*	QL	
lice treatment 1% creme rinse (NIX)	QL	
lice treatment shampoo (LICE KILLING)	QL	
sb lice killing shampoo (LICE KILLING)	QL	
sm lice treatment 1% crm rinse (NIX)	QL	

Diabetic Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs glucose 4 gram tablet chew (ULTILET)	QL	
glucose 4 gram tablet chew (ULTILET)	QL	
GLUTOSE-15 GEL *(dextrose)*	QL	
GLUTOSE-45 GEL *(dextrose)*	QL	
GLUTOSE-5 GEL *(dextrose)*	QL	
gnp glucose 4 gram tablet chew (ULTILET)	QL	
sm glucose 4 gram tab chew (ULTILET)	QL	

Diagnostic Test Reagents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CHEK-STIX STRIPS *(urine multiple test strips)*	QL	
CHEMSTRIP 10 MD *(urine multiple test strips)*	QL	
CHEMSTRIP 10 WITH SG *(urine multiple test strips)*	QL	
CHEMSTRIP 2 GP *(urine multiple test strips)*	QL	
CHEMSTRIP 50B *(urine multiple test strips)*	QL	
CHEMSTRIP 7 *(urine multiple test strips)*	QL	
CHEMSTRIP-9 *(urine multiple test strips)*	QL	
COMBISTIX REAGENT STRIPS *(urine multiple test strips)*	QL	
HEMA-COMBISTIX REAGENT STRIPS *(urine multiple test strips)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Diagnostic Test Reagents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
LABSTIX REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 10 SG REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 5 STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 7 REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 8 SG REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 9 REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX 9 SG REAGENT STRIPS *(urine multiple test strips)*	QL	
MULTISTIX REAGENT STRIPS *(urine multiple test strips)*	QL	
URISTIX 4 REAGENT STRIPS *(urine multiple test strips)*	QL	
URISTIX REAGENT STRIPS *(urine multiple test strips)*	QL	

Digestive Aids		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs lactase 3,000 unit caplet (LACTAID)	QL	
DAIRY RELIEF 3,000 UNIT CAPLET *(lactase)*	QL	
LAC-DOSE 3,000 UNIT CAPTAB *(lactase)*	QL	
LACTAID 3,000 UNIT CAPLET *(lactase)*	QL	
lactase 3,000 unit caplet (LACTAID)	QL	

Expectorants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
adult wal-tussin liquid (CHEST CONGESTION RELIEF)	QL	
children's chest congest liq (CHEST CONGESTION RELIEF)	QL	
children's mucus relief liq (CHEST CONGESTION RELIEF)	QL	
CHL MUCINEX CHEST CONGEST LIQ *(guaifenesin)*	QL	
COUGH SYRUP 200 MG/10 ML *(guaifenesin)*	QL	
cvs tussin 100 mg/5 ml liquid (CHEST CONGESTION RELIEF)	QL	
DIABETIC SILTUSSIN DAS-NA LIQ *(guaifenesin)*	QL	
GERI-TUSSIN SYRUP *(guaifenesin)*	QL	
gs tussin mucus-cong 100 mg/5 (CHEST CONGESTION RELIEF)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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Expectorants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gs tussin mucus-cong 200 mg/10 (CHEST CONGESTION RELIEF)	QL	
guaifenesin 100 mg/5 ml liquid (MUCUS-CHEST CONGESTION)	QL	
guaifenesin 100 mg/5 ml soln (MUCUS-CHEST CONGESTION)	QL	
guaifenesin 100 mg/5 ml syrup (MUCUS-CHEST CONGESTION)	QL	
guaifenesin 200 mg tablet (GLYTUSS)	QL	
guaifenesin 200 mg/10 ml soln (MUCUS-CHEST CONGESTION)	QL	
guaifenesin 300 mg/15 ml soln (MUCUS-CHEST CONGESTION)	QL	
hm adult tussin chest cong liq (CHEST CONGESTION RELIEF)	QL	
mucus rlf chest congest 200 mg (ORGAN-I NR)	QL	
MUCUS-CHEST CONG 200 MG/10 ML *(guaifenesin)*	QL	
qc tussin mucus-cong 200 mg/10 (CHEST CONGESTION RELIEF)	QL	
ROBAFEN 100 MG/5 ML SYRUP *(guaifenesin)*	QL	
ROBAFEN 200 MG/10 ML SYRUP *(guaifenesin)*	QL	
SILTUSSIN SA 100 MG/5 ML SYR *(guaifenesin)*	QL	
sm tussin mucus-cong 200 mg/10 (CHEST CONGESTION RELIEF)	QL	
TUSNEL-EX 100 MG/5 ML LIQUID *(guaifenesin)*	QL	
tussin 100 mg/5 ml syrup (CHEST CONGESTION RELIEF)	QL	
tussin chest congestion liquid (CHEST CONGESTION RELIEF)	QL	
tussin honey syrup (CHEST CONGESTION RELIEF)	QL	
tussin mucus-cong 200 mg/10 (CHEST CONGESTION RELIEF)	QL	

Gastrointestinal Antiflatulents and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
anti-gas 180 mg softgel (GAS RELIEF)	QL	
cvs anti-gas 180 mg softgel (GAS RELIEF)	QL	
cvs gas relf(simeth) 80 mg chw (GAS RELIEF)	QL	
cvs gas relief 125 mg chew tab (GAS RELIEF)	QL	
cvs gas relief 125 mg softgel (GAS RELIEF)	QL	
cvs gas relief ex-str drops (INFANTS' GAS RELIEF)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Gastrointestinal Antiflatulents and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gas relief (simeth) 80 mg chew (GAS RELIEF)	QL	
GAS RELIEF (SIMETH) 80 MG CHEW *(simethicone)*	QL	
gas relief 125 mg chew tablet (GAS RELIEF)	QL	
GAS RELIEF 125 MG CHEW TABLET *(simethicone)*	QL	
gas relief 125 mg softgel (GAS RELIEF)	QL	
GAS RELIEF 125 MG SOFTGEL *(simethicone)*	QL	
gas relief 180 mg softgel (GAS RELIEF)	QL	
GAS RELIEF 180 MG SOFTGEL *(simethicone)*	QL	
GAS RELIEF 20 MG/0.3 ML DROPS *(simethicone)*	QL	
gas relief drops 20 mg/0.3 ml (INFANTS' GAS RELIEF)	QL	
GAS-X EX-STR 125 MG TAB CHEW *(simethicone)*	QL	
GAS-X EXTRA STRENGTH SOFTGEL *(simethicone)*	QL	
GAS-X ULTRA STRENGTH SOFTGEL *(simethicone)*	QL	
gnp gas rlf(simeth) 80 mg chew (GAS RELIEF)	QL	
gs gas relief 125 mg softgel (GAS RELIEF)	QL	
gs simethicone 20 mg/0.3 ml (MYLICON)	QL	
hm gas relief(simeth) 80mg chw (GAS RELIEF)	QL	
hm inf gas relief 20 mg/0.3 ml (INFANTS' GAS RELIEF)	QL	
INF GAS REL 20 MG/0.3 ML DROP *(simethicone)*	QL	
infant gas relief drops (INFANTS' GAS RELIEF)	QL	
infants' gas rlf 20 mg/0.3 ml (INFANTS' GAS RELIEF)	QL	
INFANTS' MYLICON 20 MG/0.3 ML *(simethicone)*	QL	
MI-ACID GAS 80 MG TAB CHEW *(simethicone)*	QL	
PHAZYME 180 MG SOFTGEL *(simethicone)*	QL	
qc anti-gas 180 mg softgel (GAS RELIEF)	QL	
qc gas relief 125 mg softgel (GAS RELIEF)	QL	
simethicone 125 mg softgel (PHAZYME 125)	QL	
simethicone 125 mg tab chew (GAS-X)	QL	
simethicone 180 mg softgel (GAS-X ULTRA STRENGTH)	QL	
simethicone 40 mg/0.6 ml drop (MYLICON)	QL	
simethicone 80 mg tab chew (GAS-X)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

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Gastrointestinal Antiflatulents and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
sm gas rel antiflatuent 180 mg (GAS RELIEF)	QL	
sm gas relief 125 mg chew tab (GAS RELIEF)	QL	
sm gas relief 125 mg softgel (GAS RELIEF)	QL	
sm gas relief 180 mg softgel (GAS RELIEF)	QL	
sm gas relief(simeth) 80mg chw (GAS RELIEF)	QL	
sm inf gas relief 20 mg/0.3 ml (INFANTS' GAS RELIEF)	QL	
GENITOURINARY AGENTS : MISC		
Drug Name	**Drug Status**	**Criteria**
Preferred		
sod citrate-citric acid soln (BICITRA)	QL	
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
potass cit-sod cit-citric soln (POLYCITRA-LC)	PA,QL	Prior Authorization required.
potassium cit-citric acid soln (POLYCITRA-K)	PA,QL	Prior Authorization required.
TRICITRATES ORAL SOLUTION *(sodium/potassium/potassium citrate/sodium citrate/cit ac)*	PA,QL	Prior Authorization required.
GLUCOSE MONITORING SUPPLIES : CGMs		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
GUARDIAN TRANSMITTER TAPE *(diabetic supplies,miscell)*	PA,QL	Prior Authorization Required.
OVAL TAPE *(diabetic supplies,miscell)*	PA,QL	Prior Authorization Required.
GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ONETOUCH ULTRA2 GLUCOSE SYST *(blood-glucose meter)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH ULTRAMINI METER *(blood-glucose meter)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO FLEX METER *(blood-glucose meter)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO IQ METER *(blood-glucose meter)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO METER *(blood-glucose meter)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO REFLECT METER *(blood-glucose meter)*	QL	Limited to 90 EA per 30 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACCU-CHEK AVIVA PLUS METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK GUIDE ME GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK GUIDE MONITOR SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK NANO SMARTVIEW METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE BLOOD GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE REDI-CODE GLU METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE REDI-CODE GLU MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE REDI-CODE PLUS METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
AGAMATRIX AMP GLUC MONITOR SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ASSURE PLATINUM GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ASSURE PRISM MULTI METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
BLOOD GLUCOSE MONITORING SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
blood glucose monitoring syst (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
blood glucose monitoring syst (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
careone glucose monitoring sys (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CARESENS N BLOOD GLUCOSE SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CARESENS N VOICE GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CARETOUCH GLUCOSE MONITOR SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHEK BLOOD GLUCOSE SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE BLOOD GLUCOS SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE HD GLUCOSE SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE MICRO MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE PRO GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CLEVER CHOICE TALK GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR LINK METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
CONTOUR METER SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR NEXT EZ METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR NEXT EZ METER SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR NEXT LINK 2.4 METER KT *(blood-glucose meter, wireless)*	PA,QL	Prior Authorization Required.
CONTOUR NEXT LINK METER *(blood-glucose meter, wireless)*	PA,QL	Prior Authorization required.
CONTOUR NEXT METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CONTOUR NEXT ONE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
COOL BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
COOL BLOOD GLUCOSE METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
cvs advanced glucose meter (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
DIATRUE PLUS BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY PLUS II BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY STEP BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY STEP GLUCOSE SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY TALK BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY TOUCH GLUCOSE MONITOR SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY TRAK BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY-TOUCH BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYGLUCO METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYGLUCO METER STARTER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYMAX L BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYMAX NG BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYMAX NG GLUCOSE SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYMAX V SPEAKING GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASYMAX V2 BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ELEMENT COMPACT GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ELEMENT COMPACT V GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ELEMENT PLUS BLOOD GLUCOSE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE BLOOD GLUCOSE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE EVO BLOOD GLUCOSE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE PRO BLOOD GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE TALK BLOOD GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EMBRACE TALK BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EVENCARE G2 BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EVENCARE G3 BLOOD GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EVENCARE MINI MONITOR SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EVOLUTION BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EZ SMART PLUS SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EZ SMART SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FIFTY50 2.0 GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA G20 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA G30A BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA GD50 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA GTEL MULTIFUNCTN MONITOR *(blood ketone and glucose monitor)*	PA,QL	Prior Authorization required.
FORA PREMIUM V10 GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA TEST N'GO VOICE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA TN'G VOICE GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA V10 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA V10-V12-D10-D20 STRP-LNCT *(lancets with blood glucose test strips)*	PA,QL	Prior Authorization required.
FORA V12 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA V20 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA V30A BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORACARE GD20 GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FORACARE GD40A GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORACARE GD40B GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORTISCARE BLOOD GLUCOSE SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE FLASH SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE FREEDOM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE FREEDOM LITE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE FREEDOM LITE NFRS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE INSULINX GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE LITE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE LITE METER NFRS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE PRECISION NEO METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE SIDEKICK II VALPK *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FREESTYLE SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GE100 BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD 01 METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD EXPRESSION METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD EXPRESSION METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD SHINE CONNEX METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD SHINE EXPRESS METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD SHINE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD SHINE METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD SHINE XL METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCARD VITAL METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCOM BLOOD GLUCOSE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCOM BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCOM VALUE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GNP EASY TOUCH GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
gs blood glucose monitor sys (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
HEALTHPRO GLUCOSE MONITOR SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
humana true metrix air glu mtr (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
humana true metrix air meter (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
IGLUCOSE BLOOD GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
INFINITY METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
INFINITY STARTER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
INFINITY VOICE GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
JAZZ WIRELESS 2 METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
kro premium blood glucose syst (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MICRODOT BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MYGLUCOHEALTH MONITORING KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
NOVA MAX BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ON CALL EXPRESS METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ON CALL EXPRESS METER SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ON CALL PLUS METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ON CALL VIVID METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ON CALL VIVID PAL METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH ULTRA2 GLUCOSE SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH ULTRAMINI METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO FLEX STARTR KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO IQ SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH VERIO REFLECT STR KIT *(blood-glucose meter)*	PA,QL	Prior Authorization required. Limited to 90 EA per 30 days.
OPTUMRX BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
OPTUMRX BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PHARMACIST CHOICE GLUCOSE SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PHARMACIST CHOICE MINI GLU SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PRECISION XTRA KETONE-GLUC KIT *(blood ketone and glucose monitor)*	PA,QL	Prior Authorization required.
PRECISION XTRA MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRECISION XTRA MONITOR NFRS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
premium blood glucose system (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PREMIUM V10 BLOOD GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRESTO PRO BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRO VOICE V8 GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRO VOICE V9 GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRODIGY AUTOCODE METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRODIGY AUTOCODE MONITOR SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRODIGY POCKET METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRODIGY VOICE METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
QUINTET AC BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
QUINTET BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
REFUAH PLUS MONITORING SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion all-in-one meter kit (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion confirm system kit (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion micro system kit (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion premier blu glucose mtr (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion premier compact meter (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion premier voice gluco mtr (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion prime blood glucose mtr (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
RELION TRUE METRIX AIR GLU MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
relion ultima glucose meter (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
REVEAL BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
rexall glucose monitoring sys (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
RIGHTEST GM100 SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
RIGHTEST GM300 SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
RIGHTEST GM550 SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
sidekick blood glucose system	PA,QL	Prior Authorization required.
smart sense monitoring system (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SMARTEST EJECT METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SMARTEST PERSONA STARTER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SMARTEST PRONTO STARTER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SMARTEST PROTEGE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SOLUS V2 AUDIBLE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SOLUS V2 AUDIBLE METER SYS KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SURE-TEST EASYPLUS MINI METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
TELCARE BGM BLOOD GLUCOSE KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
TELCARE BLOOD GLUCOSE MONITOR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
TEST N'GO BLOOD GLUCOSE SYSTEM *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
true metrix air glucose meter (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
TRUE METRIX BLOOD GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
true metrix blood glucose mtr (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
true metrix go glucose meter (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
trueresult blood glucose systm (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
truetrack blood glucose system (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
truetrack smart system (ONETOUCH ULTRAMINI)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTRATRAK BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTRATRAK PRO GLUCOSE MTR SYS *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTRATRAK PRO METER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTRATRAK ULTIMATE GLUCOSE MTR *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
UP & UP BLOOD MONITORING SYST *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
up & up blood monitoring syst (ONETOUCH ULTRA2)	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

Drug List

GLUCOSE MONITORING SUPPLIES : DEVICES AND KITS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VERASENS BLOOD GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
VERASENS METER STARTER KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
VIVAGUARD INO GLUCOSE METER *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
WAVESENSE AMP SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
WAVESENSE PRESTO SYSTEM KIT *(blood-glucose meter)*	PA,QL,FL	Prior Authorization required. Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
ONETOUCH ULTRA BLUE TEST STRP *(blood sugar diagnostic)*	QL	Limited to 360 EA over 90 days.
ONETOUCH VERIO TEST STRIP *(blood sugar diagnostic)*	QL	Limited to 360 EA over 90 days.
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
ACCU-CHEK AVIVA PLUS TEST STRP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ACCU-CHEK COMPACT PLUS STRIPS *(blood sugar diagnostic, drum-type)*	PA,QL	Prior Authorization required.
ACCU-CHEK GUIDE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ACCU-CHEK SMARTVIEW TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ACCUTREND GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ADVOCATE REDI-CODE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ADVOCATE REDI-CODE+ TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ADVOCATE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
AGAMATRIX AMP TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ASSURE 4 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ASSURE PLATINUM TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ASSURE PLATINUM TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ASSURE PRISM MULTI TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
BLOOD GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
blood glucose test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
BLOOD GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
blood glucose test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
BREEZE 2 DISC TEST STRIP *(blood sugar diagnostic, disc-type)*	PA,QL	Prior Authorization required. Limited to 300 EA over 90 days.
careone blood glucose tst strp (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CARESENS N TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CARETOUCH TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CLEVER CHOICE MICRO TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CLEVER CHOICE PRO TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CLEVER CHOICE TALK TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CLEVER CHOICE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CLEVER CHOICE VOICE+ TST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CONTOUR NEXT TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
CONTOUR TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
COOL GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
cvs advanced glucose test str (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
DIATRUE PLUS TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY PLUS II TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY STEP GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY TALK GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY TOUCH GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY TRAK GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASY TRAK II TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization Required.
EASYGLUCO PLUS TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASYGLUCO TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASYMAX 15 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EASYMAX GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ELEMENT COMPACT TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ELEMENT TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
EMBRACE EVO TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EMBRACE GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EMBRACE PRO TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EMBRACE TALK TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EMBRACE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
eq blood glucose test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EVENCARE G2 TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EVENCARE G3 TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EVENCARE MINI GLUCOSE TEST STR *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EVENCARE PROVIEW TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EVOLUTION TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EZ SMART PLUS TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
EZ SMART TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FIFTY50 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA 6 CONNECT GLUCOSE STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required.
FORA BLOOD GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA D15G GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA D20 GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA D40-G31 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA G20 GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA G30-PREMIUM V10 TEST STRP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA GD50 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA GTEL GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA TN'G VOICE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA V10 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA V10-V12-D10-D20 STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA V12 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
FORA V20 GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORA V30A GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORACARE GD20 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORACARE GD40 GLUCOSE STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FORTISCARE GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE INSULINX STRIP NFRS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE INSULINX TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE INSULINX TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE LITE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE LITE TEST STRIP NFRS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE PREC NEO TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
FREESTYLE TEST STRIPS NFRS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GE100 BLOOD GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
genstrip glucose test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GHT BLOOD GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCO NAVII GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 300 EA over 90 days.
GLUCO NAVII GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCARD 01 SENSOR PLUS STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCARD EXPRESSION TEST STRP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCARD SHINE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCARD VITAL SENSOR STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCARD VITAL TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GLUCOCOM GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GNP EASY TOUCH GLUC TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GOJJI BLOOD GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
GOJJI LANCET 30G-GLUC TST STRP *(lancets with blood glucose test strips)*	PA,QL	Prior Authorization required.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
gs blood glucose test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
HARMONY GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
HEALTHPRO GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
humana true metrix test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
IGLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
INFINITY TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
INFINITY VOICE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
kro premium blood glucose test (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
MICRODOT TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
MICRODOT XTRA TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
MYGLUCOHEALTH TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
NEUTEK 2TEK TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
NOVA MAX GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ON CALL EXPRESS TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ON CALL PLUS TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ON CALL VIVID TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ONETOUCH VERIO TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 300 EA over 90 days.
OPTIUM EZ TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
OPTIUM TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
OPTUMRX TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PHARMACIST CHOICE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
pharmacist choice test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRECISION PCX PLUS TEST STR *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRECISION PCX TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRECISION POINT OF CARE STR *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRECISION Q-I-D TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRECISION XTRA TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
premium blood glucose test str (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
premium blood glucose tst strp (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PREMIUM V10 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRO VOICE V8-V9 TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
PRODIGY NO CODING TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
QUINTET AC GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
QUINTET GLUCOSE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
REFUAH PLUS TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
relion confirm-micro test strp (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
relion micro test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
relion premier test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
relion prime test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
RELION TRUE METRIX TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
relion ultima test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
REVEAL TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
rexall blood glucose test strp (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
RIGHTEST GS100 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
RIGHTEST GS300 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
RIGHTEST GS550 TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
smart sense test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
SMARTEST TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
SOLUS V2 AUDIBLE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
SURE-TEST EASYPLUS MINI STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
TELCARE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
TEST N'GO GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
TRUE METRIX GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
true metrix glucose test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

GLUCOSE MONITORING SUPPLIES : TEST STRIPS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
true metrix pro test strip (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
truetest glucose test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
truetrack glucose test strips (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ULTIMA TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ULTRATRAK TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
ULTRATRAK ULTIMATE TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
UNISTRIP1 GLUCOSE TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
up & up blood glucose tst strp (ONETOUCH ULTRA BLUE TEST STRP)	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
VERASENS TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
VIVAGUARD INO TEST STRIP *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
WAVESENSE JAZZ TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
WAVESENSE PRESTO TEST STRIPS *(blood sugar diagnostic)*	PA,QL	Prior Authorization required. Limited to 360 EA over 90 days.
Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
BEST FIBER POWDER *(wheat dextrin)*	QL	
bisa-lax ec 5 mg tablet (ALOPHEN PILLS)	QL	
bisacodyl 10 mg suppository (DULCOLAX)	QL	
bisacodyl ec 5 mg tablet (BISACODYL)	QL	
BISCOLAX 10 MG SUPPOSITORY *(bisacodyl)*	QL	
child glycerin suppository (SANI-SUPP)	QL	
citrate of magnesia soln (CITROMA)	QL	
CITRUCEL 500 MG CAPLET *(methylcellulose)*	QL	
CITRUCEL POWDER *(methylcellulose (with sugar))*	QL	
CITRUCEL POWDER S-F *(methylcellulose)*	QL	
clearlax powder (CLEARLAX)	QL	
clearlax powder packet (GAVILAX)	QL	
COLACE 100 MG CAPSULE *(docusate sodium)*	QL	
COLACE 2-IN-1 TABLET *(sennosides/docusate sodium)*	QL	
COLACE CLEAR 50 MG SOFTGEL *(docusate sodium)*	QL	
COLACE-T 100 MG CAPSULE *(docusate sodium)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs bisacodyl 10 mg suppos (DULCOLAX)	QL	
cvs bisacodyl ec 5 mg tablet (BISACODYL)	QL	
cvs fiber laxative 625 mg cplt (FIBER)	QL	
cvs fiber therapy 500 mg caplt (CITRUCEL)	QL	
cvs gentle laxative 10 mg supp (DULCOLAX)	QL	
cvs gentle laxative ec 5 mg tb (ALOPHEN PILLS)	QL	
cvs glycerin suppository (SANI-SUPP)	QL	
cvs milk of magnesia susp (DULCOLAX)	QL	
cvs natural daily fiber powder (GERI-MUCIL)	QL	
cvs purelax powder (CLEARLAX)	QL	
cvs purelax powder packet (GAVILAX)	QL	
cvs senna laxative 8.6 mg tab (EVAC-U-GEN)	QL	
cvs senna plus tablet (COLACE 2-IN-1)	QL	
cvs stool softener 100 mg cap (COLACE)	QL	
cvs stool softener 100 mg sftg (COLACE)	QL	
cvs stool softener 240 mg sfgl (KAOPECTATE)	QL	
cvs stool softener 250 mg sfgl (DSS)	QL	
cvs stool softener 50 mg sftgl (COLACE CLEAR)	QL	
cvs stool softener-laxative tb (COLACE 2-IN-1)	QL	
cvs stool softener-stim lax tb (COLACE 2-IN-1)	QL	
DOC-Q-LACE 100 MG SOFTGEL *(docusate sodium)*	QL	
DOCU LIQUID 100 MG/10 ML *(docusate sodium)*	QL	
DOCU LIQUID 50 MG/5 ML *(docusate sodium)*	QL	
docusate cal 240 mg softgel (KAOPECTATE)	QL	
docusate sodium 100 mg capsule (GENASOFT)	QL	
docusate sodium 100 mg softgel (GENASOFT)	QL	
docusate sodium 100 mg tablet (REGUTOL)	QL	
docusate sodium 250 mg softgel (DOK)	QL	
docusate sodium 50 mg/5 ml liq (DIOCTO)	QL	
docusate sodium-senna tablet (COLACE 2-IN-1)	QL	
docusil 100 mg softgel (COLACE)	QL	
DOK 100 MG SOFTGEL *(docusate sodium)*	QL	
DOK 100 MG TABLET *(docusate sodium)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
DOK PLUS TABLET *(sennosides/docusate sodium)*	QL	
ducodyl ec 5 mg tablet (ALOPHEN PILLS)	QL	
DULCOLAX 10 MG SUPPOSITORY *(bisacodyl)*	QL	
DULCOLAX EC 5 MG TABLET *(bisacodyl)*	QL	
ENEMA *(sodium phosphate,monobasic/sodium phosphate,dibasic)*	QL	
enema ready to use (ENEMA)	QL	
ENEMA READY TO USE *(sodium phosphate,monobasic/sodium phosphate,dibasic)*	QL	
eq clearlax powder (CLEARLAX)	QL	
eq gentle laxative dr 5 mg tab (ALOPHEN PILLS)	QL	
eq stool softener 100 mg sftgl (COLACE)	QL	
EX-LAX PILLS *(sennosides)*	QL	
fiber laxative 625 mg caplet (FIBER)	QL	
fiber laxative 625 mg tablet (FIBER)	QL	
fiber laxative capsule (METAMUCIL)	QL	
FIBER TABLET *(calcium polycarbophil)*	QL	
fiber tabs (FIBER)	QL	
fiber therapy 500 mg caplet (CITRUCEL)	QL	
fiber therapy caplet (CITRUCEL)	QL	
FIBER THERAPY POWDER *(methylcellulose (with sugar))*	QL	
FIBER-LAX CAPTABS *(calcium polycarbophil)*	QL	
FIBERCON 625 MG CAPLET *(calcium polycarbophil)*	QL	
FLEET BISACODYL EC 5 MG TAB *(bisacodyl)*	QL	
FLEET ENEMA *(sodium phosphate,monobasic/sodium phosphate,dibasic)*	QL	
FLEET GLYCERIN 2 GM ADULT SUPP *(glycerin)*	QL	
FLEET GLYCERIN ADULT SUPPOS *(glycerin)*	QL	
FLEET PEDIA-LAX SUPPOSITORIES *(glycerin)*	QL	
GAVILAX POWDER *(polyethylene glycol 3350)*	QL	
gentle laxative 10 mg supposit (DULCOLAX)	QL	
gentle laxative ec 5 mg tablet (ALOPHEN PILLS)	QL	
GERI-KOT 8.6 MG TABLET *(sennosides)*	QL	
glycerin suppository (SANI-SUPP)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
GLYCOLAX POWDER *(polyethylene glycol 3350)*	QL	
gs clearlax powder (CLEARLAX)	QL	
gs milk of magnesia suspension (DULCOLAX)	QL	
gs senna laxative 8.6 mg tab (EVAC-U-GEN)	QL	
hm clearlax powder (CLEARLAX)	QL	
hm fiber 0.52 gram capsule (METAMUCIL)	QL	
hm fiber 500 mg caplet (CITRUCEL)	QL	
hm fiber powder (GERI-MUCIL)	QL	
hm fiber powder (GERI-MUCIL)	QL	
HM FIBER POWDER *(psyllium husk (with sugar))*	QL	
hm laxative ec 5 mg tablet (ALOPHEN PILLS)	QL	
hm magnesium citrate solution (CITROMA)	QL	
hm milk of magnesia suspension (DULCOLAX)	QL	
hm senna 8.6 mg tablet (EVAC-U-GEN)	QL	
hm senna-s tablet (COLACE 2-IN-1)	QL	
hm stool softener 100 mg sftgl (COLACE)	QL	
hm stool softener 100 mg tab (DOCUPRENE)	QL	
hm stool softener 250 mg sftgl (DSS)	QL	
hm stool softener-laxative tab (COLACE 2-IN-1)	QL	
hm stool softener-stim lax tab (COLACE 2-IN-1)	QL	
HYDROCIL INSTANT POWDER *(psyllium seed)*	QL	
KAO-TIN 240 MG SOFTGEL *(docusate calcium)*	QL	
KAOPECTATE 240 MG SOFTGEL *(docusate calcium)*	QL	
KONSYL 520 MG CAPSULE *(psyllium husk)*	QL	
KONSYL 6 GM PACKET *(psyllium husk)*	QL	
KONSYL FIBER 625 MG CAPLET *(calcium polycarbophil)*	QL	
KONSYL FORMULA-D FIBER POWDER *(psyllium husk (with dextrose))*	QL	
KONSYL ORIGINAL FIBER POWDER *(psyllium husk)*	QL	
KONSYL PSYLLIUM FIBER POWDER *(psyllium husk (with sugar))*	QL	
laxative 15 mg pills (EX-LAX)	QL	
laxative 15 mg tablet (EX-LAX)	QL	
laxative ec 5 mg tablet (ALOPHEN PILLS)	QL	
LAXATIVE EC 5 MG TABLET *(bisacodyl)*	QL	

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Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
magnesium citrate solution (CITROMA)	QL	
METAMUCIL FIBER SINGLES PACKET *(psyllium husk/aspartame)*	QL	
METAMUCIL POWDER *(psyllium husk)*	QL	
METAMUCIL POWDER *(psyllium husk/aspartame)*	QL	
METAMUCIL POWDER *(psyllium seed (with sugar))*	QL	
METAMUCIL SUGAR-FREE POWDER *(psyllium husk/aspartame)*	QL	
milk of magnesia suspension (DULCOLAX)	QL	
milk of magnesia suspension (PHILLIPS' MILK OF MAGNESIA)	QL	
MIRALAX POWDER *(polyethylene glycol 3350)*	QL	
NATURAL FIBER LAX POWDER *(psyllium husk (with sugar))*	QL	
NATURAL FIBER LAX POWDER *(psyllium seed (with dextrose))*	QL	
NATURAL FIBER LAX POWDER *(psyllium seed (with sugar))*	QL	
natural fiber laxative capsule (METAMUCIL)	QL	
natural fiber powder (GERI-MUCIL)	QL	
natural fiber powder (GERI-MUCIL)	QL	
natural fiber powder (METAMUCIL)	QL	
NUTRISOURCE FIBER POWDER *(guar gum)*	QL	
PERDIEM OVERNIGHT RELIEF TB *(sennosides)*	QL	
PHILLIPS' MILK OF MAGNESIA *(magnesium hydroxide)*	QL	
polyethylene glycol 3350 powd (MIRALAX)	QL	
qc gentle laxative 10 mg supp (DULCOLAX)	QL	
qc magnesium citrate solution (CITROMA)	QL	
qc milk of magnesia suspension (DULCOLAX)	QL	
qc natura-lax 17 gm powder (CLEARLAX)	QL	
qc natural veg laxative tablet (EVAC-U-GEN)	QL	
qc natural vegetable powder (HYDROCIL INSTANT)	QL	
QC NATURAL VEGETABLE POWDER *(psyllium seed (with dextrose))*	QL	
qc stool softener 100 mg sftgl (COLACE)	QL	
qc stool softener-laxative tab (COLACE 2-IN-1)	QL	
qc women's laxative ec 5 mg tb (ALOPHEN PILLS)	QL	
REGULOID 3.4 G/12 G POWDER *(psyllium husk (with sugar))*	QL	

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Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
REGULOID 3.4 G/7 G POWDER *(psyllium husk (with sugar))*	QL	
REGULOID LAXATIVE POWDER *(psyllium seed)*	QL	
sb bisacodyl ec 5 mg tablet (BISACODYL)	QL	
sb docusate sod 100 mg capsule (GENASOFT)	QL	
SENEXON 8.6 MG TABLET *(sennosides)*	QL	
SENEXON-S 50-8.6 MG TABLET *(sennosides/docusate sodium)*	QL	
SENEXON-S TABLET *(sennosides/docusate sodium)*	QL	
senna 8.6 mg tablet (EVAC-U-GEN)	QL	
SENNA 8.6 MG TABLET *(sennosides)*	QL	
senna 8.8 mg/5 ml syrup (SENEXON)	QL	
senna 8.8 mg/5 ml syrup grx (SENEXON)	QL	
senna lax 8.6 mg tablet (EVAC-U-GEN)	QL	
senna laxative 8.6 mg tablet (EVAC-U-GEN)	QL	
senna plus 8.6-50 mg tablet (COLACE 2-IN-1)	QL	
senna plus tablet (COLACE 2-IN-1)	QL	
SENNA PLUS TABLET *(sennosides/docusate sodium)*	QL	
SENNA SYRUP *(senna leaf extract)*	QL	
senna-lax 8.6 mg tablet (EVAC-U-GEN)	QL	
SENNA-LAX 8.6 MG TABLET *(sennosides)*	QL	
SENNA-S TABLET *(sennosides/docusate sodium)*	QL	
SENNA-TIME 8.6 MG TABLET *(sennosides)*	QL	
SENNA-TIME S TABLET *(sennosides/docusate sodium)*	QL	
senno tablet (EVAC-U-GEN)	QL	
sennosides-docusate sodium tab (COLACE 2-IN-1)	QL	
SENOKOT 8.6 MG TABLET *(sennosides)*	QL	
SENOKOT-S TABLET *(sennosides/docusate sodium)*	QL	
SILACE 50 MG/5 ML LIQUID *(docusate sodium)*	QL	
SILACE 60 MG/15 ML SYRUP *(docusate sodium)*	QL	
sm clearlax powder (CLEARLAX)	QL	
sm fiber 625 mg caplet (FIBER)	QL	
sm fiber laxative 500 mg cplt (CITRUCEL)	QL	
SM FIBER POWDER *(psyllium husk (with sugar))*	QL	
SM FIBER POWDER *(psyllium seed (with dextrose))*	QL	

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Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
sm fiber smooth powder (HYDROCIL INSTANT)	QL	
sm fiber smooth texture pwd (METAMUCIL)	QL	
sm gentle laxative ec 5 mg tab (ALOPHEN PILLS)	QL	
sm glycerin pediatric suppo (SANI-SUPP)	QL	
sm laxative 10 mg suppository (DULCOLAX)	QL	
sm laxative pediatric suppos (PEDIA-LAX)	QL	
sm magnesium citrate solution (CITROMA)	QL	
sm milk of magnesia suspension (DULCOLAX)	QL	
sm milk of magnesia suspension (PHILLIPS' MILK OF MAGNESIA)	QL	
sm nat lax plus stool softener (COLACE 2-IN-1)	QL	
sm senna laxative 8.6 mg tab (EVAC-U-GEN)	QL	
sm senna-s tablet (COLACE 2-IN-1)	QL	
sm stool softener 100 mg sftgl (COLACE)	QL	
sm stool softener 100 mg tab (DOCUPRENE)	QL	
sm stool softener 240 mg sftgl (KAOPECTATE)	QL	
sm stool softener 250 mg sftgl (DSS)	QL	
sm stool softener-laxative tab (COLACE 2-IN-1)	QL	
smoothlax powder (CLEARLAX)	QL	
smoothlax powder packet (GAVILAX)	QL	
SOF-LAX 100 MG GELCAP *(docusate sodium)*	QL	
stool softener 100 mg capsule (COLACE)	QL	
STOOL SOFTENER 100 MG CAPSULE *(docusate sodium)*	QL	
stool softener 100 mg softgel (COLACE)	QL	
STOOL SOFTENER 100 MG SOFTGEL *(docusate sodium)*	QL	
STOOL SOFTENER 240 MG SOFTGEL *(docusate calcium)*	QL	
stool softener 250 mg softgel (DSS)	QL	
stool softener 50 mg/5 ml liq (DIOCTO)	QL	
stool softener 60 mg/15 ml syr (DIOCTO)	QL	
STOOL SOFTENER-LAXATIVE TABLET *(sennosides/docusate sodium)*	QL	
stool softener-stim lax tablet (COLACE 2-IN-1)	QL	
sw clearlax powder (CLEARLAX)	QL	
vegetable lax-stool softnr tab (COLACE 2-IN-1)	QL	
wal-mucil 100% natural fiber (GERI-MUCIL)	QL	

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Drug List

Laxatives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
women's gentle lax ec 5 mg tab (ALOPHEN PILLS)	QL	
women's laxative ec 5 mg tab (ALOPHEN PILLS)	QL	
Medical Supplies and DME - Applicators and Cotton Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cotton swabs (CURITY)	QL	
CURITY COTTON TIP APPLICATOR *(swab)*	QL	
cvs cotton swabs (CURITY)	QL	
cvs plastic swabs (CURITY)	QL	
gnp cotton swabs (CURITY)	QL	
hm cotton swabs (CURITY)	QL	
leader cotton swabs (CURITY)	QL	
NO-STING SKIN-PREP SWAB *(swab)*	QL	
Q-TIPS WOOD STICK APPL. 3" *(swab)*	QL	
Q-TIPS WOOD STICK APPL. 6" *(swab)*	QL	
ra cotton swabs (CURITY)	QL	
sm cotton swabs (CURITY)	QL	
TOOTHETTE DISPOSABLE ORAL SWAB *(swab)*	QL	
Medical Supplies and DME - Bandages-Dressings-Tape		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs gauze pads 4" x 4" (BAND-AID GAUZE PADS)	QL	
gauze dressing 4"x4" (BAND-AID GAUZE PADS)	QL	
gauze pads 4"x4" (BAND-AID GAUZE PADS)	QL	
ra gauze pads 4" x 4" (BAND-AID GAUZE PADS)	QL	
ra sterile pads 4"x4" (BAND-AID GAUZE PADS)	QL	
sm sterile pads 4" x 4" (BAND-AID GAUZE PADS)	QL	
sterile pads 4" x 4" (BAND-AID GAUZE PADS)	QL	
Medical Supplies and DME - Contraceptives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
AIMSCO LATEX CONDOM *(condoms, latex, lubricated)*	QL	
CONDOMS LUBRICATED *(condoms, latex, lubricated)*	QL	

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Medical Supplies and DME - Contraceptives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
FANTASY CONDOM *(condoms, latex, lubricated)*	QL	
KIMONO CONDOMS *(condoms, latex, non-lubricated)*	QL	
KIMONO MAXX CONDOM *(condoms, latex, non-lubricated)*	QL	
KIMONO MICROTHIN AQUA LUBE *(condoms, latex, lubricated)*	QL	
KIMONO MICROTHIN CONDOM *(condoms, latex, non-lubricated)*	QL	
KIMONO MICROTHIN LARGE CONDOM *(condoms, latex, lubricated)*	QL	
KIMONO TEXTURED CONDOM *(condoms, latex, lubricated)*	QL	
TRUSTEX CONDOM *(condoms, latex, lubricated)*	QL	
TRUSTEX CONDOM *(condoms, latex, non-lubricated)*	QL	
TRUSTEX LATEX CONDOM *(condoms, latex, lubricated)*	QL	
TRUSTEX-RIA CONDOM *(condoms, latex, lubricated)*	QL	
TRUSTEX-RIA CONDOM *(condoms, latex, non-lubricated)*	QL	

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
1st tier comfortouch 28g lanct (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
1st tier comfortouch 30g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
1st tier unifine pentp 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
1st tier unifine pntip 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
1st tier unifine pntip 6mm 31g (CAREFINE PEN NEEDLE)	QL	
1st tier unifine pntip 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
1st tier unifine pntp 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
1st tier unifine pntp 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	
1st tier unifine pntp 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
1st tier unifine pntp 31gx3/16 (ABOUTTIME PEN NEEDLE)	QL	
1st tier unifine pntp 31gx5/16 (ABOUTTIME PEN NEEDLE)	QL	
1st tier unifine pntp 32gx5/32 (ABOUTTIME PEN NEEDLE)	QL	
ACCU-CHEK FASTCLIX LANCET DRUM *(lancets)*	QL	Limited to 408 EA over 90 days.

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ACCU-CHEK FASTCLIX LANCING DEV *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK MULTICLIX LANCET KIT *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK MULTICLIX LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ACCU-CHEK SAFE-T-PRO 23G LANCT *(lancets)*	QL	Limited to 400 EA over 90 days.
ACCU-CHEK SAFE-T-PRO PLUS 23G *(lancets)*	QL	Limited to 400 EA over 90 days.
ACCU-CHEK SOFTCLIX LANCET KIT *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ACCU-CHEK SOFTCLIX LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
acti-lance lite 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
ACTI-LANCE LITE 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
acti-lance special 17g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
ACTI-LANCE SPECIAL 17G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
acti-lance univers 23g lancets (ACCU-CHEK SAFE-T-PRO)	QL	Limited to 400 EA over 90 days.
ACTI-LANCE UNIVERS 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ADJUSTABLE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
advanced lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
advanced travel 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
advanced travel 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ADVOCATE 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ADVOCATE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ADVOCATE CONTROL SOLUTION HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ADVOCATE CONTROL SOLUTION LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ADVOCATE INS 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ADVOCATE INS 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ADVOCATE INS 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
ADVOCATE INS 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
ADVOCATE INS 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ADVOCATE INS SYR 0.3ML 29GX1/2 *(syringe with needle,insulin,0.3 ml)*	QL	
ADVOCATE INS SYR 0.5ML 29GX1/2 *(syringe with needle,insulin,0.5 ml)*	QL	

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ADVOCATE INS SYR 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ADVOCATE INS SYR 1 ML 30GX5/16 *(syringe with needle,disposable,insulin 1 ml)*	QL	
ADVOCATE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE PEN NDL 12.7MM 29G *(pen needle, diabetic)*	QL	
ADVOCATE PEN NEEDLE 4MM 33G *(pen needle, diabetic)*	QL	
ADVOCATE PEN NEEDLES 5MM 31G *(pen needle, diabetic)*	QL	
ADVOCATE PEN NEEDLES 8MM 31G *(pen needle, diabetic)*	QL	
ADVOCATE RAPID-SAFE LANCING *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ADVOCATE REDI-CODE+ CTRL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ADVOCATE REDI-CODE+ CTRL SOLN *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
AGAMATRIX HIGH CONTROL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
alternate site 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ALTERNATE SITE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
AQUA LANCE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ASSURE COMFORT 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE HAEMOLANCE PLUS 21G *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE HAEMOLANCE PLUS 25G *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE HAEMOLANCE PLUS 28G *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE HAEMOLANCE PLUS BLADE *(blade lancet, safety)*	QL,FL	Limited to 400 EA over 90 days.
ASSURE LANCE 25G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE LANCE 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE LANCE 28G SAFETY LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE LANCE PLUS 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE LANCE PLUS 25G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ASSURE LANCE PLUS 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
AUTO-LANCET MINI LANCING DEV *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
AUTOLET IMPRESS LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

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Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
AUTOLET IMPRESSION LANCING DEV *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
AUTOLET PLUS LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
BD ECLIPSE 30GX1/2" SYRINGE *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INS SYR UF 0.3ML 12.7MMX30G *(syringe with needle,insulin,0.3 ml)*	QL	
BD INS SYR UF 0.5ML 12.7MMX30G *(syringe with needle,insulin,0.5 ml)*	QL	
BD INS SYRN UF 1 ML 12.7MMX30G *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INS SYRNG 0.3 ML 29GX12.7MM *(syringe with needle,insulin,0.3 ml)*	QL	
BD INS SYRNG 0.5 ML 29GX12.7MM *(syringe with needle,insulin,0.5 ml)*	QL	
BD INS SYRNG UF 0.3 ML 8MMX31G *(syringe with needle,insulin,0.3 ml)*	QL	
BD INS SYRNG UF 0.5 ML 8MMX31G *(syringe with needle,insulin,0.5 ml)*	QL	
BD INSULIN SYR 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
BD INSULIN SYR 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
BD INSULIN SYR 1 ML 25GX1" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 25GX5/8" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 26GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 27GX12.7MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 27GX5/8" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR 1 ML 29GX12.7MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYR UF 1 ML 8MMX31G *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD INSULIN SYRINGE 1 ML *(syringe without needle,insulin disposible, 1 ml)*	QL	
BD LANCETS 33G *(lancets)*	QL	Limited to 400 EA over 90 days.
BD LUER-LOK SYRINGE 1 ML *(syringe without needle,insulin disposible, 1 ml)*	QL	
BD MICROTAINER 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
BD MICROTAINER 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
BD MICROTAINER LANCETS *(blade lancet, safety)*	QL	Limited to 400 EA over 90 days.
BD NANO 2 GEN PEN NDL 32GX4MM *(pen needle, diabetic)*	QL	

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
BD SAFETGLD INS 0.3 ML 8MMX31G *(syringe with needle,insulin,0.3 ml)*	QL	
BD SAFETGLD INS 0.3ML 13MMX29G *(syringe with needle,insulin,0.3 ml)*	QL	
BD SAFETGLD INS 0.5 ML 8MMX30G *(syringe with needle,insulin,0.5 ml)*	QL	
BD SAFETGLD INS 0.5ML 13MMX29G *(syringe with needle,insulin,0.5 ml)*	QL	
BD SAFETYGLD INS 1 ML 13MMX29G *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD SAFETYGLIDE SYRINGE 27GX5/8 *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD UF MICRO PEN NEEDLE 6MMX32G *(pen needle, diabetic)*	QL	
BD UF MINI PEN NEEDLE 5MMX31G *(pen needle, diabetic)*	QL	
BD UF NANO PEN NEEDLE 4MMX32G *(pen needle, diabetic)*	QL	
BD UF ORIG PEN NDL 12.7MMX29G *(pen needle, diabetic)*	QL	
BD UF SHORT PEN NEEDLE 8MMX31G *(pen needle, diabetic)*	QL	
BD ULTRA-FINE 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
BD ULTRA-FINE II 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
BD VEO INS SYRING 1 ML 6MMX31G *(syringe with needle,disposable,insulin 1 ml)*	QL	
BD VEO INS SYRN 0.3 ML 6MMX31G *(syringe with needle,insulin,0.3 ml)*	QL	
BD VEO INS SYRN 0.5 ML 6MMX31G *(syringe with needle,insulin,0.5 ml)*	QL	
BLOOD LANCETS 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
BREEZE 2 SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
BREEZE 2 SOLUTION *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
BULLSEYE MINI SAFETY 21G *(lancets)*	QL	Limited to 400 EA over 90 days.
BULLSEYE MINI SAFETY 25G LANCT *(lancets)*	QL	Limited to 400 EA over 90 days.
BULLSEYE MINI SAFETY 28G LANCT *(lancets)*	QL	Limited to 400 EA over 90 days.
ca ins syr 0.3 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ca ins syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ca ins syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ca ins syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ca insulin syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ca insulin syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ca insulin syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ca insulin syr 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ca insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
CAREFINE PEN NEEDLE 12.7MM 29G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLE 4MM 32G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLE 5MM 32G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLE 6MM 31G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLE 8MM 30G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLES 6MM 32G *(pen needle, diabetic)*	QL	
CAREFINE PEN NEEDLES 8MM 31G *(pen needle, diabetic)*	QL	
CARELANCE ULT LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CAREONE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CAREONE SYR 0.3 ML 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
CAREONE SYR 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
CAREONE SYR 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
CAREONE SYR 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
CAREONE SYR 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
CAREONE SYR 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
CAREONE THIN LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
careone ultra thin lancet (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
CAREONE ULTRA THIN LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
careone unifine pentip 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
CAREONE UNIFINE PENTIP 4MM 32G *(pen needle, diabetic)*	QL	
careone unifine pentip 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
CAREONE UNIFINE PENTIP 5MM 31G *(pen needle, diabetic)*	QL	
careone unifine pentip 6mm 31g (CAREFINE PEN NEEDLE)	QL	
careone unifine pentip 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
careone unifine pentp 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CAREONE UNIFINE PENTP 29GX1/2" *(pen needle, diabetic)*	QL	
careone unifine pentp 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
CAREONE UNIFINE PENTP 31GX1/4" *(pen needle, diabetic)*	QL	
careone unifine pntp 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
careone unifine pntp 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
CAREONE UNIFINE PNTP 31GX3/16" *(pen needle, diabetic)*	QL	
careone unifine pntp 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
CAREONE UNIFINE PNTP 31GX5/16" *(pen needle, diabetic)*	QL	
careone unifine pntp 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
CAREONE UNIFINE PNTP 32GX5/32" *(pen needle, diabetic)*	QL	
CARESENS PREM LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CARESENS ULTRA THIN 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
CARETOUCH 26G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
CARETOUCH 28G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
CARETOUCH LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
CARETOUCH PEN NEEDLE 31GX1/4" *(pen needle, diabetic)*	QL	
CARETOUCH PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
CARETOUCH PEN NEEDLE 31GX5/16" *(pen needle, diabetic)*	QL	
CARETOUCH PEN NEEDLE 32GX3/16" *(pen needle, diabetic)*	QL	
CARETOUCH PEN NEEDLE 32GX5/32" *(pen needle, diabetic)*	QL	
CARETOUCH SYR 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
CARETOUCH SYR 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
CARETOUCH SYR 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
CARETOUCH SYR 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
CARETOUCH SYR 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
CARETOUCH TWIST 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
CARETOUCH TWIST 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CARETOUCH TWIST 33G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
CLEVER CHEK ULTRA THIN 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
CLEVER CHOICE LVL 1 CONTRL SOL *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
CLEVER CHOICE LVL 3 CONTRL SOL *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
clickfine 31g x 1/4" needles (CAREFINE PEN NEEDLE)	QL	
clickfine 31g x 5/16" needles (ABOUTTIME PEN NEEDLE)	QL	
clickfine pen needle 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
clickfine universal 31g x 1/4" (CAREFINE PEN NEEDLE)	QL	
clickfine universal 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
COAGUCHEK LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
COMFORT EZ INS 0.3ML 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
COMFORT EZ INS 0.5ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
COMFORT EZ INS 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
COMFORT EZ PEN NEEDLES 4MM 32G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 4MM 33G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 5MM 31G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 5MM 32G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 6MM 31G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 6MM 32G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 8MM 31G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 8MM 32G *(pen needle, diabetic)*	QL	
COMFORT EZ PEN NEEDLES 8MM 33G *(pen needle, diabetic)*	QL	
COMFORT EZ SAFETY 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
COMFORT EZ SAFETY 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
COMFORT EZ SAFETY 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
COMFORT EZ SYR 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
COMFORT EZ SYR 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
COMFORT EZ SYR 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
comfort lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
COMFORT POINT PEN NDL 29GX1/2" *(pen needle, diabetic)*	QL	
COMFORT POINT PEN NDL 31GX1/4" *(pen needle, diabetic)*	QL	
CONTOUR NEXT LEV 1 CONTROL SOL *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
CONTOUR SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
CONTOUR SOLUTION *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
COOL CONTROL B SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
cvs lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
cvs micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
cvs thin 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
cvs ultra thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
CVS ULTRA THIN 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
DARIO 100 STERILE LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
DIASTIX REAGENT STRIPS *(urine glucose test strip)*	QL	
DIATRUE LEVEL 1 CONTROL SOLN *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
DIATRUE LEVEL 3 CONTROL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
droplet 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
droplet ins 0.3 ml 29gx12.5mm (ADVOCATE SYRINGES)	QL	
droplet ins 0.3ml 30gx12.5mm (COMFORT EZ INSULIN SYRINGE)	QL	
droplet ins syr 0.3 ml 30gx8mm (ADVOCATE SYRINGES)	QL	
droplet ins syr 0.3 ml 31gx8mm (ADVOCATE SYRINGES)	QL	
droplet ins syr 1 ml 30gx8mm (ADVOCATE SYRINGES)	QL	
droplet ins syr 1 ml 31gx8mm (ADVOCATE SYRINGES)	QL	
droplet ins syr 1ml 29gx12.5mm (ADVOCATE SYRINGES)	QL	
droplet ins syr 1ml 30gx12.5mm (COMFORT EZ INSULIN SYRINGE)	QL	
DROPLET LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
DROPLET PEN NEEDLE 29GX1/2" *(pen needle, diabetic)*	QL	
DROPLET PEN NEEDLE 31GX1/4" *(pen needle, diabetic)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
DROPLET PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
DROPLET PEN NEEDLE 31GX5/16" *(pen needle, diabetic)*	QL	
DROPLET PEN NEEDLE 32GX5/32" *(pen needle, diabetic)*	QL	
drug mart ultra comfort syr (ADVOCATE SYRINGES)	QL	
drug mart ultra comfort syr (ADVOCATE SYRINGES)	QL	
drug mart ultra comfort syr (ADVOCATE SYRINGES)	QL	
e-z ject colored lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
e-z ject lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
E-Z PULL & CLICK LANCING DEV *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
e-zject color 32g lancets (EASY TOUCH)	QL	Limited to 400 EA over 90 days.
e-zject color 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
e-zject super thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
e-zject thin lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
EASY CLICK LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY COMFORT 0.3 ML SYRINGE *(syringe with needle,insulin,0.3 ml)*	QL	
EASY COMFORT 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY COMFORT PEN NDL 31GX3/16" *(pen needle, diabetic)*	QL	
EASY COMFORT PEN NDL 31GX5/16" *(pen needle, diabetic)*	QL	
EASY COMFORT PEN NDL 33G 4MM *(pen needle, diabetic)*	QL	
EASY COMFORT PEN NDL 33G 5MM *(pen needle, diabetic)*	QL	
EASY COMFORT PEN NDL 33G 6MM *(pen needle, diabetic)*	QL	
EASY GLIDE INS 0.3 ML 31GX6MM *(syringe with needle,insulin,0.3 ml)*	QL	
EASY GLIDE INS 0.5 ML 31GX6MM *(syringe with needle,insulin,0.5 ml)*	QL	
EASY GLIDE INS 1 ML 31GX6MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
EASY PLUS II CONTROL SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY PLUS II CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY STEP CONTRL SOLN-HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY STEP CONTROL SOLN-LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
EASY TALK CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY TALK HIGH CONTROL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY TOUCH 0.3 ML SYR 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
EASY TOUCH 0.5 ML SYR 27GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
EASY TOUCH 0.5 ML SYR 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
EASY TOUCH 1 ML SYR 27GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
EASY TOUCH 1 ML SYR 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
EASY TOUCH BUTTON 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH INSULIN SYR 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
EASY TOUCH INSULIN SYR 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
EASY TOUCH INSULIN SYR 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
EASY TOUCH LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
EASY TOUCH LUER LOK INSUL 1 ML *(syringe without needle,insulin disposible, 1 ml)*	QL	
EASY TOUCH PEN NEEDLE 29GX1/2" *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 30GX5/16 *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 31GX1/4" *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 31GX3/16 *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 31GX5/16 *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 32GX1/4" *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 32GX3/16 *(pen needle, diabetic)*	QL	
EASY TOUCH PEN NEEDLE 32GX5/32 *(pen needle, diabetic)*	QL	
EASY TOUCH PULL-TOP 26G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH PULL-TOP 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH PULL-TOP 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH PULL-TOP 32G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH SAFETY 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH SAFETY 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
EASY TOUCH SAFETY 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH SAFETY 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH SAFETY 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH SAFETY 32G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH TWIST 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH TWIST 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH TWIST 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH TWIST 32G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH TWIST 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY TOUCH UNI-SLIP SYR 1 ML *(syringe without needle,insulin disposible, 1 ml)*	QL	
EASY TRAK CONTROL SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY TRAK CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASY TWIST & CAP 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EASY-TOUCH INS 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
EASYMAX 15 LEVEL 1 SOLUTION *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EASYMAX LOW CONTROL SOLN *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ELEMENT COMPACT SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ELEMENT CONTROL SOLUTION HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ELEMENT CONTROL SOLUTION LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EMBRACE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EMBRACE EVO LEVEL 1 CTRL SOLN *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EMBRACE GLUC CONTROL SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EMBRACE GLUC CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EMBRACE TALK CTRL SOL-HIGH(L2) *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
EMBRACE TALK CTRL SOLN-LOW(L1) *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
eql 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
eql ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
eql insul syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
eql insul syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
eql insulin 0.3 ml syringe (INSULIN SYRINGE)	QL	
eql insulin 0.3 ml syringe (ULTILET INSULIN SYRINGE)	QL	
eql insulin 0.5 ml syringe (LITE TOUCH)	QL	
eql insulin 1 ml syringe (INSULIN SYRINGE)	QL	
eql insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
eql micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
EXEL INS SYR U100 1 ML 28GX1/2 *(syringe with needle,disposable,insulin 1 ml)*	QL	
EXEL U100 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
EXEL U100 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
EXEL U100 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
EXEL U100 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
EXEL U100 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
EXEL U100 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
EXEL U100 INS SYR 1 ML 29GX1/2 *(syringe with needle,disposable,insulin 1 ml)*	QL	
EZ SMART 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
EZ SMART HIGH CONTROL SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EZ SMART LOW CONTROL SOLUTION *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
EZ-VAC *(diabetic supplies,miscell)*	QL	
FIFTY50 INS 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
FIFTY50 INS 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
FIFTY50 INS SYR 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
FIFTY50 LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FIFTY50 PEN 31G X 3/16" NEEDLE *(pen needle, diabetic)*	QL	

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
FIFTY50 PEN 31G X 5/16" NEEDLE *(pen needle, diabetic)*	QL	
FIFTY50 PEN NEEDLE 32G X 1/4" *(pen needle, diabetic)*	QL	
FIFTY50 PEN NEEDLE 32G X 5/32" *(pen needle, diabetic)*	QL	
FIFTY50 SAFETY SEAL 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
FIFTY50 SAFETY SEAL 32G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
FIFTY50 UNILET 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FINE 30 UNIVERSAL 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FINGERSTIX LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FORA 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FORA HIGH CONTROL SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FORA LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
FORA LOW CONTROL SOLUTION *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FORACARE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FORACARE GDH HIGH CONTROL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FORACARE GDH LOW CONTROL SOLN *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FORTISCARE CONTROL SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FORTISCARE CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
FREESTYLE 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
FREESTYLE PREC 0.5 ML 30GX5/16 *(syringe with needle,insulin,0.5 ml)*	QL	
FREESTYLE PREC 0.5 ML 31GX5/16 *(syringe with needle,insulin,0.5 ml)*	QL	
FREESTYLE PREC 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
FREESTYLE PREC 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
FREESTYLE UNISTIK 2 LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
GE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
GLUCOCOM 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
GLUCOCOM 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
GLUCOCOM 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
GLUCOCOM CONTROL SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
gnp clickfine 31g x 1/4" ndl (CAREFINE PEN NEEDLE)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gnp clickfine 31g x 5/16" ndl (ABOUTTIME PEN NEEDLE)	QL	
gnp clickfine pen ndl 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
gnp clickfine pen ndl 31gx5/16 (ABOUTTIME PEN NEEDLE)	QL	
gnp ins syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
gnp insul syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
gnp insul syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
gnp insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
gnp micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
gnp ult cmfrt 0.5 ml 29gx1/2" (LITE TOUCH)	QL	
gnp ultr cmfrt 0.5 ml 28gx1/2" (LITE TOUCH)	QL	
gnp ultr cmfrt 0.5 ml 30gx5/16 (LITE TOUCH)	QL	
gnp ultr comfort 1 ml 29gx1/2" (LITE TOUCH)	QL	
gnp ultra comfort 0.5 ml syr (LITE TOUCH)	QL	
gnp ultra comfort 1 ml syringe (INSULIN SYRINGE)	QL	
gnp ultra comfort 1 ml syringe (LITE TOUCH)	QL	
gnp ultra comfort 3/10 ml syr (INSULIN SYRINGE)	QL	
gnp ultra comfrt 1 ml 28gx1/2" (LITE TOUCH)	QL	
gnp universal 1 standard 21g (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
gnp universal 1 super thin 30g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
gnp universal 1 thin 26g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
gs lancing device and lancets (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
gs pen needle 31g x 1/4" (CAREFINE PEN NEEDLE)	QL	
gs pen needle 31g x 5/16" (ABOUTTIME PEN NEEDLE)	QL	
gs pen needle 31g x 5mm (ABOUTTIME PEN NEEDLE)	QL	
gs pen needle 31g x 6mm (CAREFINE PEN NEEDLE)	QL	
gs pen needle 31g x 8mm (ABOUTTIME PEN NEEDLE)	QL	
gs pen needle 32g x 4mm (ABOUTTIME PEN NEEDLE)	QL	
gs universal 1 micro thin 33g (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gs universal 1 thin 26g lancet (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
gs universal 1 ultra thin 30g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
HEALTHWISE INS 0.3ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
HEALTHWISE INS 0.3ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
HEALTHWISE INS 0.5ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
HEALTHWISE INS 0.5ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
HEALTHWISE INS 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
HEALTHWISE INS 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
HEALTHWISE PEN NEEDLE 31G 5MM *(pen needle, diabetic)*	QL	
HEALTHWISE PEN NEEDLE 31G 8MM *(pen needle, diabetic)*	QL	
HEALTHWISE PEN NEEDLE 32G 4MM *(pen needle, diabetic)*	QL	
HEALTHY ACCENTS AUTOLET DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
healthy accents pentip 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
healthy accents pentip 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
HEALTHY ACCENTS PENTIP 5MM 31G *(pen needle, diabetic)*	QL	
healthy accents pentip 6mm 31g (CAREFINE PEN NEEDLE)	QL	
HEALTHY ACCENTS PENTIP 6MM 31G *(pen needle, diabetic)*	QL	
healthy accents pentip 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
HEALTHY ACCENTS PENTIP 8MM 31G *(pen needle, diabetic)*	QL	
healthy accents unilet 30g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
HEALTHY ACCENTS UNILET 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
heb micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
heb unifine pntp plus 31gx3/16 (ABOUTTIME PEN NEEDLE)	QL	
heb unifine pntp plus 32gx5/32 (ABOUTTIME PEN NEEDLE)	QL	
HM ULTICARE PEN NEEDLE 4MM 32G *(pen needle, diabetic)*	QL	
HM ULTICARE PEN NEEDLE 6MM 31G *(pen needle, diabetic)*	QL	
HM ULTICARE PEN NEEDLE 8MM 31G *(pen needle, diabetic)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
HYPOLANCE AST LANCING KIT *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
incontrol pen needle 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
incontrol pen needle 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
incontrol pen needle 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
incontrol pen needle 6mm 31g (CAREFINE PEN NEEDLE)	QL	
incontrol pen needle 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
incontrol super thin 30g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
incontrol ultra thin 28g lanct (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
INFINITY CONTROL SOLN HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
INFINITY CONTROL SOLN LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
INJECT EASE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
INSUL-CAP INSULIN HOLDER *(diabetic supplies,miscell)*	QL	
insulin 1 ml syringe (INSULIN SYRINGE)	QL	
insulin 1/2 ml syringe (LITE TOUCH)	QL	
insulin 3/10 ml syringe (INSULIN SYRINGE)	QL	
insulin 3/10 ml syringe (ULTILET INSULIN SYRINGE)	QL	
INSULIN SYR 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
INSULIN SYRIN 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
INSULIN SYRIN 0.3 ML 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
INSULIN SYRIN 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
insulin syrin 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
INSULIN SYRIN 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
INSULIN SYRIN 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
INSULIN SYRIN 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
INSULIN SYRIN 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
insulin syrin 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
INSULIN SYRIN 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
insulin syrin 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
INSULIN SYRIN 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
INSULIN SYRIN 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRING 0.5 ML 27GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
INSULIN SYRING 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
INSULIN SYRINGE 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
INSULIN SYRINGE 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
INSULIN SYRINGE 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRINGE 1 ML 27GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRINGE 1 ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRINGE 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRINGE 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSULIN SYRINGE 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
insulin syringe 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
INSULIN SYRINGE 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
INSUPEN 30G ULTRAFIN NEEDLE *(pen needle, diabetic)*	QL	
INSUPEN 31G ULTRAFIN NEEDLE *(pen needle, diabetic)*	QL	
INSUPEN 32G 6MM PEN NEEDLE *(pen needle, diabetic)*	QL	
INSUPEN 32G 8MM PEN NEEDLE *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 29GX1/2" *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 29GX12MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 30GX8MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 31GX5/16" *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 31GX6MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 31GX8MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 32GX4MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 32GX5/32" *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 32GX6MM *(pen needle, diabetic)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
INSUPEN PEN NEEDLE 32GX8MM *(pen needle, diabetic)*	QL	
INSUPEN PEN NEEDLE 33GX4MM *(pen needle, diabetic)*	QL	
INVACARE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
INVACARE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
KETOSTIX REAGENT STRIP *(urine acetone test,strips)*	QL	
kinray ins syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kinray syring 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kinray syring 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kmart valu plus syr 1/2 ml (LITE TOUCH)	QL	
kro ins syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
kro ins syrin 0.3 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
kro ins syrin 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kro ins syrin 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
kro ins syrin 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kro ins syring 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
kro ins syringe 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
kro ins syringe 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
kro ins syringe 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kro insulin syr 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
kro lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
kro universal 1 thin 26g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
kroger ins syr 0.3 ml 30gx5/16 (ADVOCATE SYRINGES)	QL	
kroger ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
kroger ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
kroger ins syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
kroger lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
kroger pen needles 31g x 5/16" (ABOUTTIME PEN NEEDLE)	QL	
kroger super thin lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
kroger syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
kroger syring 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
LANCETS 26G *(lancets)*	QL	Limited to 400 EA over 90 days.
LANCETS 26G X 1.8MM *(lancets)*	QL	Limited to 400 EA over 90 days.
lancets 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
LANCETS 28G X 1.8MM *(lancets)*	QL	Limited to 400 EA over 90 days.
LANCETS 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
LANCETS THIN 23G *(lancets)*	QL	Limited to 400 EA over 90 days.
lancets ultra fine 28g (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
LANCETS ULTRA THIN 26G *(lancets)*	QL	Limited to 400 EA over 90 days.
lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
LANZO LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
leader ins syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
leader ins syr 0.5 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
leader ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
leader ins syr 0.5 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
leader ins syr 1 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
leader ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
leader ins syr 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
leader ins syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
leader insulin syringe 0.3 ml (INSULIN SYRINGE)	QL	
leader syring 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
leader syring 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
LITE TOUCH 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
LITE TOUCH 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
LITE TOUCH 31GX1/4" PEN NEEDLE *(pen needle, diabetic)*	QL	
LITE TOUCH 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
LITE TOUCH INSULIN 0.5 ML SYR *(syringe with needle,insulin,0.5 ml)*	QL	
LITE TOUCH INSULIN 1 ML SYR *(syringe with needle,disposable,insulin 1 ml)*	QL	
LITE TOUCH INSULIN SYR 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
LITE TOUCH INSULIN SYR 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
LITE TOUCH INSULIN SYR 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
LITE TOUCH LANCING PEN *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
LITE TOUCH PEN NEEDLE 29G *(pen needle, diabetic)*	QL	
LITE TOUCH PEN NEEDLE 31G *(pen needle, diabetic)*	QL	
LITETOUCH INS 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
LITETOUCH INS 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
LITETOUCH INS 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
LITETOUCH INS 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
LITETOUCH SYR 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
LITETOUCH SYR 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
LITETOUCH SYR 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
LITETOUCH SYRIN 1 ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
LITETOUCH SYRIN 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
LITETOUCH SYRIN 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
live better advanced lancing (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
live better pen needles 8mm (ABOUTTIME PEN NEEDLE)	QL	
live better super thin lancet (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
live better ultra thin lancet (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
longs thin lancets 26g (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
longs thin lancets 30g (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
MAXI-COMFORT INS 0.5 ML 28G *(syringe with needle,insulin,0.5 ml)*	QL	
MAXI-COMFORT INS 1 ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
MAXICOMFORT II PEN NDL 31GX6MM *(pen needle, diabetic)*	QL	
MAXICOMFORT INS 0.5ML 27GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
MAXICOMFORT INS 1 ML 27GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
MAXICOMFORT PEN NDL 29G X 5MM *(pen needle, diabetic, safety)*	QL	
MAXICOMFORT PEN NDL 29G X 8MM *(pen needle, diabetic, safety)*	QL	
MEDISENSE THIN 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
MEDISENSE THIN LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
medlance plus 21g lancets (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
MEDLANCE PLUS 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
medlance plus 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
MEDLANCE PLUS 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
medlance plus extra 21g lancet (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
MEDLANCE PLUS EXTRA 21G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
medlance plus lite 25g lancets (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
MEDLANCE PLUS LITE 25G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
meijer lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
meijer lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
meijer universal 1 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
MICRODOT PEN NEEDLE 31GX6MM *(pen needle, diabetic)*	QL	
MICRODOT PEN NEEDLE 32GX4MM *(pen needle, diabetic)*	QL	
MICRODOT PEN NEEDLE 33GX4MM *(pen needle, diabetic)*	QL	
MICROLET 2 LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MICROLET LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
MICROLET NEXT LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MINI LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MINI ULTRA-THIN II PEN NDL 31G *(pen needle, diabetic)*	QL	
MONOJECT 1 ML SYRN 27X1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
MONOJECT 1 ML SYRN 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
MONOJECT INSUL SYR U100 *(syringe with needle,insulin,0.3 ml)*	QL	
MONOJECT INSUL SYR U100 *(syringe with needle,insulin,0.5 ml)*	QL	
MONOJECT INSUL SYR U100 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
MONOJECT INSUL SYR U100 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
MONOJECT INSULIN SYR 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
MONOJECT INSULIN SYR 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
MONOJECT INSULIN SYR 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
MONOJECT INSULIN SYR U-100 *(syringe with needle,insulin disposable)*	QL	
MONOJECT INSULIN SYRN 3/10 ML *(syringe with needle,insulin,0.3 ml)*	QL	
MONOJECT SYRINGE 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
MONOJECT SYRINGE 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
MONOJECT SYRINGE 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
MONOLET 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
MONOLET THIN 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ms ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ms ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ms ins syringe 1 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
ms insul syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ms insul syr 0.5 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
ms insul syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ms insulin syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ms insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ms insulin syringe 0.3 ml (INSULIN SYRINGE)	QL	
ms pen needle 6mm 31g (CAREFINE PEN NEEDLE)	QL	
MULTI-LANCET DEVICE 2 KIT *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
MYGLUCOHEALTH 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
no-stick glucose test strips (DIASTIX REAGENT)	QL	
NOVA SAFETY 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
NOVA SAFETY 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
NOVA SUREFLEX LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
NOVA SUREFLEX LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
NOVA SUREFLEX THIN LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
NOVOFINE 30G X 1/3" NEEDLES *(pen needle, diabetic)*	QL	
NOVOFINE 32G NEEDLES *(pen needle, diabetic)*	QL	
ON CALL 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
ON CALL LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ON CALL PLUS 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
ON CALL PLUS LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
on-the-go 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ON-THE-GO 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH DELICA 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH DELICA 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH DELICA LANCING DEV *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH DELICA PLUS 30G LANCT *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH DELICA PLUS 33G LANCT *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH DELICA PLUS LANC DEV *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH SURESOFT 18G LANC DEV *(lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH SURESOFT 21G LANC DEV *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH SURESOFT 28G LANC DEV *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH ULTRA CONTROL SOLN *(blood glucose calibration control solution, normal)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ONETOUCH ULTRASOFT LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ONETOUCH VERIO HIGH CNTRL SOLN *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
ONETOUCH VERIO MID CNTRL SOLN *(blood glucose calibration control solution, normal)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
pc super thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
pc unifine pentips 12mm needle (ADVOCATE PEN NEEDLES)	QL	
pc unifine pentips 6mm needle (CAREFINE PEN NEEDLE)	QL	
pc unifine pentips 8mm needle (ABOUTTIME PEN NEEDLE)	QL	
PEN NEEDLE 12MM 29G *(pen needle, diabetic)*	QL	
pen needle 31g x 1/4" (CAREFINE PEN NEEDLE)	QL	
PEN NEEDLE 31G X 1/4" *(pen needle, diabetic)*	QL	
pen needle 31g x 3/16" (ABOUTTIME PEN NEEDLE)	QL	
PEN NEEDLE 31G X 3/16" *(pen needle, diabetic)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
pen needle 31g x 5/16" (ABOUTTIME PEN NEEDLE)	QL	
PEN NEEDLE 31G X 5/16" *(pen needle, diabetic)*	QL	
PEN NEEDLE 32G X 1/4" *(pen needle, diabetic)*	QL	
PEN NEEDLE 32G X 3/16" *(pen needle, diabetic)*	QL	
pen needle 32g x 5/32" (ABOUTTIME PEN NEEDLE)	QL	
PEN NEEDLE 32G X 5/32" *(pen needle, diabetic)*	QL	
PEN NEEDLE 4MM 32G *(pen needle, diabetic)*	QL	
PEN NEEDLE 5MM 31G *(pen needle, diabetic)*	QL	
pen needle 6mm 31g (CAREFINE PEN NEEDLE)	QL	
PEN NEEDLE 8MM 31G *(pen needle, diabetic)*	QL	
pen needles 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
PEN NEEDLES 12MM 29G *(pen needle, diabetic)*	QL	
PEN NEEDLES 4MM 32G *(pen needle, diabetic)*	QL	
pen needles 6mm 31g (CAREFINE PEN NEEDLE)	QL	
pen needles 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
pentips pen needle 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	
PENTIPS PEN NEEDLE 29GX1/2" *(pen needle, diabetic)*	QL	
pentips pen needle 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
pentips pen needle 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
PENTIPS PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
pentips pen needle 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
PENTIPS PEN NEEDLE 31GX5/16" *(pen needle, diabetic)*	QL	
pentips pen needle 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
PENTIPS PEN NEEDLE 32GX5/32" *(pen needle, diabetic)*	QL	
PENTIPS PEN NEEDLE 6MM 31G *(pen needle, diabetic)*	QL	
PHARMACIST CHOICE 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
PHARMACIST CHOICE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
PIP 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
PIP 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
pref plus ins 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
pref plus syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
pref plus syring 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
preferred plus 0.3 ml 30gx5/16 (ADVOCATE SYRINGES)	QL	
preferred plus 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
preferred plus lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
preferred plus syringe 0.5 ml (LITE TOUCH)	QL	
preferred plus syringe 1 ml (LITE TOUCH)	QL	
preferred plus thin lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
prefpls ins syr 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
PRESSURE ACTIVATED 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
PRESSURE ACTIVATED 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
PRO COMFORT 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
PRO COMFORT 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
PRO COMFORT 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
PRO COMFORT 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
PRO COMFORT 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
PRO COMFORT 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
PRO COMFORT PEN NDL 31GX5/16" *(pen needle, diabetic)*	QL	
PRO COMFORT PEN NDL 32G X 1/4" *(pen needle, diabetic)*	QL	
PRO COMFORT PEN NDL 4MM 32G *(pen needle, diabetic)*	QL	
PRODIGY CONTROL SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
PRODIGY CONTROL SOLUTION LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
PRODIGY INS SYR 1ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
PRODIGY LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
PRODIGY PRESSURE ACTIVATED 28G *(lancets)*	QL	Limited to 400 EA over 90 days.
PRODIGY SAFETY 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
PRODIGY SYRNG 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
PRODIGY SYRNGE 0.3ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
PRODIGY TWIST TOP 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
pub 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
pub advanced lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
pub ins syrin 0.3 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
pub ins syringe 1 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
pub insul syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
pub insul syr 0.5 ml 30gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
pub insul syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
pub insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
pub pen 12mm 29g needles (ADVOCATE PEN NEEDLES)	QL	
pub pen 8mm 31g needles (ABOUTTIME PEN NEEDLE)	QL	
pub pen needle 6mm 31g (CAREFINE PEN NEEDLE)	QL	
pub unifine pntp plus 31gx3/16 (ABOUTTIME PEN NEEDLE)	QL	
PUSH BUTTON SAFETY 21G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
PUSH BUTTON SAFETY 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
qc unifine pentips 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
qc unifine pentips 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
qc unilet super thin 30g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
qc unilet ultra thin 28g lanct (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
ra e-zject 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ra e-zject 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
ra e-zject 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ra e-zject color 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
ra health care lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ra ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ra ins syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ra ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ra ins syringe 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ra pen needle 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
ra pen needle 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
READYLANCE 21G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
READYLANCE 23G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
READYLANCE 26G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
READYLANCE 28G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
READYLANCE 30G SAFETY LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
REFUAH PLUS CONTROL SOLUTION *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
reli on 31g x 1/4" needles (CAREFINE PEN NEEDLE)	QL	
reli-on insulin 0.3 ml syr (ULTILET INSULIN SYRINGE)	QL	
reli-on insulin 0.5 ml syr (LITE TOUCH)	QL	
reli-on insulin 1 ml syr (INSULIN SYRINGE)	QL	
reliamed 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
reliamed 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
reliamed safety 23g lancets (ACCU-CHEK SAFE-T-PRO)	QL	Limited to 400 EA over 90 days.
reliamed safety 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
reliamed safety seal 28g lanct (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
reliamed safety seal 30g lanct (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
reliamed twist&cap 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
relion 2-in-1 lancet device (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
relion ins syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
relion ins syr 0.3 ml 30gx5/16 (ADVOCATE SYRINGES)	QL	
relion ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
relion ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
relion ins syr 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
relion ins syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
relion insulin syr 0.5 ml (LITE TOUCH)	QL	
relion lancing device (ACCU-CHEK)	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
relion micro thin 33g lancet (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
relion mini pen 31g x 1/4" ndl (CAREFINE PEN NEEDLE)	QL	
relion pen 29g needle (ADVOCATE PEN NEEDLES)	QL	
relion pen 31g needle (ABOUTTIME PEN NEEDLE)	QL	
relion pen needle 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	
relion pen needle 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
relion pen needle 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
relion pen needle 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
relion pen needles 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
relion syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
relion syring 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
relion syring 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
relion thin 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
relion ultra thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
relion ultra thin plus 33g (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
relion ultra thin plus lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
rexall universal 1 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
RIGHTEST CONTROL SOLUTION HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
RIGHTEST GD500 LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
RIGHTEST GL300 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SAFESNAP INSUL SYRINGE 0.3 ML *(syringe w-needle 0.3 ml,insulin,safety w-self-cont.dis.unit)*	QL	
SAFESNAP INSUL SYRINGE 0.5 ML *(insulin syringe-needle,safety,disposal unit,0.5 ml)*	QL	
SAFESNAP INSULIN SYRINGE 1 ML *(syringe with needle 1 ml,insulin,safety w-self-con.disp.unit)*	QL	
SAFETY 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SAFETY 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SAFETY SEAL 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SAFETY SEAL 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SAFETY-LET 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
SAPS TWIST TOP 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
SAPS TWIST TOP 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
shopko on-the-go 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
shopko unifine pentips 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
shopko unifine pentips 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
shopko unifine pentips 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
shopko unifine pntips 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
shopko unilet super thin 30g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
shopko unilet ultra thin 28g (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
SINGLE-LET LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
sm color lancets 21g (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
sm ins syr 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
sm ins syr 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
sm ins syr 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
sm ins syring 0.3 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
sm ins syringe 1 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
sm ins syringe 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
sm insul syr 0.3 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
sm insul syr 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
sm insulin syr 0.3 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
sm insulin syr 0.5 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
sm insulin syr 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
sm lancets 21g (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
sm micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
sm super thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
sm thin lancets 26g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
smart sense color 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
smart sense standard 21g (ASSURE HAEMOLANCE PLUS)	QL	Limited to 400 EA over 90 days.
smart sense super thin 30g (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
smart sense thin 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
SMARTEST LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
SOFT TOUCH LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SOLUS V2 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SOLUS V2 30G TWIST LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SOLUS V2 CONTROL SOLUTION HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
SOLUS V2 CONTROL SOLUTION LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
SOLUS V2 LANCING DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
STERILANCE TL TWIST 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
STERILANCE TL TWIST 32G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
super thin 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
super thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
SURE COMFORT 0.3 ML SYRINGE *(syringe with needle,insulin,0.3 ml)*	QL	
SURE COMFORT 0.5 ML SYRINGE *(syringe with needle,insulin,0.5 ml)*	QL	
SURE COMFORT 1 ML SYRINGE *(syringe with needle,disposable,insulin 1 ml)*	QL	
SURE COMFORT 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE COMFORT 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE COMFORT 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE COMFORT 3/10 ML SYRINGE *(syringe with needle,insulin,0.3 ml)*	QL	
SURE COMFORT 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE COMFORT 30G PEN NEEDLE *(pen needle, diabetic)*	QL	
SURE COMFORT 31G PEN NEEDLE *(pen needle, diabetic)*	QL	
SURE COMFORT LANCING PEN *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SURE COMFORT PEN NDL 29GX1/2" *(pen needle, diabetic)*	QL	
SURE COMFORT PEN NDL 31GX3/16" *(pen needle, diabetic)*	QL	
SURE COMFORT PEN NDL 32GX1/4" *(pen needle, diabetic)*	QL	
SURE COMFORT PEN NDL 32GX5/32" *(pen needle, diabetic)*	QL	
SURE-FINE PEN NEEDLES 12.7MM *(pen needle, diabetic)*	QL	
SURE-FINE PEN NEEDLES 5MM *(pen needle, diabetic)*	QL	

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Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
SURE-FINE PEN NEEDLES 8MM *(pen needle, diabetic)*	QL	
SURE-JECT INS 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
SURE-JECT INS 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
SURE-JECT INSU SYR U100 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
SURE-JECT INSU SYR U100 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
SURE-JECT INSU SYR U100 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
SURE-JECT INSUL SYR U100 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
SURE-JECT INSULIN SYRINGE 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
SURE-LANCE 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE-LANCE FLAT LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE-LANCE THIN 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE-LANCE ULTRA THIN 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
SURE-PEN LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
SURE-TOUCH LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
TD GOLD LEVEL 1 GLUC CTRL SOL *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
TD GOLD LEVEL 3 GLUC CTRL SOL *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
TECHLITE 25G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
TECHLITE 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
TECHLITE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
TECHLITE INS SYR 1 ML 29GX12MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
TECHLITE INS SYR 1 ML 30GX12MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
TECHLITE INS SYR 1 ML 30GX8MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
TECHLITE INS SYR 1 ML 31GX6MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
TECHLITE INS SYR 1 ML 31GX8MM *(syringe with needle,disposable,insulin 1 ml)*	QL	
TECHLITE PEN NEEDLE 29GX1/2" *(pen needle, diabetic)*	QL	
TECHLITE PEN NEEDLE 31GX1/4" *(pen needle, diabetic)*	QL	
TECHLITE PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
TECHLITE PEN NEEDLE 31GX5/16" *(pen needle, diabetic)*	QL	
TECHLITE PEN NEEDLE 32GX1/4" *(pen needle, diabetic)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
TECHLITE PEN NEEDLE 32GX5/16" *(pen needle, diabetic)*	QL	
TECHLITE PEN NEEDLE 32GX5/32" *(pen needle, diabetic)*	QL	
TELCARE ULTRA THIN 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
TERUMO INS SYR 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
TERUMO INS SYRINGE U100-1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
TERUMO INS SYRINGE U100-1/2 ML *(syringe with needle,insulin,0.5 ml)*	QL	
TERUMO INS SYRINGE U100-1/3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
TERUMO INS SYRNG U100-1/2 ML *(syringe with needle,insulin,0.5 ml)*	QL	
thin 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
THIN LANCETS 28G *(lancets)*	QL	Limited to 400 EA over 90 days.
THINPRO INS SYRIN U100-0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
THINPRO INS SYRIN U100-0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
THINPRO INS SYRIN U100-1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
today's hlth pn needle 6mm 31g (CAREFINE PEN NEEDLE)	QL	
topcare clickfine 31g x 1/4" (CAREFINE PEN NEEDLE)	QL	
topcare clickfine 31g x 5/16" (ABOUTTIME PEN NEEDLE)	QL	
topcare ultra comfort syringe (ADVOCATE SYRINGES)	QL	
topcare ultra comfort syringe (ADVOCATE SYRINGES)	QL	
topcare ultra comfort syringe (ADVOCATE SYRINGES)	QL	
topcare universal1 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
topcare universal1 thin lancet (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
TRUE COMFORT 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
TRUE COMFORT 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
TRUE COMFORT 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
TRUE COMFORT PEN NDL 31GX5MM *(pen needle, diabetic)*	QL	
TRUE COMFORT PEN NDL 31GX6MM *(pen needle, diabetic)*	QL	
TRUE COMFORT PEN NDL 32GX4MM *(pen needle, diabetic)*	QL	
trueplus 26g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
trueplus 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
trueplus 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
trueplus pen needle 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	
trueplus pen needle 31g x 1/4" (CAREFINE PEN NEEDLE)	QL	
trueplus pen needle 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
trueplus pen needle 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
trueplus pen needle 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
trueplus safety 28g lancet (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
trueplus safety 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
trueplus super thin 28g lancet (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
trueplus syr 0.3ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
trueplus syr 0.3ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus syr 0.3ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus syr 0.5ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
trueplus syr 0.5ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
trueplus syr 0.5ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus syr 0.5ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus syr 1ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
trueplus syr 1ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
trueplus syr 1ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus syr 1ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
trueplus ultra thin 30g lancet (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
TWIST LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
TWIST LANCETS 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
TWIST LANCETS 32G *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTCARE INS SYR 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTI-LANCE AUTO-AD DEVICE *(lancing device/lancets)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTI-LANCE AUTOMATIC DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
ULTICARE INS 0.3 ML 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTICARE INS 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ULTICARE INS SYR 1 ML 28GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTICARE INS SYR 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTICARE INS SYR 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTICARE PEN NDL 12.7 MM 29G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLE 31GX3/16" *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLE 4MM 32G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLE 6MM 31G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLE 8MM 31G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLES 12MM 29G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLES 4MM 32G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLES 6MM 31G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLES 6MM 32G *(pen needle, diabetic)*	QL	
ULTICARE PEN NEEDLES 8MM 31G *(pen needle, diabetic)*	QL	
ULTICARE SYR 0.3 ML 30GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTICARE SYR 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTICARE SYR 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTICARE SYR 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
ULTICARE SYR 0.5 ML 30GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
ULTICARE SYR 0.5 ML 30GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
ULTICARE SYR 0.5 ML 31GX5/16" *(syringe with needle,insulin,0.5 ml)*	QL	
ULTICARE SYR 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTICARE SYR 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTICARE SYRIN 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTICARE SYRIN 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
ULTICARE SYRINGE 1 ML 30GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTILET 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ULTILET BASIC 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET CLASSIC 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET CLASSIC 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET CLASSIC 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET CLASSIC 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTILET INSULIN SYRINGE 0.3 ML *(syringe with needle,insulin,0.3 ml)*	QL	
ULTILET INSULIN SYRINGE 0.5 ML *(syringe with needle,insulin,0.5 ml)*	QL	
ULTILET INSULIN SYRINGE 1 ML *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTILET PEN NEEDLE *(pen needle, diabetic)*	QL	
ULTILET PEN NEEDLE 4MM 32G *(pen needle, diabetic)*	QL	
ULTILET SAFETY 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA COMFORT 0.3 ML 29GX1/2" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTRA COMFORT 0.3 ML SYRINGE *(syringe with needle,insulin,0.3 ml)*	QL	
ultra comfort 0.5 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
ULTRA COMFORT 0.5 ML 28GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
ultra comfort 0.5 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ULTRA COMFORT 0.5 ML 29GX1/2" *(syringe with needle,insulin,0.5 ml)*	QL	
ultra comfort 0.5 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ultra comfort 0.5 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ULTRA COMFORT 0.5 ML SYRINGE *(syringe with needle,insulin,0.5 ml)*	QL	
ultra comfort 1 ml 28gx1/2" (COMFORT EZ INSULIN SYRINGE)	QL	
ultra comfort 1 ml 29gx1/2" (ADVOCATE SYRINGES)	QL	
ULTRA COMFORT 1 ML 29GX1/2" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ultra comfort 1 ml 30gx5/16" (ADVOCATE SYRINGES)	QL	
ULTRA COMFORT 1 ML 30GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ultra comfort 1 ml 31gx5/16" (ADVOCATE SYRINGES)	QL	
ULTRA COMFORT 1 ML SYRINGE *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTRA FINE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA FLO PEN NEEDLE 5MM 31G *(pen needle, diabetic)*	QL	
ultra thin 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ultra thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.
ULTRA THIN 31G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA THIN 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA THIN PEN NDL 32G X 4MM *(pen needle, diabetic)*	QL	
ULTRA-THIN II 1 ML 31GX5/16" *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTRA-THIN II 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA-THIN II 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRA-THIN II INS 0.3 ML 30G *(syringe with needle,insulin,0.3 ml)*	QL	
ULTRA-THIN II INS 0.3 ML 31G *(syringe with needle,insulin,0.3 ml)*	QL	
ULTRA-THIN II INS 0.5 ML 29G *(syringe with needle,insulin,0.5 ml)*	QL	
ULTRA-THIN II INS 0.5 ML 30G *(syringe with needle,insulin,0.5 ml)*	QL	
ULTRA-THIN II INS 0.5 ML 31G *(syringe with needle,insulin,0.5 ml)*	QL	
ULTRA-THIN II INS SYR 1 ML 29G *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTRA-THIN II INS SYR 1 ML 30G *(syringe with needle,disposable,insulin 1 ml)*	QL	
ULTRA-THIN II PEN NDL 29GX1/2" *(pen needle, diabetic)*	QL	
ULTRA-THIN II PEN NDL 31GX5/16 *(pen needle, diabetic)*	QL	
ULTRACARE INS 0.3 ML 30GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTRACARE INS 0.3 ML 31GX5/16" *(syringe with needle,insulin,0.3 ml)*	QL	
ULTRALANCE 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
ULTRATLC LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
unifine pentips 12mm 29g (ADVOCATE PEN NEEDLES)	QL	
UNIFINE PENTIPS 12MM 29G *(pen needle, diabetic)*	QL	
unifine pentips 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS 31GX3/16" *(pen needle, diabetic)*	QL	
UNIFINE PENTIPS 32GX1/4" *(pen needle, diabetic)*	QL	
unifine pentips 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS 32GX5/32" *(pen needle, diabetic)*	QL	
UNIFINE PENTIPS 33GX5/32" *(pen needle, diabetic)*	QL	
unifine pentips 6mm 31g (CAREFINE PEN NEEDLE)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
UNIFINE PENTIPS 6MM 31G *(pen needle, diabetic)*	QL	
unifine pentips 6mm needle (CAREFINE PEN NEEDLE)	QL	
unifine pentips 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS 8MM 31G *(pen needle, diabetic)*	QL	
unifine pentips 8mm needle (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS NEEDLES 29G *(pen needle, diabetic)*	QL	
unifine pentips plus 29gx1/2" (ADVOCATE PEN NEEDLES)	QL	
UNIFINE PENTIPS PLUS 29GX1/2" *(pen needle, diabetic)*	QL	
unifine pentips plus 31gx1/4" (CAREFINE PEN NEEDLE)	QL	
UNIFINE PENTIPS PLUS 31GX1/4" *(pen needle, diabetic)*	QL	
unifine pentips plus 31gx3/16" (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS PLUS 31GX3/16" *(pen needle, diabetic)*	QL	
unifine pentips plus 31gx5/16" (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS PLUS 31GX5/16" *(pen needle, diabetic)*	QL	
unifine pentips plus 32gx5/32" (ABOUTTIME PEN NEEDLE)	QL	
UNIFINE PENTIPS PLUS 32GX5/32" *(pen needle, diabetic)*	QL	
UNIFINE PENTIPS PLUS 33GX5/32" *(pen needle, diabetic)*	QL	
UNILET COMFORTOUCH 26G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNILET COMFORTOUCH LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNILET EXCELITE II LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNILET EXCELITE LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNILET GP LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNILET GP LANCET SUPERLITE *(lancets)*	QL	Limited to 400 EA over 90 days.
unilet micro thin 33g lancet (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
UNILET MICRO THIN 33G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
unilet micro thin 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
UNILET MICRO THIN 33G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
unilet super thin 30g lancets (ADVOCATE LANCET)	QL	Limited to 400 EA over 90 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
UNILET SUPER THIN 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
unilet ultra thin 28g lancets (ACTI-LANCE)	QL	Limited to 400 EA over 90 days.
UNILET ULTRA THIN 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 2 1.8 MM LANCING DEVIC *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 2 2.4 MM DEVICE *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 2 COMFORT 1.8 MM DEVIC *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 2 EXTRA 0.81 MM DEVICE *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 2 NORMAL 0.81MM DEVICE *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 3 1.8 MM LANCING DEVIC *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 3 COMFORT 1.8 ML DEVIC *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 3 COMFORT LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 3 EXTRA 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 3 GENTLE 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 3 GENTLE ON-THE-GO 30G *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 3 NEONATAL 1.8 ML DEV *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTIK 3 NORMAL 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK 3 SAFETY 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK CZT COMFORT 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK CZT NORMAL 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK PRO 21G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK PRO 25G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK PRO 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK SAFETY 28G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK SAFETY 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK TOUCH 21G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK TOUCH 23G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK TOUCH 28G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK TOUCH 30G LANCETS *(lancets)*	QL	Limited to 400 EA over 90 days.
UNISTIK-2 3 MM DEVICE *(lancing device/lancets)*	QL,FL	Limited to 100 EA per fill; Limited to 1 fill per 365 days.
UNISTRIP CONTROL SOLUTION HIGH *(blood glucose calibration control solution, high)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Diabetic Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
UNISTRIP CONTROL SOLUTION LOW *(blood glucose calibration control solution, low)*	QL,FL	Limited to 1 EA per fill; Limited to 1 fill per 365 days.
universal 1 33g lancets (BD ULTRA-FINE)	QL	Limited to 400 EA over 90 days.
VANISHPOINT 0.5 ML 30GX1/2" SY *(syringe with needle,insulin,0.5 ml)*	QL	
VANISHPOINT U-100 29X1/2 SYR *(syringe with needle,disposable,insulin 1 ml)*	QL	
VANTAGE LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
VERIFINE PEN NEEDLE 31G X 6MM *(pen needle, diabetic)*	QL	
VERIFINE PEN NEEDLE 31G X 8MM *(pen needle, diabetic)*	QL	
VERIFINE PEN NEEDLE 32G X 4MM *(pen needle, diabetic)*	QL	
VERIFINE PEN NEEDLE 32G X 5MM *(pen needle, diabetic)*	QL	
VIVAGUARD 30G LANCET *(lancets)*	QL	Limited to 400 EA over 90 days.
VIVAGUARD LANCING DEVICE *(lancing device)*	QL,FL	Limited to 1 EA per 30 days; Limited to 1 fill per 365 days.
walgreens thin lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
walgreens ultra thin lancets (ACCU-CHEK)	QL	Limited to 400 EA over 90 days.
wm unifine pentip plus 4mm 32g (ABOUTTIME PEN NEEDLE)	QL	
wm unifine pentip plus 5mm 31g (ABOUTTIME PEN NEEDLE)	QL	
wm unifine pentip plus 6mm 31g (CAREFINE PEN NEEDLE)	QL	
wm unifine pentip plus 8mm 31g (ABOUTTIME PEN NEEDLE)	QL	
YOURX ULTICARE PEN NDL 4MM 32G *(pen needle, diabetic)*	QL	
YOURX ULTICARE PEN NDL 6MM 31G *(pen needle, diabetic)*	QL	
YOURX ULTICARE PEN NDL 8MM 31G *(pen needle, diabetic)*	QL	

Medical Supplies and DME - Miscellaneous Other		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ADVOCATE BLOOD PRESSURE MONITR *(blood pressure test kit-large)*	QL	Limited to 1 EA per 30 days.
BD SAFE-CLIP NEEDL STORAGE DEV *(needle clipping and storage device)*	QL	
cvs needle collection-disposal (AMBER GLASS BOTTLE)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Medical Supplies and DME - Parenteral Administration Supplies		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
BD 3 ML SYRINGE WITH NEEDLE *(syringe with needle,disposable, 3 ml)*	QL	Limited to 100 EA per month.
BD LUER-LOK SYRINGE 1ML 20GX1" *(syringe with needle,disposable, 1 ml)*	QL	Limited to 100 EA per month.
BD NEEDLE 23GX1" *(needles, disposable)*	QL	Limited to 100 EA per month.
BD NEEDLES 25GX0.625" *(needles, disposable)*	QL	Limited to 100 EA per month.
EASY TOUCH HYPODERMIC 23GX1" *(needles, disposable)*	QL	Limited to 100 EA per month.
EASY TOUCH HYPODERMIC 25GX5/8" *(needles, disposable)*	QL	Limited to 100 EA per month.
EASY TOUCH SYRINGE 3 ML 20GX1" *(syringe with needle,disposable, 3 ml)*	QL	Limited to 100 EA per month.
TERUMO HYPODERMIC NDL-SYRIN *(syringe with needle,disposable, 5 ml)*	QL	Limited to 100 EA per month.
TERUMO SYRINGE 3 ML *(syringe with needle,disposable, 3 ml)*	QL	Limited to 100 EA per month.

Medical Supplies and DME - Respiratory Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
VORTEX LADYBUG TODDLER MASK *(inhaler, assist devices, accessories)*	QL,FL	Limited to 1 EA per fill; Limited to 2 fills per 365 days.

Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CALCI-CHEW TABLET *(calcium carbonate)*	QL	
CALCITRATE + VIT D CAPLET *(calcium citrate/cholecalciferol (vitamin d3))*	QL	
CALCITRATE 200 MG (950 MG) TAB *(calcium citrate)*	QL	
calcium 250-d tablet (OYSCO D)	QL	
calcium 250-vit d3 125 tablet (OYSCO D)	QL	
calcium 500 mg chewable tablet	QL	
calcium 500 mg chewable tablet (CALCI-CHEW)	QL	
calcium 500 mg tablet (OS-CAL 500)	QL	
calcium 500-vit d3 200 caplet (HI-CAL)	QL	
calcium 500-vit d3 200 tablet (HI-CAL)	QL	
calcium 500-vit d3 400 tablet (OYSTERCAL-D)	QL	
calcium 600 mg tablet (CALTRATE 600)	QL	
calcium 600 mg tablet (SUPER CALCIUM)	QL	
calcium 600+d plus minerals tb (CALTRATE-600 PLUS)	QL	
calcium 600-vit d3 200 tablet (SUPER CALCIUM-VITAMIN D)	QL	
calcium 600-vit d3 400 caplet (CALCARB 600 WITH VITAMIN D)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
calcium 600-vit d3 400 tablet (CALCARB 600 WITH VITAMIN D)	QL	
calcium 600-vit d3 800 tablet (CALTRATE 600 PLUS D3)	QL	
calcium carb 1,250 mg/5 ml sus	QL	
calcium carb 500 (1,250) mg tb (OS-CAL 500)	QL	
calcium carbonate 1.25 gm tab (OS-CAL 500)	QL	
calcium citrate - vit d caplet (CITRUS CALCIUM + D)	QL	
calcium citrate-vit d3 caplet (CITRUS CALCIUM + D)	QL	
calcium citrate-vit d3 tablet (CITRUS CALCIUM + D)	QL	
calcium-500 mg tablet chewable	QL	
CALTRATE 600 PLUS D3 TABLET *(calcium carbonate/cholecalciferol (vitamin d3))*	QL	
child ferrous sulfate 15 mg/ml (FER-IN-SOL)	QL	
CHILDREN'S IRON 15 MG/ML DROPS *(ferrous sulfate)*	QL	
CITRACAL + D MAXIMUM CAPLET *(calcium citrate/cholecalciferol (vitamin d3))*	QL	
CITRACAL-D3 MAXIMUM PLUS CAPLT *(calcium citrate/vit d3/zinc oxide/copper gluc/manganese gluc)*	QL	
citrus calcium + d tablet (CITRACAL + D MAXIMUM)	QL	
citrus calcium 200-vit d3 250 (CITRACAL-D3 PETITES)	QL	
cvs calcium 600 mg tablet (CALTRATE 600)	QL	
cvs iron 27 mg tablet (FERATE)	QL	
cvs iron 65 mg tablet (FEOSOL)	QL	
FEOSOL 65 MG TABLET *(ferrous sulfate)*	QL	
FER-IN-SOL 15 MG/ML DROPS *(ferrous sulfate)*	QL	
FEROSUL 220 MG/5 ML ELIXIR *(ferrous sulfate)*	QL	
FEROSUL 325 MG TABLET *(ferrous sulfate)*	QL	
FERREX 150 CAPSULE *(iron polysaccharide complex)*	QL	
FERRO-TIME 325 MG TABLET *(ferrous sulfate)*	QL	
ferrous gluconate 240 mg tab (FERATE)	QL	
ferrous gluconate 324 mg tab	QL	
ferrous sulf 15 mg iron/ml drp (FER-IN-SOL)	QL	
ferrous sulf 220 mg/5 ml elix (FEROSUL)	QL	
ferrous sulf 300 mg/5 ml liq	QL	
ferrous sulf 44 mg iron/5ml lq	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ferrous sulf ec 324 mg tablet	QL	
ferrous sulf ec 325 mg tablet	QL	
ferrous sulfate 325 mg tablet (FEOSOL)	QL	
FERROUSUL 325 MG TABLET *(ferrous sulfate)*	QL	
gnp calcium 600 mg tablet (CALTRATE 600)	QL	
gnp calcium 600 mg-d3 800 unit (CALTRATE 600 PLUS D3)	QL	
gnp calcium citrate-vit d3 tab (CITRUS CALCIUM + D)	QL	
gnp magnesium 250 mg tablet	QL	
IFEREX 150 CAPSULE *(iron polysaccharide complex)*	QL	
iron 65 mg tablet (FEOSOL)	QL	
magnesium 250 mg tablet	QL	
magnesium 250 mg tablet (MG-250)	QL	
magnesium 400 mg tablet	QL	
magnesium 500 mg tablet (PHILLIPS)	QL	
magnesium oxide 250 mg caplet	QL	
magnesium oxide 250 mg tablet	QL	
magnesium oxide 400 mg tablet (MAGOX 400)	QL	
magnesium oxide 500 mg tablet (PHILLIPS)	QL	
MAGOX 400 TABLET *(magnesium oxide)*	QL	
NU-IRON 150 CAPSULE *(iron polysaccharide complex)*	QL	
ORALYTE FREEZER POPS *(electrolytes/dextrose)*	QL	
ORALYTE SOLUTION *(electrolytes/dextrose)*	QL	
OS-CAL 500-VIT D3 200 CAPLET *(calcium carbonate/cholecalciferol (vitamin d3))*	QL	
OYSCO 500-VIT D3 200 TABLET *(calcium carbonate/cholecalciferol (vitamin d3))*	QL	
OYSCO-500 TABLET *(calcium carbonate)*	QL	
oyster shell 250 mg-vit d 125 (OYSCO D)	QL	
oyster shell 500-vit d3 200 tb (HI-CAL)	QL	
oyster shell 500mg-vit d3 5mcg (HI-CAL)	QL	
oyster shell calcium 500 mg tb (OYSCO-500)	QL	
oyster shell calcium-vit d tab (OYSTERCAL-D)	QL	
oyster shell-d 250 mg tablet (OYSCO D)	QL	
PEDIALYTE ELECTROLYTE SINGLES *(electrolytes/dextrose)*	QL	
PEDIALYTE FREEZER POPS *(electrolytes/dextrose)*	QL	

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Drug List

Minerals and Electrolytes		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
PEDIALYTE SOLUTION *(electrolytes/dextrose)*	QL	
PHOS-NAK PACKET *(sodium phosphate/potassium phosphates, monobasic and bibasic)*	QL	
POLY-IRON 150 MG CAPSULE *(iron polysaccharide complex)*	QL	
polysaccharide iron 150 mg cap (NU-IRON 150)	QL	
qc calcium 600 mg-vit d tab (CALTRATE-600 PLUS)	QL	
qc calcium 600-vit d3 400 tab (CALCARB 600 WITH VITAMIN D)	QL	
sm calcium 500-vit d3 400 tab (OYSTERCAL-D)	QL	
sm calcium 600 mg tablet (CALTRATE 600)	QL	
sm calcium 600+minerals tab (CALTRATE-600 PLUS)	QL	
sm calcium 600-vit d3 400 tab (CALCARB 600 WITH VITAMIN D)	QL	
sm calcium citrate-vit d cplt (CITRACAL + D)	QL	
sm iron 325 mg tablet (FEOSOL)	QL	
sm magnesium 250 mg tablet (MG-250)	QL	
sodium chloride 1,000 mg tab	QL	
super calcium 600-vit d3 400 (CALCARB 600 WITH VITAMIN D)	QL	
sv iron 65 mg tablet (FEOSOL)	QL	
sv magnesium oxide 400 mg tab	QL	
zinc 50 mg capsule (ORAZINC)	QL	
zinc sulfate 220 mg capsule (ORAZINC)	QL	

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
COMPLETENATE TABLET CHEW *(prenatal vitamins no.14/ferrous fumarate/folic acid)*	QL,GR,AL	Limited to 30 EA per 30 days; Limited to females only; Limited to members between the ages of 10 and 55.
ELITE-OB CAPLET *(multivitamin with minerals no.69/iron,carbonyl/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
M-NATAL PLUS TABLET *(prenatal vits with calcium no.72/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55 years
NIVA-PLUS TABLET *(multivitamin-minerals no.60/ferrous fumarate/folic acid)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
OB COMPLETE CAPLET *(multivitamin with minerals no.69/iron,carbonyl/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
PNV 29-1 TABLET *(prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
PNV-VP-U CAPSULE *(multivitamin combination no.51/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
prenatal vitamin plus low iron (M-NATAL PLUS)	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.

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Drug List

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
prenatal vitamin plus low iron (M-NATAL PLUS)	QL,GR,AL	Limited to 30 EA per 30 days; Limited to females only; Limited to members between the ages of 10 and 55.
PREPLUS CA-FE 27 MG-FA 1 MG TB *(prenatal vits with calcium no.72/ferrous fumarate/folic acid)*	QL,AL	Limited to 30 EA per 30 days; Limited to members between the ages of 10 and 55.
PRETAB 29 MG-1 MG TABLET *(prenatal vits with calcium no.78/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
SE-NATAL 19 CHEWABLE TABLET *(prenatal vits with calcium 118/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
SE-NATAL-19 TABLET *(prenatal vitamins no.119/iron fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
THRIVITE RX TABLET *(prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55 years
TRICARE PRENATAL TABLET *(prenatal vits with calcium 103/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
TRINATAL RX 1 TABLET *(prenatal vitamin 27 with calcium/ferrous fumarate/folic acid)*	QL,GR,AL	Limited to 30 EA per 30 days; Limited to females only; Limited to members between the ages of 10 and 55.
VIRT-NATE TABLET *(prenatal vits with calcium no.73/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
VITAFOL-OB CAPLET *(prenatal vits with calcium no.10/ferrous fumarate/folic acid)*	QL,AL	Limited to members between the ages of 10 and 55.
VOL-PLUS TABLET *(multivitamin-minerals no.60/ferrous fumarate/folic acid)*	QL,GR,AL	Limited to 30 EA per 30 days; Limited to females only; Limited to members between the ages of 10 and 55.
WESTAB PLUS TABLET *(prenatal vits with calcium no.72/ferrous fumarate/folic acid)*	QL	
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
C-NATE DHA SOFTGEL *(prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CITRANATAL B-CALM COMBO PACK *(prenatal vitamin no.48/iron,carbonyl,gluconate/folic acid/b6)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
COMPLETE NATAL DHA *(prenatal vitamin no.52/iron/folic acid/omega-3/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CONCEPT DHA CAPSULE *(mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
CONCEPT OB CAPSULE *(mv-mins no.74/ferrous fumarate/iron ps cplx/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
DERMACINRX PRENATRIX CAPLET *(prenatal vitamins no.170/ferrous fumarate/folic acid)*	PA,QL,AL	Prior Authorization Required. Limited to members between the ages of 10 and 55.
DERMACINRX PRENATRYL CAPLET *(prenatal vitamins no.170/ferrous fumarate/folic acid)*	PA,QL,AL	Prior Authorization Required. Limited to members between the ages of 10 and 55.
ENBRACE HR SOFTGEL *(multivit no.41/iron cysteine glycinat/folate no.8/phosph-dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
FOLIVANE-OB CAPSULE *(mv-mins no.74/ferrous fumarate/iron ps cplx/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.

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Drug List

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
NESTABS DHA COMBO PACK *(prenatal vits with calcium no.87/iron bisgly/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
NESTABS ONE SOFTGEL *(multivit 42/iron carbonyl,b-g che/methyltetrahydrofolate/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
NESTABS TABLET *(prenatal vitamin no.86/iron bis-glycinate/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
OB COMPLETE ONE SOFTGEL *(prenatal vit no.85/iron carb,asp.gly/folic acid/dha/fish oil)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
OB COMPLETE PETITE SOFTGEL *(prenatal no56/iron carbonyl,asparto glycinate/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
OB COMPLETE PREMIER TABLET *(prenatal vits no.83/iron,carbonyl,iron aspart.gly/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
OB COMPLETE WITH DHA SOFTGEL *(prenatal vit no.30/iron carbonyl,asp glyc/folic acid/omega-3)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PNV-DHA SOFTGEL *(multivitamin combination no.47/ferrous fum/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PNV-OMEGA SOFTGEL *(multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PNV-SELECT TABLET *(prenatal vit with calcium no.40/iron fumarate/folate no.1)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE AM TABLET *(multivit no.38/methyltetrahydfolate glucos,folic acid/ginger)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE CHEWABLE TABLET *(multivitamin no.36/methyltetrahydrofolate gluc,folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE DHA SOFTGEL *(prenatal vitamins no.78/iron asparto glycin/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE ELITE TABLET *(prenatal vits no.114/ferrous aspart glycinate/folate no.1)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE ENHANCE SOFTGEL *(prenatal vitamins no.68/iron fumarate/folate no.6/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE ESSENTIAL SOFTGEL *(multivitamin no.40/iron asparto glycinate/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE MINI SOFTGEL *(prenatal vits no.87/iron carb-asp.glycinate/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE PIXIE SOFTGEL *(prenatal vitamins no.85/iron asparto glycin/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE RESTORE SOFTGEL *(prenatal vitamins no.69/iron fumarate/folate comb no.6/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PRENATE STAR TABLET *(prenatal vitamins no.77/ferrous asparto glycinate/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.

Drug List

MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
PRIMACARE SOFTGEL *(prenatal vits no.118/iron asparto glycinate/folate no.6/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PROVIDA OB CAPSULE *(prenatal vits no.65/iron fumarate,polysac complex/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
PUREFE OB PLUS CAPSULE *(multivit-mins no.73/iron fumarate,polysacc comp/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
SELECT-OB + DHA PACK *(prenatal vitamins no.33/iron polysach complex/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
SELECT-OB CHEWABLE CAPLET *(prenatal vit no.128/iron polysaccharide complex/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
SELECT-OB CHEWABLE CAPLET *(prenatal vitamin no.13/iron polysaccharides/folate comb no.1)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
TARON-C DHA CAPSULE *(mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
TRICARE PRENATAL DHA ONE SFTGL *(prenatal vit no.156/iron/levomefolate/om-3/dha/epa/fish oil)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
TRISTART DHA SOFTGEL *(prenatal vitamins no.93/iron carbonyl/folate comb no.9/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VINATE DHA RF GELCAP *(multivit no.37/iron/l-mefolate calc./algal oil/soy lecithin)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VIRT-C DHA SOFTGEL *(mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VIRT-NATE DHA SOFTGEL *(prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VIRT-PN DHA SOFTGEL *(multivitamin combination no.47/ferrous fum/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VIRT-PN PLUS SOFTGEL *(multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VIRT-PN TABLET *(prenatal vit with calcium no.40/iron fumarate/folate no.1)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VITAFOL FE PLUS SOFTGEL *(prenatal vits no.102/iron polysacch/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VITAFOL GUMMIES *(prenatal vit no.112/iron phosph/folic acid/omega-3s/dha/epa)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VITAFOL NANO TABLET *(prenatal vitamins no.75/ferrous fumarate/folate comb. no.1)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VITAFOL ULTRA SOFTGEL *(prenatal vit no.67/iron polysaccharides/folate comb.no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VITAFOL-OB+DHA COMBO PACK *(prenatal vits with calcium no.10/ferrous fum/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.

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MULTIVITAMINS : PRENATAL VITAMINS		
Drug Name	**Drug Status**	**Criteria**
Non-Preferred		
VITAFOL-ONE CAPSULE *(prenatal vits no.26/iron polysaccharide cplex/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VP-GGR-B6 TABLET *(folic acid/pyridoxine hcl/ca phos dibasic & tribasic/ginger)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VP-HEME OB TABLET *(prenatal vit no.21/iron polysacch,heme polypep/folic acid)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VP-HEME ONE SOFTGEL *(prenatal vitamin no.19/iron polysac,iron heme/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
VP-PNV-DHA SOFTGEL *(prenatal vitamins no.52/ferrous fumarate/folic acid/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
WESTGEL DHA SOFTGEL *(prenatal vitamins no.93/iron carbonyl/folate comb no.9/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
ZATEAN-PN DHA CAPSULE *(multivitamin combination no.47/ferrous fum/folate no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
ZATEAN-PN PLUS SOFTGEL *(multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)*	PA,QL,AL	Prior Authorization required. Limited to members between the ages of 10 and 55.
Nasal Preparations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
AYR SALINE 0.65% NOSE DROPS *(sodium chloride)*	QL	
AYR SALINE 0.65% NOSE SPRAY *(sodium chloride)*	QL	
BABY AYR SALINE 0.65% DROPS *(sodium chloride)*	QL	
cromolyn sodium nasal spray (NASALCROM)	QL	
cvs saline 0.65% nasal spray (ALTAMIST)	QL	
DEEP SEA 0.65% NOSE SPRAY *(sodium chloride)*	QL	
eq nasal 0.65% spray (ALTAMIST)	QL	
gnp saline 0.65% nose spray (ALTAMIST)	QL	
gs nasal moist 0.65% spray (ALTAMIST)	QL	
hm saline 0.65% nasal spray (ALTAMIST)	QL	
LITTLE REMEDIES 0.65% SPRAY *(sodium chloride)*	QL	
nasal moisturizing 0.65% spray (ALTAMIST)	QL	
OCEAN 0.65% NASAL SPRAY *(sodium chloride)*	QL	
saline 0.65% nasal spray (ALTAMIST)	QL	
saline 0.65% nose spray (ALTAMIST)	QL	
saline mist 0.65% nose spry (ALTAMIST)	QL	
sb saline 0.65% nose spray (ALTAMIST)	QL	
sm saline 0.65% nasal spray (ALTAMIST)	QL	

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Nasal Preparations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
v-r nasal allergy sym spray (NASALCROM)	QL	
Nutritional Product - Nutritional Therapy		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ELECARE JR POWDER *(nutritional therapy for impaired digestive function)*	QL	
Ophthalmic - Decongestants and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs eye allergy relief drops (OPCON-A)	QL	
eye allergy relief drops (OPCON-A)	QL	
OPCON-A EYE DROPS *(naphazoline hcl/pheniramine maleate)*	QL	
Ophthalmic - Hyperosmolar Agents		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
MURO-128 2% EYE DROPS *(sodium chloride)*	QL	
MURO-128 5% EYE DROPS *(sodium chloride)*	QL	
MURO-128 5% EYE OINTMENT *(sodium chloride)*	QL	
sodium chloride 5% eye drop (MURO-128)	QL	
sodium chloride 5% eye oint (MURO-128)	QL	
Otic (Ear) - Wax Removers-Softeners		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
carbamide peroxide 6.5% drops (MURINE EAR DROPS)	QL	
cvs ear drops 6.5% (CARBAMOXIDE)	QL	
cvs ear wax removal 6.5% drop (CARBAMOXIDE)	QL	
cvs ear wax removal 6.5% kit (CARBAMOXIDE)	QL	
DEBROX 6.5% EAR DROPS *(carbamide peroxide)*	QL	
EAR DROPS 6.5% *(carbamide peroxide)*	QL	
ear drops 6.5% (CARBAMOXIDE)	QL	
ear system 6.5% (CARBAMOXIDE)	QL	
ear wax removal 6.5% drop (CARBAMOXIDE)	QL	
ear wax removal 6.5% drops (CARBAMOXIDE)	QL	
ear wax removal 6.5% kit (CARBAMOXIDE)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Otic (Ear) - Wax Removers-Softeners		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
EARWAX TREATMENT 6.5% DROPS *(carbamide peroxide)*	QL	
hm ear wax removal 6.5% drops (CARBAMOXIDE)	QL	
hm ear wax removal kit (CARBAMOXIDE)	QL	
MURINE 6.5% EAR DROPS *(carbamide peroxide)*	QL	
MURINE EAR WAX REMOVAL SYSTEM *(carbamide peroxide)*	QL	
sb ear wax removal 6.5% drop (CARBAMOXIDE)	QL	
sm ear drops 6.5% (CARBAMOXIDE)	QL	
Platelet Aggregation Inhibitors and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
adult aspirin ec 81 mg tablet (ADULT LOW DOSE ASPIRIN EC)	QL	
adult aspirin regimen ec 81 mg (ADULT LOW DOSE ASPIRIN EC)	QL	
aspir ec 81 mg tablet (ADULT LOW DOSE ASPIRIN EC)	QL	
ASPIR-LOW EC 81 MG TABLET *(aspirin)*	QL	
aspirin 81 mg chewable tablet (BAYER CHEWABLE ASPIRIN)	QL	
aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
BAYER ASPIRIN 81 MG CHEW TAB *(aspirin)*	QL	
child aspirin 81 mg chew tab (BAYER CHEWABLE ASPIRIN)	QL	
cvs aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
cvs aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
ECOTRIN EC 81 MG TABLET *(aspirin)*	QL	
eq aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
eq aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
eql aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
eql aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
gs aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
gs aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
hm aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
hm aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
kro aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
kro aspirin ec 81 mg tablet (SUREPRIN 81)	QL	

Drug List

Platelet Aggregation Inhibitors and Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
low dose aspirin ec 81 mg tab (ADULT LOW DOSE ASPIRIN EC)	QL	
qc aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
qc aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
sb aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
sb child aspirin 81 mg chw tab (BAYER CHEWABLE ASPIRIN)	QL	
sm aspirin 81 mg chewable tab (BAYER CHEWABLE ASPIRIN)	QL	
sm aspirin ec 81 mg tablet (SUREPRIN 81)	QL	
sm child aspirin 81 mg chw tab (BAYER CHEWABLE ASPIRIN)	QL	

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : SMOKING DETERRENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
gs nicotine 2 mg chewing gum (NICORELIEF)	QL,FL	Limited to 6 fills per 365 days.
gs nicotine 2 mg mini lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
gs nicotine 4 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
gs nicotine 4 mg chewing gum (NICORETTE)	QL,FL	Limited to 6 fills per 365 days.
gs nicotine 4 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
gs nicotine 4 mg mini lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 14 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 2 mg chewing gum (NICORELIEF)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 2 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 2 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 2 mg mini lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 21 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 4 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 4 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
hm nicotine 4 mg mini lozenge (NICORETTE)	QL	
hm nicotine 7 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 14 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 2 mg chewing gum (NICORELIEF)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 2 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 2 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 2 mg mini lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS : SMOKING DETERRENTS		
Drug Name	**Drug Status**	**Criteria**
Preferred		
nicotine 21 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 1 EA per day; Limited to 6 fills per 365 days.
nicotine 21 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 4 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 4 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 4 mg mini lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
nicotine 7 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
nicotine transdermal system	QL,FL	Limited to 6 fills per 365 days.
sm nicotine 14 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 2 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 2 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 21 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 4 mg chewing gum (NICORETTE)	QL,FL	Limited to 336 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 4 mg lozenge (NICORETTE)	QL,FL	Limited to 360 EA per 30 days; Limited to 6 fills per 365 days.
sm nicotine 7 mg/24hr patch (NICODERM CQ)	QL,FL	Limited to 30 EA per 30 days; Limited to 6 fills per 365 days.
Respiratory Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
adult wal-tussin dm max liq (DIABETIC SILTUSSIN-DM MAX STR)	QL	
adult wal-tussin dm syrup (COUGH DM)	QL	
CHERATUSSIN AC SYRUP *(codeine phosphate/guaifenesin)*	QL	
codeine-guaifen 10-100 mg/5 ml (G TUSSIN AC)	QL	
COUGH DM SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
COUGH SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
cvs tussin dm liquid (BIOCOTRON)	QL	
cvs tussin dm max liquid (DIABETIC SILTUSSIN-DM MAX STR)	QL	
DIABETIC SILTUSSIN-DM LIQUID *(guaifenesin/dextromethorphan hbr)*	QL	
DIABETIC SILTUSSIN-DM MAX-STR *(guaifenesin/dextromethorphan hbr)*	QL	
DIABETIC TUSSIN DM LIQUID *(guaifenesin/dextromethorphan hbr)*	QL	
DIABETIC TUSSIN DM MAX-STR LIQ *(guaifenesin/dextromethorphan hbr)*	QL	
eq tussin dm cough-chest syr (COUGH DM)	QL	
EXTRA ACTION COUGH SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
gs tussin dm cough syrup (COUGH DM)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Respiratory Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
gs tussin dm cough-chest soln (COUGH DM)	QL	
gs tussin dm liquid (COUGH DM)	QL	
gs tussin dm max liquid (DIABETIC SILTUSSIN-DM MAX STR)	QL	
guaifen-codeine 100-10 mg/5 ml (G TUSSIN AC)	QL	
guaifenesin dm syrup (COUGH FORMULA DM)	QL	
guaifenesin-codeine syrup (G TUSSIN AC)	QL	
guaifenesin-dm 100-10 mg/5 ml (CHERACOL D)	QL	
guaifenesin-dm 200-20 mg/10 ml (CHERACOL D)	QL	
hm adt tussin cough cong dm lq (BIOCOTRON)	QL	
hm adult tussin dm syrup (COUGH DM)	QL	
hm tussin dm max liquid (DIABETIC SILTUSSIN-DM MAX STR)	QL	
qc tussin dm liquid (BIOCOTRON)	QL	
ROBAFEN DM CGH-CHEST CONG SYRP *(guaifenesin/dextromethorphan hbr)*	QL	
ROBAFEN DM COUGH LIQUID *(guaifenesin/dextromethorphan hbr)*	QL	
ROBAFEN DM COUGH SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
ROBAFEN-DM SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
SAFETUSSIN DM LIQUID *(guaifenesin/dextromethorphan hbr)*	QL	
SILTUSSIN DM COUGH SYRUP *(guaifenesin/dextromethorphan hbr)*	QL	
SILTUSSIN DM DAS 100-10MG/5 ML *(guaifenesin/dextromethorphan hbr)*	QL	
sm tussin dm liquid (BIOCOTRON)	QL	
sm tussin dm max liquid (DIABETIC SILTUSSIN-DM MAX STR)	QL	
sm tussin dm syrup (COUGH DM)	QL	
TUSNEL DIABETIC LIQUID *(guaifenesin/dextromethorphan hbr)*	QL	
tussin dm clear syrup (COUGH DM)	QL	
tussin dm liquid (BIOCOTRON)	QL	
tussin dm max liquid (DIABETIC SILTUSSIN-DM MAX STR)	QL	
tussin dm syrup (COUGH DM)	QL	
VIRTUSSIN AC 10-100 MG/5 ML LQ *(codeine phosphate/guaifenesin)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Sedative-Hypnotics		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs nighttime sleep 25 mg cplt (ALKA-SELTZER PLUS ALLERGY)	QL	
gs nighttime sleep aid 25 mg (ALKA-SELTZER PLUS ALLERGY)	QL	
gs sleep time 25 mg softgel (ZZZQUIL)	QL	
hm z-sleep 25 mg softgel (ZZZQUIL)	QL	
nighttime sleep aid 25 mg cplt (ALKA-SELTZER PLUS ALLERGY)	QL	
qc nighttime sleep 25 mg tab (ALKA-SELTZER PLUS ALLERGY)	QL	
qc sleep aid 50 mg softgel (UNISOM)	QL	
sb sleep tablet (ALKA-SELTZER PLUS ALLERGY)	QL	
sleep aid 25 mg caplet (ALKA-SELTZER PLUS ALLERGY)	QL	
sleep aid 25 mg liquid gel (ZZZQUIL)	QL	
sleep aid 50 mg liquidgel (UNISOM)	QL	
sleep aid 50 mg softgel (UNISOM)	QL	
SLEEP TABS 25 MG TABLET *(diphenhydramine hcl)*	QL	
sm nighttime sleep 25 mg cplt (ALKA-SELTZER PLUS ALLERGY)	QL	
sm sleep aid 25 mg caplet (ALKA-SELTZER PLUS ALLERGY)	QL	
sm sleep aid softgel (UNISOM)	QL	
sm z-sleep 25 mg softgel (ZZZQUIL)	QL	
wal-sleep z 25 mg softgel (ZZZQUIL)	QL	
wal-som 50 mg softgel (UNISOM)	QL	

Systemic Sympathomimetic Decongestants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CHILDREN'S SILFEDRINE LIQ *(pseudoephedrine hcl)*	QL	
CHILDS SUDAFED 15 MG/5 ML LIQ *(pseudoephedrine hcl)*	QL	
cvs nasal decongest 30 mg tab (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
hm nasal decongest 30 mg tab (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
NASAL DECON(P-EPHED)30 MG/5 ML *(pseudoephedrine hcl)*	QL	
nasal decongestant 30 mg tab (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
NASAL DECONGESTANT 30 MG TAB *(pseudoephedrine hcl)*	QL	Limited to 240 EA per 30 days.
pseudoephed 30 mg/5 ml soln (NASAL DECON (PSEUDOEPHEDRINE))	QL	
pseudoephedrine 30 mg tablet (SUDAFED)	QL	Limited to 240 EA per 30 days.

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Systemic Sympathomimetic Decongestants		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
pseudoephedrine 60 mg tablet (SUDOGEST)	QL	Limited to 120 EA per 30 days.
qc suphedrine 30 mg tablet (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
sm nasal decongest 30 mg tab (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
SUDAFED 30 MG TABLET *(pseudoephedrine hcl)*	QL	Limited to 240 EA per 30 days.
SUDOGEST 30 MG TABLET *(pseudoephedrine hcl)*	QL	Limited to 240 EA per 30 days.
SUDOGEST 60 MG TABLET *(pseudoephedrine hcl)*	QL	Limited to 120 EA per 30 days.
suphedrin 30 mg tablet (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
suphedrin liquid (CHILDREN'S SILFEDRINE)	QL	
suphedrine sinus cong 30 mg tb (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.
wal-phed 30 mg tablet (NASAL DECONGESTANT)	QL	Limited to 240 EA per 30 days.

Vaginal Anti-infectives		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
3-DAY VAGINAL CREAM *(clotrimazole)*	QL	
clotrimazole-3 2% cream (3-DAY VAGINAL CREAM)	QL	
cvs clotrimazole-3 2% cream (3-DAY VAGINAL CREAM)	QL	
miconazole 2% vaginal cream (MONISTAT 7)	QL,GR	Limited to females only.
miconazole 3 combo pack (MONISTAT 3)	QL,GR	Limited to females only.
miconazole 7 100 mg vag supp (MONISTAT 7)	QL,GR	Limited to females only.
miconazole 7 cream (MONISTAT 7)	QL,GR	Limited to females only.
qc miconazole-7 cream (MONISTAT 7)	QL,GR	Limited to females only.
sm 3-day vaginal cream (3-DAY VAGINAL CREAM)	QL	
sm miconazole 2% vaginal cream (MONISTAT 7)	QL,GR	Limited to females only.
sm miconazole 7 100 mg vag sup (MONISTAT 7)	QL,GR	Limited to females only.
sm miconazole 7 cream (MONISTAT 7)	QL,GR	Limited to females only.

Vitamin Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ANIMAL CHEWS TABLET *(multivitamin)*	QL	
ANIMAL SHAPES CHEWABLE TABLET *(pediatric multivitamin no.17)*	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Vitamin Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
b complex number 1 tablet (BALANCE B-100)	QL	
b complex tablet (BALANCED B-50)	QL	
b-complex plus vitamin c cplt (VITA-BEE WITH C)	QL	
b-complex w-vitamin c caplet (VITA-BEE WITH C)	QL	
b-complex with b12 tablet (BALANCED B-50)	QL	
BEE-ZEE TABLET *(multivitamin with minerals)*	QL	
CENTAMIN LIQUID *(multivitamin with minerals/ferrous gluconate)*	QL	
CENTRUM CHEWABLES ADULTS TAB *(multivitamin with minerals/iron,carbonyl/folic acid/vit k1)*	QL	
CENTRUM COMPLETE MULTIVIT TAB *(multivitamin/ferrous fumarate/folic acid)*	QL	
CENTRUM KIDS CHEWABLE TABLET *(pediatric multivitamin no.180/iron,carbonyl/vit k1)*	QL	
CENTRUM MULTIVIT-MINERAL LIQ *(multivitamin with minerals/ferrous gluconate)*	QL	
CENTRUM SILVER CHEWABLE TABLET *(folic acid/multivit with minerals/lutein)*	QL	
CENTRUM SILVER TABLET *(multivitamin with minerals/folic acid/lycopene/lutein)*	QL	
CENTRUM SILVER ULTRA MEN'S TAB *(multivitamin with minerals/folic acid/lycopene/lutein)*	QL	
CENTURY ADULTS 50 PLUS TABLET *(multivitamin with minerals/folic acid/lycopene/lutein)*	QL	
CENTURY TABLET *(multivitamin/ferrous fumarate/folic acid)*	QL	
CENTURY ULTIMATE WOMEN'S TAB *(multivitamin/ferrous fumarate/folic acid)*	QL	
CEROVITE ADVANCED FORM TAB *(multivitamin/ferrous fumarate/folic acid)*	QL	
CEROVITE JR TABLET CHEW *(pediatric multivitamin no.158/ferrous fumarate/phytonadione)*	QL	
CEROVITE SENIOR TABLET *(multivitamin with minerals/lutein)*	QL	
CERTA PLUS TABLET *(folic acid/multivit with iron, minerals/lutein)*	QL	
CERTAVITE SENIOR TABLET *(multivitamin with minerals/folic acid/lycopene/lutein)*	QL	
CERTAVITE-ANTIOXIDANT TABLET *(multivitamin/ferrous fumarate/folic acid)*	QL	
CHEW-VITES-IRON TABLET CHEW *(multivitamin with iron)*	QL	
CHEWABLE-VITE TABLET *(multivitamin)*	QL	

Drug List

Vitamin Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
CHILD CHEW + IRON TAB CHEW *(multivitamin with iron)*	QL	
CHILD VITAMIN-IRON TAB CHEW *(multivitamin with iron)*	QL	
CHILDRENS CHEW VITAMIN TAB *(multivitamin)*	QL	
COMPLETE MULTIVITAMIN TAB *(multivitamin,therapeutic with iron and minerals)*	QL	
COMPLETE SENIOR TABLET *(multivitamin with iron and other minerals)*	QL	
DAILY VITAMIN + IRON TABLET *(multivitamin with iron)*	QL	
DAILY VITAMIN FORMULA TABLET *(multivitamin)*	QL	
DAILY VITAMIN FORMULA TABLET *(multivitamin with minerals)*	QL	
DAILY VITE TABLET *(multivitamin)*	QL	
DAILY-VITE TABLET *(multivitamin)*	QL	
DAILY-VITES WITH IRON TABLET *(multivitamin with iron)*	QL	
DIALYVITE 800 TABLET *(folic acid/vitamin b complex and vitamin c)*	QL	
eql b complex 50 tablet (VENATON)	QL	
EQL ONE DAILY MEN'S TABLET *(multivitamin with minerals)*	QL	
FLINTSTONES TABLET CHEWABLE *(multivitamin)*	QL	
GUMMI BEAR MULTIVIT TAB CHEW *(multivitamin)*	QL	
HEALTHY EYES TABLET *(beta-carotene(a) w-c and e/lutein/minerals)*	QL	
I-VITE TABLET *(beta-carotene(a) w-c and e/lutein/minerals)*	QL	
MULTI-VITAMIN DAILY TABLET *(multivitamin)*	QL	
MULTILEX T-M TABLET *(multivitamin with minerals/ferrous fumarate)*	QL	
MULTILEX TABLET *(multivitamin with minerals/ferrous sulfate)*	QL	
MULTIPLE VITAMIN TABLET *(multivitamin with folic acid)*	QL	
multiple vitamin with iron tab (DAILY VITAMIN + IRON)	QL	
multiple vitamins tablet (DAILY MULTIPLE VITAMIN)	QL	
multivit-fluor 0.25 mg tab chw	QL,AL	Limited to members age 10 and under.
multivit-fluor 0.5 mg tab chew	QL,AL	Limited to members age 10 and under.
multivit-fluoride 1 mg tab chw	QL,AL	Limited to members age 10 and under.
multivit-minerals tablet (ONE DAILY COMPLETE)	QL	
multivitamins tablet (DAILY VITE)	QL	

Drug List

Vitamin Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
NEPHRO-VITE TABLET *(folic acid/vitamin b complex and vitamin c)*	QL	
OCUVITE WITH LUTEIN TABLET *(beta-carotene(a) w-c and e/lutein/minerals)*	QL	
ONCE DAILY TABLET *(multivitamin)*	QL	
ONCE DAILY WITH IRON TABLET *(multivitamin with iron)*	QL	
ONCOVITE TABLET *(multivitamin,therapeutic)*	QL	
ONE DAILY ESSENTIAL TABLET *(multivitamin)*	QL	
ONE DAILY MULTIVIT-MINERAL TAB *(multivitamin with minerals/ferrous sulfate)*	QL	
ONE DAILY MULTIVITAMIN TAB *(multivitamin)*	QL	
ONE-A-DAY WOMEN'S TABLET *(multivits with calcium and minerals/iron fumarate/folic acid)*	QL	
ONE-DAILY MULTI-VITAMIN TAB *(multivitamin)*	QL	
POLY-VI-FLOR 0.25 MG TAB CHEW *(pediatric multivitamin no.33 with sodium fluoride)*	QL	
POLY-VI-FLOR 0.5 MG TAB CHEW *(pediatric multivitamin no.33 with sodium fluoride)*	QL	
POLY-VI-FLOR 1 MG TAB CHEW *(pediatric multivitamin no.33 with sodium fluoride)*	QL	
POLY-VITAMIN TAB CHEW *(multivitamin)*	QL	
POLYVITAMIN WITH IRON TAB CHEW *(pediatric multivitamin no.156/ferrous fumarate)*	QL	
SM COMPLETE MULTI-VIT-MINERAL *(multivitamin/ferrous fumarate/folic acid)*	QL	
SM COMPLETE SENIOR FORMULA TAB *(multivitamin with iron and other minerals)*	QL	
SM COMPLETE SENIOR FORMULA TAB *(multivitamin with minerals/folic acid/lycopene/lutein)*	QL	
sm multivitamin w-iron tab (DAILY VITAMIN + IRON)	QL	
sm multivitamins tablet (DAILY VITE)	QL	
SM OPTI-VITAMIN TABLET *(beta-carotene (a) w-c and e/lutein/minerals)*	QL	
SM SUPER B COMPLEX-C CAPLET *(b-complex with vitamin c)*	QL	
SM THERAPEUTIC M TABLET *(multivit,therapeutic with calcium,iron,minerals/folic acid)*	QL	
STRESS FORMULA TABLET *(multivitamin,stress formula)*	QL	
STRESS FORMULA WITH ZINC TAB *(multivitamin,stress formula/zinc)*	QL	

Drug List

Vitamin Combinations		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
SUPER THERA VITE M TABLET *(multivitamin,therapeutic with minerals)*	QL	
TAB-A-VITE MULTIVIT WITH IRON *(multivitamin/ferrous sulfate/folic acid)*	QL	
TAB-A-VITE TABLET *(multivitamin with folic acid)*	QL	
THERA CAPLET *(multivitamin,therapeutic)*	QL	
THERA M PLUS TABLET *(multivits with calcium and minerals/iron fumarate/folic acid)*	QL	
THERA TABLET *(multivitamin with folic acid)*	QL	
THERA-M CAPLET *(multivit,therapeutic with calcium,iron,minerals/folic acid)*	QL	
THERA-M CAPLET *(multivitamin,therapeutic with iron and minerals)*	QL	
THERA-M TABLET *(multivits with calcium and minerals/iron fumarate/folic acid)*	QL	
THERA-TABS CAPLET *(multivitamin,therapeutic)*	QL	
THERAPEUTIC-M CAPLET *(multivits with calcium and minerals/iron fumarate/folic acid)*	QL	
THEREMS TABLET *(multivitamin,therapeutic)*	QL	
tri-vit-fluor 0.25 mg/ml drop (TRI-VITE WITH FLUORIDE)	QL,AL	Limited to members age 10 and under.
tri-vit-fluor 0.5 mg/ml drop	QL,AL	Limited to members age 10 and under.
tri-vit-fluor-iron 0.25 mg/ml (TRI-VI-FLOR W/IRON)	QL,AL	Limited to members age 10 and under.
UNICOMPLEX-M TABLET *(multivitamin with iron and other minerals)*	QL	
vitamin and minerals tablet (SUPER THERAVITE-M)	QL	
vitamin b complex tablet (BALANCE B-100)	QL	

Vitamins		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
ascorbic acid 500 mg tablet (CEVALIN)	QL	
b-1 100 mg tablet (VITAMIN B-1)	QL	
b-12 5,000 mcg sublingual tab	QL	
c-500 mg tablet (SOOTHING PUREWAY-C)	QL	
cvs b-1 100 mg tablet (VITAMIN B-1)	QL	
cvs vit c-rose hips 500 mg tab (SOOTHING PUREWAY-C)	QL	
cvs vitamin b-1 100 mg tablet (VITAMIN B-1)	QL	
cvs vitamin b-6 100 mg tablet (VITAMIN B-6)	QL	
cvs vitamin c 250 mg tablet (CEVALIN)	QL	
cvs vitamin c 500 mg caplet (SOOTHING PUREWAY-C)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Vitamins		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
cvs vitamin c 500 mg tablet (CEVALIN)	QL	
folic acid 1,000 mcg tablet (FOLACIN-K)	QL	
gnp vitamin b-1 100 mg tablet (VITAMIN B-1)	QL	
gnp vitamin b-6 100 mg tablet (VITAMIN B-6)	QL	
gnp vitamin d3 1,000 unit tab	QL	
gnp vitamin d3 25 mcg tablet	QL	
niacin 100 mg tablet (B-3 NIACIN)	QL	
niacin 500 mg capsule sa (NICOTINIC ACID)	QL	
niacin 500 mg tablet (NIACOR-B3)	QL	
niacin er 500 mg capsule (NICOTINIC ACID)	QL	
niacin sa 250 mg capsule (NIACIN)	QL	
niacin tr 250 mg capsule (NIACIN)	QL	
niacin tr 500 mg caplet (ENDUR-ACIN)	QL	
niacin tr 500 mg capsule (NICOTINIC ACID)	QL	
niacin tr 500 mg tablet (ENDUR-ACIN)	QL	
pyridoxine 25 mg tablet (HEXA-BETALIN)	QL	
pyridoxine 50 mg tablet (HEXA-BETALIN)	QL	
sm vit c-rose hips 500 mg tab (SOOTHING PUREWAY-C)	QL	
sm vitamin b-1 100 mg tablet (VITAMIN B-1)	QL	
sm vitamin b-6 100 mg tablet (VITAMIN B-6)	QL	
sm vitamin c 250 mg tablet (VITAMIN C)	QL	
sm vitamin c 500 mg tablet (SOOTHING PUREWAY-C)	QL	
sm vitamin d3 1,000 unit tab	QL	
sv vit c-rose hips 500 mg tab (SOOTHING PUREWAY-C)	QL	
thiamine 100 mg tablet (VITAMIN B-1)	QL	
v-r vitamin c 500 mg tablet (SOOTHING PUREWAY-C)	QL	
vit c-rose hips 500 mg tablet (SOOTHING PUREWAY-C)	QL	
vitamin a 10,000 unit capsule (NATURAL A FISH LIVER OIL)	QL	
vitamin b-1 100 mg tablet	QL	
vitamin b-1 100 mg tablet (VITAMIN B-1)	QL	
vitamin b-1 50 mg tablet (VITAMIN B-1)	QL	
vitamin b-12 5,000 mcg tab sl (B-12)	QL	
vitamin b-6 100 mg tablet (VITAMIN B-6)	QL	
vitamin b-6 25 mg tablet (VITAMIN B-6)	QL	
vitamin b-6 50 mg tablet (VITAMIN B-6)	QL	
vitamin c 250 mg tablet (VITAMIN C)	QL	

SP Specialty Medication	**PA** Prior Authorization Required	**ST** Step Therapy Required	**DS** Days Supply Limit	**FL** Fill Limit	**QL** Quantity Limit	**GR** Gender Restriction	**AL** Age Limit

Drug List

Vitamins		
Drug Name	**Drug Status**	**Criteria**
Supplemental Coverage		
vitamin c 500 mg tablet (CEVALIN)	QL	
vitamin c 500 mg tablet (SOOTHING PUREWAY-C)	QL	
vitamin c-500 mg tablet (SOOTHING PUREWAY-C)	QL	
vitamin d-400 tablet (DELTA D3)	QL	
vitamin d3 1,000 unit tablet	QL	
vitamin d3 10 mcg(400 unit)/ml (JUST D)	QL	
vitamin d3 10 mcg/ml liquid (JUST D)	QL	
vitamin d3 25 mcg tablet	QL	
vitamin d3 400 unit tablet (DELTA D3)	QL	
vitamin d3 400 unit/ml liquid (JUST D)	QL	